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RETIREMENT & ESTATE PLANNING BULLETIN

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RETIREMENT & ESTATE PLANNING BULLETIN

Walking the line — a broad analysis of the recent decisions of *Hunter* and *Brightwater*

Roshaan Singh Raina *TRESSCOX LAWYERS*

The conflicting interests of a competent adult's right to self-determination (the right to control one's own body) and the interests of the state in preserving the lives of their patients has now become a matter at the forefront of health law.

This contest has been considered in different capacities in the recent decisions of *Brightwater Care Group (Inc) v Rossiter*[1] and *Hunter and New England Area Health Service v A*[2], both of which were handed down in August 2009.

Advance care directives

A person may make an "advance care directive" which specifies the medical treatment they wish (or do not wish) to receive — such as blood transfusions. If an advance care directive (ACD) made by a capable adult is clear and unambiguous, and extends to the situation at hand, it must be respected.

By their very nature, ACDs are prepared in relation to future medical treatment. The scenario in *Hunter* provides a factual matrix which is becoming increasingly prevalent, and health professionals are encouraged[3] to turn to the courts for judicial declarations as to the applicability and validity of ACDs. There is a particular reliance on the common law in this regard: the use of ACDs has not been legislated in the State of NSW at the time of the publication of this article.

Hunter and New England Area Health Service v A

Mr A, a Jehovah's Witness, had been admitted to the emergency department in a critical state with a decreased level of consciousness. His condition later deteriorated, resulting in renal failure. He was kept alive by mechanical ventilation and kidney dialysis.

The hospital later became aware of an ACD prepared one year earlier, which indicated Mr A would refuse dialysis. The absence of dialysis would undoubtedly hasten his death. The hospital sought a judicial declaration to determine the validity of the ACD given by Mr A.

The court noted that ACDs are not always executed by legal professionals, and that:

> the court must feel a sense of actual persuasion that the individual acted freely and voluntarily, and intended his or her decision to apply to the situation at hand.[4]

The court reaffirmed that a direction to refuse medical treatment (by a patient with capacity) did not have to be sensible, rational or well considered.[5] Even a direction lacking any apparent justification must be respected — regardless of how unwise those choices may appear to others.[6]

Unless the presumption of capacity is rebutted, or there is evidence which would result in a vitiation of that consent (eg undue influence; the terms of consent were ambiguous; or no proper explanation of the medical treatment was provided despite adequate opportunity to do so), the individual's right must be respected.

The individual's right to self-determination may be judicially overridden in exceptional circumstances: to deal with a widespread and dangerous threat to the population at large;[7] or where the exercise of the individual's right would lead to the death of a viable foetus.[8]

Treatment may also be administered when it is not practicable to obtain consent.[9] This "emergency principle" also applies where there was a reasonable basis[10] for doubting the validity and applicability of an ACD. These principles extend beyond medical practitioners — and apply to anyone who may administer medical treatment, ambulance officers and paramedics.[11]

In this instance, the Supreme Court of NSW declared the ACD was valid. Justice McDougall clarified from the outset that this case was not concerned with the "right to die" — but the recognition of Mr A's right to refuse medical treatment.[12]

Brightwater Care Group (Inc) v Rossiter

Brightwater was decided in WA on 14 August 2009, not a fortnight after *Hunter*.[13]

Mr Rossiter suffered a number of serious injuries over the course of 20 years in four notable incidents, the last of which culminated in spastic quadriplegia. In the course of his medical treatment, he was eventually transferred to the Brightwater facility, which provided residential care for disabled individuals. Mr Rossiter had been a resident at that facility since 4 November 2008.

Mr Rossiter was unable to take nutrition or hydration orally on account of his quadriplegia. The nutrition and hydration required was provided by way of a percutaneous endoscopic gastronomy (PEG) tube, which had been surgically inserted directly into his stomach.

Despite his physical disabilities, Mr Rossiter was not terminally ill — nor was he dying. If the services provided by Brightwater continued, he would have lived on for many years. His mental faculties remained intact. The court noted he was capable of making reasoned decisions in respect of his future medical treatment.[14]

Mr Rossiter had "clearly and unequivocally" indicated to the representatives of Brightwater that he wished to die on many occasions.[15] As he lacked the physical capacity to bring about his own death, he directed the staff at Brightwater to discontinue the provision of nutrition and general hydration[16] through the PEG.

Mr Rossiter was aware that he would die from starvation if nutrition and hydration was no longer administered through the PEG.[17]

A guardianship order, which was previously in place, had been revoked prior to the Supreme Court proceedings. Therefore, there was no question of other persons making decisions on Mr Rossiter's behalf. Both parties sought judicial declarations as to their respective rights and obligations.

In particular, Brightwater sought relief in respect of potential criminal prosecution[18] that might arise as a result of compliance with Mr Rossiter's directions. While this article will not delve into a detailed analysis of those statutory provisions, it is notable that this particular issue, in the author's opinion, was justly resolved in favour of the right to self-determination.

Hunter distinguished

Chief Justice Martin distinguished *Hunter* on the question of the extent to which an individual's decision to refuse consent to treatment must be an informed decision[19] — noting that Mr Rossiter had the capacity to receive and consider the information he was given, and to make informed decisions after considering that information.[20] His Honour expressed doubts as to whether Mr Rossiter had been fully informed on the physiological consequences of starvation and included, in the declaration, a discreet requirement that Mr Rossiter be given advice by "an appropriately qualified medical practitioner as to the consequences which would flow".[21]

The author cannot reconcile this approach with established case law[22] (cited with approval in *Hunter*) which states that a direction lacking any apparent justification must be respected, no matter how unwise it may appear to others.

The author submits, with respect, that an individual's consent to or refusal of medical treatment should not need to be predicated with qualified medical opinion before being judicially validated. To do otherwise would only serve to frustrate the social, religious or moral values which underpin the direction in question.[23]

On this basis, the extent of Mr Rossiter's knowledge regarding the physiological consequences of the withdrawal of treatment should not have been called into question, even though he was fully conscious at the time he provided his direction and hence capable of receiving information (in contrast to typical cases involving ACDs, where the patient presents in an unconscious state).

His Honour declared that if Mr Rossiter maintains his direction (for the refusal of general hydration and nutrition), even after receiving qualified medical advice regarding the consequences of such treatment (ie starvation), then Brightwater could not lawfully continue to administer nutrition and hydration unless Mr Rossiter revoked that direction. Simply put, the direction sought by Mr Rossiter was within his rights to request.

Further, it was declared that the provision of palliative care to Mr Rossiter would not result in criminal liability, despite the fact that the need for palliative care resulted from the direction which withdrew treatment to sustain his life.[24]

Walking the line

Chief Justice Martin, in what appears to be judicial de rigueur in such matters, opened his judgment with the following:

> [it] is important to emphasise at the outset what this case is not about. It is not about euthanasia. Nor is it about physicians providing lethal treatments to patients who wish to die. Nor is it about the right to life or even the right to death...[25]

His Honour later reiterated the illegality for any person, including a health professional, to administer medication for the purpose of causing or hastening the death of another person.[26]

While Hunter and Brightwater can be factually distinguished on a number of grounds, both cases recognise the following right:

> [that a] competent adult is generally entitled to reject a specific treatment or all treatment, or select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community ... it is the patient who has the final say on whether to undergo the treatment.[27]

The traditional concept of euthanasia is often associated with the administration of treatment to end the life of an individual (ie lethal injection) and not the passive act of the withdrawal of treatment. The author submits that allowing an individual to refuse medical treatment which results in death does not equate to a judicial step towards the legalisation of euthanasia.

Instead, both cases rightfully reaffirm the individual's right to self-determination and, to a thinly veiled extent, the right to dictate the terms of our departure.

Roshaan Singh Raina
<roshaan_raina@tresscox.com.au>
Solicitor,
TressCox Lawyers
<www.tresscox.com.au>

Footnotes

1. *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229; BC200907548.
2. *Hunter and New England Area Health Service v A* [2009] NSWSC 761; BC200907152.
3. *Re T* [1992] EWCA Civ 18 at [37].
4. Above, n2, at [37].
5. *Re T* [1992] EWCA Civ 18 at [37].
6. *Malette v Shulman* (1990) 72 OR (2d) 417; 67 DLR (4th) 321 at 328; [1991] 2 Med LR 162.
7. Id at [17].
8. Above, n3, at [3]; *In re* AC 573 A 2d 1235 (1990).
9. Id at [5].
10. Ibid.
11. Above, n2, at [41].
12. Id at [4].
13. The decision in *Hunter* was handed down on 6 August 2009.
14. Above, n1, at [14].
15. Id at [11].
16. General hydration was taken to exclude the necessary hydration to dissolve painkillers, the prescription of which Mr Rossiter wished to be maintained throughout the refusal of nutrition and hydration.
17. There was an ancillary issue regarding the degree of advice given to Mr Rossiter on the effects of starving to death. This was addressed by Martin CJ in His Honour's declaration.
18. Importantly, Martin CJ noted that declarations are not generally made in respect of the criminality of conduct which has already taken place — to do so would usurp the criminal process and the possible role of the jury.
19. Above, n1, at [28].
20. Id at [29].
21. Id at [58].
22. *Malette v Shulman* (1990) 72 OR (2d) 417; 67 DLR (4th) 321 at 328; [1991] 2 Med LR 162; *Sidaway v Board of Governors of the Bethlem Royal Hospital & Maudsley Hospital Board* [1985] AC 871; [1985] 1 All ER 643; [1985] 2 WLR 480; *Airedale National Health Service Trust v Bland(Tony Bland's case)* [1994] 1 FCR 531; [1993] AC 789; [1993] 1 All ER 821; [1993] Crim LR 877.
23. Above, n2, at [14].
24. Above, n1, at [55].
25. Id at [2].
26. Id at [54].
27. Above, n6, at 328.