RE HERRINGTON: ABORIGINALITY AND THE QUALITY OF HUMAN RIGHTS JURISPRUDENCE IN END-OF-LIFE DECISIONS BY THE AUSTRALIAN JUDICIARY

In Re Herrington [2007] VSC 151 (King’s Case) the partner and family of an Aboriginal woman (diagnosed as being in a persistent vegetative state after an accident) sought an order from the Victorian Supreme Court that the decision of her treating doctors to withhold further medical treatment be opposed. The resultant judicial decision contains a very brief review of the now considerable case law in this area, does not mention the increasingly important role of clinical ethics committees in this context, or discuss the relevance of recently passed human rights legislation in Victoria. Given the statutory requirement for judicial reference to international human rights norms in jurisdictions such as Victoria and the Australian Capital Territory, and their increasing importance in other developed nations, the authors highlight the need for the Australian judiciary to lift the quality of their jurisprudence in relation to end-of-life cases.

INTRODUCTION

Ms Rosalie King, an Aboriginal woman of undisclosed age, suffered substantial hypoxic brain damage as a result of an accident, and was subsequently diagnosed as being in a persistent vegetative state (PVS). Six months later, against the wishes of her partner and family, medical practitioners at a Victorian hospital made a decision to refuse further medical treatment and continue only with palliative care. This action was brought by Ms partner (Mr Herrington) and family. They asked the Supreme Court of Victoria to exercise its parens patriae jurisdiction to order that medical treatment be resumed on the basis that it was in Ms King’s best interests.

The facts of Re Herrington [2007] VSC 151 (King’s Case) are becoming familiar to Australian courts. Since the landmark English decision of Airedale NHS Trust v Bland [1993] AC 789 (Bland), the legal framework relating to the refusal of medical treatment has been frequently discussed and considerably developed by Australian courts, apart from the High Court. These cases generally involved patients diagnosed as PVS, with the withdrawal of their medical treatment (most commonly a feeding tube) being the issue for the court to decide. Yet it seems that the reasoning of Australian judges (and by implication the quality of advocacy before them) in such cases continues to inadequately reflect the depth of this evolving jurisprudence and in particular its connection with international human rights norms, even taking into account the hurried nature of such applications. The issue becomes more acute when the relevant jurisdiction introduces legislation requiring judicial reference to international human rights norms, as Victoria has recently.

CLINICAL OPINION: A SILENT SCREAM

Re Herrington concerned an application for the recommencement of medical treatment of Ms King, by her partner Mr Herrington. Ms King suffered a hypoxic arrest and subsequently substantial hypoxic brain damage as a result of an accident in October 2006. She was admitted to the Royal Melbourne Hospital, and a month later moved to a private rehabilitation facility.

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The court accepted evidence from Dr Silvester, an intensive care specialist, who visited the facility in February and watched as she was examined by a member of staff, where “she demonstrated to him all the signs of being in a persistent vegetative state” (at [6]). At this point, she was being fed through a naso-gastric tube, which was later replaced by a percutaneous endoscopic gastrostomy (PEG) tube. Over the next few months Ms King’s condition deteriorated, and she was periodically admitted to hospital for various reasons, including a chest infection, staphylococcal septicaemia and an obstructed right kidney.

She was subsequently examined by a neurologist who concluded that she showed “no evidence of a meaningful response to the environment … [and] that this was consistent with a vegetative state” (at [10]). However, it was also noted that the neurologist, as with many of the medical experts, had only seen Ms King once. Evidence was also accepted from Dr Silvester regarding the rehabilitation specialist’s diagnosis, which confirmed PVS and rejected any chance Ms King had of recovery.

In early April 2007, a decision was made to remove Ms King’s PEG feeding tube due to concerns about vomiting. The treating clinicians informed the family that in their opinion the most appropriate course of action was palliative care, which would result in the cessation of her feeding, blood examinations, and antibiotics for the various infections she was still fighting. Dr Silvester’s opinion supported this, as he believed that “if she were to be given fluid treatment for re-hydration, she could suffer from pulmonary oedema or infection as a result” (at [13]). The judge accepted his evidence that “Ms King’s body is in a rigid position with her legs crossed, making her personal care very difficult for those looking after her and resulting in their actions causing her discomfort”. Williams J also accepted that “Dr Silvester perceived her to grimace in a silent scream when pressure was applied to her body” (at [13]).

The judge additionally accepted expert opinion alleging that any attempt to treat Ms King would not preserve her life, and may even hasten her death, and that the administration of fluids “would have no favourable outcome … [and] would be futile” (at [15]). Regarding the medical evidence, Williams J concluded that “there would be no clinical justification for the administration of any treatment, other than by way of palliative care” (at [16]).

**The partner’s parens patriae submission**

Mr Herrington, Ms King’s partner, asked the court to exercise its parens patriae jurisdiction and order that treatment of Ms King be recommenced. He submitted that he had been with her in the hospital every day, and “believes that she does show signs of responding to him by blinking and moving her head. He feels that he has observed her more than the medical staff have done, because he has been constantly by her side” (at [17]). He also said that it would be contrary to Ms King’s wishes to have her treatment suspended, an opinion voiced also by both her mother and father. Mr Herrington also noted that he would have liked to see an independent examination of Ms King (which did not occur) as he believed that the doctors could be wrong.

Williams J very briefly discussed affidavits filed by Ms King’s parents and social worker, which concern the Aboriginal cultural approach to these issues, particularly illness and continuation of treatment. This included the belief that, regardless of illness, people should be cared for and never be left to die. Mr King’s evidence showed that he wanted “her to be given food and drink in accordance with Aboriginal cultural values” (at [18]). Mrs King also pointed out that “Aboriginal culture involves caring for people who are unwell” (at [18]).

**Williams J’s decision**

Recognising that the exercise of the parens patriae jurisdiction requires the court to “act in the best interests of her health and welfare in all the circumstances, responding to the situation with which it is confronted” (at [22]), Williams J concluded (at [24]):

I am satisfied by the only evidence before me that it would not be in Ms King’s interests to recommence any treatment involving the administration of fluids … The only evidence before me is that it is the universal opinion of the medical witnesses that that treatment would be futile and, possibly, that it would have the effect of hastening her inevitable death. They also believe that Ms King is likely to
suffer unwarranted pain and indignity from any further treatment measures.

Regarding the submissions of the applicant, Williams J simply stated (at [23]): “I have considered everything said about the cultural values of Aboriginal society by them and by the social worker.” Applying Bland, Williams J concluded that it would not be reasonable to continue treatment “when it would serve no therapeutic purpose” (at [24]).

**CRITIQUE**

This case is of interest as it is one of the few that address the difficult area of end-of-life decisions in the Australian context and for a patient of Aboriginal culture. It is also of great concern as the judge apparently failed to consider the complex body of relevant legislation and case law that has developed in Australia and internationally. While the ultimate finding may have been correct and proper, the argument is made here that a much more thorough analysis of medical ethics, health law, international human rights and relevant aspects of indigenous culture should be undertaken by judges in making such important decisions.

**Failure to consider relevant cases and legislation**

This area of law has experienced significant development since the Bland case. Contrary to the finding of Williams J, it is still far from providing one definitive formulation of the law on end-of-life decision-making. Over the last seven years, Australian State Supreme Courts have had the opportunity to address end-of-life issues and to begin to develop Australian jurisprudence in this field. While largely maintaining the principles of Bland, the decisions have also shown that each case is fraught with individual complexities affected by evolving guidelines and legislation.

While there is still no High Court authority on this issue, the Supreme Court cases of Northridge v Central Sydney Area Health Service (2000) 50 NSWLR 549; [2000] NSWSC 1241; Gardner; Re BWV (2003) 7 VR 487; [2003] VSC 173; and Messiha (by his tutor) v South East Health [2004] NSWSC 1061 provide persuasive and thorough accounts of the Australian position of the law. Recent literature supports the notion that many principles from these cases currently represent the law in Australia.

Yet Williams J in Re Herrington made only a brief mention of the main principle of Bland. The judge made no reference to Australian case law, clinical guidelines or other relevant legislation such as the Medical Treatment Act 1988 (Vic), the Guardianship and Administration Act 1986 (Vic), the Crimes Act 1958 (Vic), the Health Professions Registration Act 2005 (Vic) or the Charter of Human Rights and Responsibilities Act 2006 (Vic). Furthermore, no consideration was given to the recent United Kingdom case of R (Burke) v General Medical Council (Official Solicitor and Others Intervening) [2006] QB 273 (Burke) which was later reaffirmed by the European Court of Human Rights (ECHR). This latter case would have been particularly relevant here as it also concerned a request to prolong (rather than withdraw) medical treatment, and is considered highly persuasive authority for Australian courts.

It may be that the way in which the case was argued was a factor. Williams J appeared to identify the inherent nature of the parens patriae jurisdiction (at [22]) as requiring that the court look after those who are incapable of doing so for themselves, by prioritising in a broad sense their best

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3 Thiagarajan, Savulescu and Skene, n 3 at 583.

4 Burke v United Kingdom (unreported, ECHR, No 19807/06, 11 July 2006).

5 Thiagarajan, Savulescu and Skene, n 3 at 583.
interests. However, with respect, this does not, and cannot, justify a failure to consider relevant legislation, guidelines and cases. In *Gardner; Re BWV* (2003) 7 VR 487; [2003] VSC 173, Morris J supported this point of view in relation to the application of Victorian guardianship and administration laws. He found (at [99]-[101]):

> Although the parens patriae jurisdiction of the Court is of considerable historical interest, I doubt if it should play any current role in the day to day administration of guardianship matters. Victoria has comprehensive laws in relation to guardianship and administration matters … The fact that a type of reserve power exists provides no logical justification for bypassing the *Guardianship and Administration Act* and the *Medical Treatment Act* … It is clearly not the intention of parliament that the usual method whereby an agent might refuse medical treatment on behalf of a patient who is dying be one where the agent seeks to invoke either the common law jurisdiction or the parens patriae jurisdiction of the Supreme Court. Further, the parliamentary debates demonstrate that recourse to the Supreme Court was seen as problematic: for reasons of cost, delay and emotional trauma to the families concerned.

With the greatest respect, neither the urgency of the application or the apparently questionable quality of argument by counsel can adequately justify Williams J failing to take into account relevant Victorian legislation in this case.

**The human rights dimension**

In determining whether treatment can be withdrawn, the distinction between medical treatment and palliative care must first be made. This is particularly important in the context of the *Medical Treatment Act 1988* (Vic) which makes this distinction and only allows refusal of medical treatment, not palliative care. In considering this issue, the *Charter of Human Rights and Responsibilities Act 2006* (Vic) needed to be (but was not) addressed by Williams J.

The latter Act came into force on 25 July 2006. It requires all Victorian statutory provisions to be interpreted in a way that is compatible with human rights. The type of care provided will be relevant to particular rights outlined in the Act, such as the protection from cruel, inhuman or degrading treatment (s 10). Whether medical treatment falls within this category may have been a major issue here. One example would be if palliative care measures (as distinguished from medical treatment under s 3 of the *Medical Treatment Act 1988* (Vic)) as recommended by the patient’s doctors, were against the Aboriginal cultural beliefs of the patient or her relatives related to caring for the unwell (continuation of food and nutrition being an important aspect in such circumstances) (at [18]). In *Re Herrington*, Williams J accepted the medical professionals’ definitions of medical treatment and palliative care without engaging in a more thorough analysis of whether Aboriginal cultural values and related human rights were being breached by removing not only medical treatment but also hydration and nutrition.

Williams J affirmed having “considered everything said about the cultural values of Aboriginal society” (at [6]) before he refused the application made on behalf of Ms King. Yet the judge failed to consider that the *Charter of Human Rights and Responsibilities Act 2006* (Vic) also requires a consideration of Aboriginal cultural rights (s 1). Given this statutory requirement, it would appear that

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6 *Secretary, Department of Health and Community Services v JWB & SMB (Marion’s Case)* (1992) 175 CLR 218 at 260 (Mason CJ, Dawson, Toohey and Gaudron JJ).

7 For the purposes of the *Medical Treatment Act 1988* (Vic), medical treatment is defined in s 3 to be the “means of carrying out: (a) an operation; or (b) the administration of a drug or other like substance; (c) any other medical procedure – but does not include palliative care.” Palliative care, also defined at s 3, includes: “(a) the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or (b) the reasonable provision of food or water.”


9 “Protection from torture and cruel, inhuman or degrading treatment: A person must not be – (a) subjected to torture; or (b) treated or punished in a cruel, inhuman or degrading way; or (c) subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.”
there was a greater onus on Williams J to explain in greater detail the content of those rights and why the judge decided they were not being infringed by any particular interpretation of the relevant legislation in this case.

Specifically, in considering the wishes of the patient and family, the following provisions of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) are now prima facie relevant to the interpretation of legislation such as the *Medical Treatment Act 1988* (Vic), the *Guardianship and Administration Act 1986* (Vic), the *Crimes Act 1958* (Vic) and the *Health Professions Registration Act 2005* (Vic) in cases involving the right to life (s 9) and the protection from cruel or inhuman or degrading treatment (s 10). Section 32(2) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) also provides that “International law and the judgments of domestic, foreign and international courts and tribunals relevant to a human right may be considered in interpreting a statutory provision”.

The right to life (s 9 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic)) is particularly apposite in this context. In *Gardner; Re BWV*, Morris J approached this question by recognising that the sanctity of life is “a fundamental principle of every civilised society” (at [42]). He drew on common law rights and general societal values to establish the existence of the right to life. This right also exists at international law in Conventions to which Australia is a party.\(^{10}\) While having no direct influence on Australian law, it has been argued that the wording in some of the Conventions, eg reference to the “inherent” right to life in Art 6(1) of the *International Covenant on Civil and Political Rights* (ICCPR) suggests that the right may be part of international customary law.\(^ {11}\) From whichever source the right is seen to arise, the right to life forms the basis of any human rights framework. However, as acknowledged by Hoffmann LJ in *Bland* (at 826), it is only one of a number of principles which need to be considered, including the right of self-determination or autonomy and dignity.

It would also have been relevant for Williams J to consider the recent United Kingdom decision of *Burke* mentioned earlier. This decision clearly established that while a patient has a right to refuse treatment, this does not give the patient a right to demand treatment which the medical professionals believe is inappropriate (at [31]), which reflects the common law position. This supports the final outcome of *Re Herrington*, but must, of course, be interpreted in light of the legislation in Victoria.

The *Charter of Human Rights and Responsibilities Act 2006* (Vic) also requires consideration of cultural rights (s 19). Of particular relevance here is s 19(2):

> Aboriginal persons hold distinct cultural rights and must not be denied the right, with other members of their community –
> (a) to enjoy their identity and culture; and
> (b) to maintain and use their language; and
> (c) to maintain their kinship ties; and
> (d) to maintain their distinctive spiritual, material and economic relationship with the land and waters and other resources with which they have a connection under traditional laws and customs.

This provision supports the view that, when considering the dignity of an Aboriginal patient, and what may constitute cruel, inhuman or degrading treatment, a judge should take into account Aboriginal cultural beliefs. Part of this process of analysis will require recognition that as the concepts of illness, life and death may differ, so will the approaches to human dignity and the measures which must be taken to preserve these rights.\(^ {12}\) Although the judge affirmed having considered the applicant’s submissions, it does not appear that Williams J has given any weight to Aboriginal cultural

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\(^{10}\) For example see Art 6(1) of the *International Covenant on Civil and Political Rights* (ICCPR) and Art 3 of the *Universal Declaration of Human Rights* (UDHR).


considerations in considering the dignity of the patient through the lens of international human rights as required by the Charter of Human Rights and Responsibilities Act 2006 (Vic). In fact, the judge bases the decision on evidence from the medical experts, noting (at [24]):

The only evidence before me is the universal opinion of the medical witnesses that treatment would be futile ... They also believe that Ms King is likely to suffer unwarranted pain and indignity from any further treatment measures.

Medical opinion remains an inappropriate basis for decisive determination of the mixed clinical and normative issue of what constitutes respect for human dignity.

In Bland, in considering the issue of dignity, Hoffmann LJ found that “it is wrong for someone to be humiliated or treated without respect for his value as a person” (at 826). Hoffmann LJ also found that Anthony Bland had an interest in the manner of his life and death, and that this should be respected. The court recognised that a PVS person’s dignity should also be considered in light of the effect an end-of-life decision will have on family members – who will be the most directly affected. Lord Brown-Wilkinson in Bland discussed this in light of the illegality of euthanasia (at 878):

How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by lethal injection, thereby saving his family from yet another ordeal to add to the tragedy that has already struck them? I find it difficult to find a moral answer to that question. But it is undoubtedly the law.

While this situation is still the law in Australia regarding positive euthanasia, the Victorian Parliament has recognised the importance of the views of family members in other situations (including PVS patients) and enacted legislation accordingly through the Guardianship and Administration Act 1986 (Vic). Consequently, any end-of-life decisions should now be made in accordance with this legislation (or the equivalent in a different State).

Best interests of the patient

Though Williams J does make reference to Ms King’s “best interests” (the common law test referred to in Bland’s case), the judge does not clearly address this in any particular context. While correctly citing the Bland case as authority for the opinion that “it would not be reasonable to administer treatment, even if it would prolong Ms King’s life for a few days, when it would serve no therapeutic purpose”, the judge makes no reference to what the meaning of this test may be, if accepted at all, in Australia. As previously discussed, Australia had developed its own position through case law since the Bland judgment.

While the United Kingdom position has remained with the objective “best interests” standard, suggestions have been made that, following the decision in Gardner; Re BWV and the enactment of legislation such as the Medical Treatment Act 1988 (Vic), Australia has also incorporated aspects of the more subjective United States “substituted judgment” approach (particularly where there is a clear statement or record of the patient’s wishes). Nonetheless, the United Kingdom “best interests” test is still a complex process, requiring consideration of broader principles than just the futility of treatment.

It is accepted that it is the role of Parliament, and not the courts, to discuss the wider ethical issues arising in these cases. In Bland, Lord Mustill expressed concern about the ability of courts to deal with such matters appropriately, suggesting:

The whole matter cries out for exploration by Parliament and then for establishment by legislation not only of a new set of ethically and intellectually consistent rules, distinct from the general criminal law,
but also a sound procedural framework within which the rules can be applied to individual cases.\textsuperscript{16} As discussed earlier, and recognised in \textit{Gardner; Re BWV}, the Victorian Parliament has now done exactly this, and provided comprehensive legislation dealing with this area of law. Of particular importance here is the \textit{Guardianship and Administration Act 1986} (Vic) which provides not only for officially appointed guardians, but also for situations where this had not occurred, such as in the present case. Section 37(1) of the Act sets out a hierarchy of people who can be “responsible” for a patient who is incapable of giving consent, including, under s 37(1)(f), “the patient’s spouse or domestic partner”. Subsequent sections then allow the person responsible to consent to medical treatment for the patient.

The legislation also expressly addresses “best interests” in s 38, providing a number of matters which must be taken into account in determining whether medical treatment would be in the best interests of a patient. These are:

(a) the wishes of the patient, so far as they can be ascertained; and
(b) the wishes of any nearest relative or any other family members of the patient; and
(c) the consequences to the patient if the treatment is not carried out; and
(d) any alternative treatment available; and
(e) the nature and degree of any significant risks associated with the treatment or any alternative treatment; and
(f) whether the treatment to be carried out is only to promote and maintain the health and well-being of the patient; and
(g) any other matters prescribed by the regulations.

The enactment of this section by the Victorian Parliament clearly intends to provide a legislative approach to considering the best interests of the patient. It is quite a significant step away from the purely objective United Kingdom position as it requires consideration of the relatives’ wishes, as well as any evidence of what the wishes of the patient may have been – which appears to be much closer to the United States substituted judgment test. This parliamentary intention is reflected in the second reading speeches of the amending Bill (\textit{Guardianship and Administration (Amendment) Bill 1999} (Vic)), where it was noted that “given that we are moving into the 21st century, it is claimed more often that citizens should decide what treatment they will undergo: they consider the issues, seek advice and question doctors more than they did 10, 15 or 20 years ago.”\textsuperscript{17}

The case of \textit{Northridge v Central Sydney Area Health Service} (2000) 50 NSWLR 549; [2000] NSWSC 1241 is an example where the diagnosis of PVS was in fact found to be incorrect, as the patient later recovered. In that case, the diagnosis was made after just days, and medical evidence in that case was far less convincing. However, evidence from an expert witness was adduced to show that members of the family are often acute observers of changes in the patient, and are a valuable source of information which should not be overlooked. O’Keefe J accepted the expert’s view that “it is a fallacy to assume that family members are not capable of noting the early minute changes which often occur in patients” (at [52]).

\textbf{Standard of care and liability of health professionals}

As well as the consideration of relevant legislation, medical practice guidelines often address end-of-life issues and give guidance in addressing the question. For example, the Australia and New Zealand Intensive Care Society (ANZICS) has issued a “statement on withholding and withdrawing treatment”\textsuperscript{18} (valid until 2008) which provides a list of principles, including:

The ethical principles which inform medical practice include respect for human life and dignity, patient autonomy, justice, beneficence and non-maleficence. These principles are sometimes in conflict. Resolution of such conflict depends on the particulars of the situation, including the likely patient outcome, and the philosophical viewpoints of those involved.

\textsuperscript{16}Airedale NHS Trust v Bland [1993] AC 789 at 891.
\textsuperscript{17}Victoria, Legislative Assembly, \textit{Hansard}, May 1999, Ms Campbell (Pascoe Vale).
There is no obligation to initiate therapy known to be ineffective, or to continue therapy that has become ineffective. Further paragraphs also refer to the fact that the decision-making process should involve the family and relatives, and that if agreement between the medical professionals and family cannot be reached, recourse should be had to clinical ethics committees and other non-medical professionals. The statement recommends (at [13]) that guidelines be developed, taking into consideration “all relevant local factors including organisational and legal issues, as well as religious, ethnic and cultural diversity”. There is no evidence in this case that a clinical ethics committee or any other non-medical professionals were consulted. This is likely to have been a major factor in the minimalist approach to discussing ethics or any non-medical considerations in this case. In the judgment, only the medical aspects are considered in any depth, as Williams J did not refer to these, or any other, health professional guidelines.

It would also have been relevant for the judge to consider the Health Professions Registration Act 2005 (Vic) which provides a definition of “unprofessional conduct” which includes “(d) providing a person with health services of a kind that are excessive, unnecessary or not reasonably required for that person’s well-being”. Similarly, the Act also creates an offence under s 85 for a person to direct a health professional to do something which may constitute unprofessional conduct. It is relevant to note that if the doctors had recommenced treatment, their actions may have been considered unprofessional conduct under Victorian law.

Conversely, s 9 of the Medical Treatment Act 1988 (Vic) protects medical practitioners from professional misconduct action, criminal and civil proceedings. However, this is only the case where medical treatment has been refused in accordance with the Act. As in this case treatment was not refused, the protection may not apply, which is also a relevant consideration.

Furthermore, the medical professionals may have been liable under the Crimes Act 1958 (Vic) if they were to continue treatment, eg under s 16 “causing serious injury intentionally”, as the evidence suggested that the continuation of treatment of Ms King may result in further infections or even hasten her death (potentially opening them up to a charge of murder).

Understanding PVS

Throughout the judgment, Williams J provided descriptions of Ms King’s condition, frequently referring to her experiencing “suffering” and feeling pain (at [13], [14], [16], [20] and [24]). Yet the judge also referred to evidence of the diagnosis of PVS, where an expert found “no evidence of a meaningful response to the environment, (meaning no response to voice noise, pain or visual target)” (at [10]).

A critical issue in many PVS cases is the failure to understand and acknowledge the nature of the condition. PVS patients have no prospect of improvement or recovery from their condition due to loss of function in the cortex. They are insensate and have no capacity to have meaningful responses to their environment. However, their brain stem is intact, and the patient can undergo sleep-wake cycles and have unassisted respiration, as well as exhibiting reflexive non-purposeful responses, including coughing, laughing and crying.20

A problem arises when defining the status of the PVS patient. In NHS Trust A v M; NHS Trust B v H [2000] ICHRL 75 it was established that a PVS patient is alive, both in the medical and legal sense. However, courts still appear confused as to how to approach the patient’s status. It has been noted that in Bland:

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19 Health Professions Registration Act 2005 (Vic), s 3

The court accepted that Bland was a legal person because his brain stem was functioning. But Bland was simultaneously constructed as an insensate body devoid of personality and meaningful existence. Similarly in Re BWV, the patient, while portrayed as a person deserving of certain rights and respect, was also presented as someone whose life had already ended, and to some extent the only issue remaining was the manner in which to treat the body.

Williams J relies on evidence from medical experts which suggested that Ms King would experience severe discomfort and pain if treatment was to be continued, eg (at [16]): “It would be cruel and unethical, according to Dr Silvester, to cause her the level of pain which would result from any further attempt to re-hydrate her.” Throughout the judgment, Williams J appears to be heavily influenced by medical evidence that Ms King would be suffering and experiencing pain. If the diagnosis of PVS was indeed correct, Ms King would not have the capacity to feel and interpret pain stimuli, as confirmed by one medical expert (at [10]). As her reflexes may be intact, she may exhibit non-purposeful responses to painful stimuli. However, it is nonetheless misleading to refer to her “suffering” and “levels of pain”, and to use such notions directly in the consideration of her best interests, or her dignity.

CONCLUSION
There is no doubt that the case of Re Herrington presented a new, complex and difficult set of legal and ethical issues. The ultimate outcome of the case is likely to have been appropriate in all the circumstances, given the extreme state of Ms King’s medical condition. However, the simplicity of the approach taken by the single judge is of great concern, as it failed to consider directly applicable legislation and case law, and as a result failed to engage in a necessary discussion of human rights and medical ethics, and apply the appropriate legal tests and considerations.

This area of law is by no means straightforward, and is becoming increasingly complex with the enactment of State legislation affecting the status of the common law. Many States and Territories in Australia have, or are currently considering enacting, human rights legislation, which will necessarily affect the ways in which relevant legislation is applied. The enactment of such human rights legislation in other jurisdictions will become increasingly important with Australia’s ageing population and the advances in medical science, as most Australians will have to face the prospect of dying in either a hospital intensive care unit or under palliative care. Re Herrington presented the opportunity for a detailed evaluation, in the context of end-of-life decision-making, of the often fine line between standard medical and palliative care and the protection of individual human dignity, cultural values and freedom from inhuman or degrading treatment. The fact that this opportunity was not taken is to the detriment of Australian jurisprudence in this area.

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RECENT DEVELOPMENTS
Advertiser Newspapers Pty Ltd v SA Health
Advertiser Newspapers Pty Ltd v SA Health Commission [2007] SASC 158 concerned an HIV-positive man, Mr Stuart McDonald, who was quarantined pursuant to s 32(1) of the Public and Environmental Health Act 1987 (SA) (the Act) after he recklessly engaged in unprotected sexual intercourse (contrary to the written directions given to him under s 33(1) of the Act). On two occasions the magistrate

extended McDonald’s quarantine and ordered, pursuant to s 69A of the Evidence Act 1929 (SA), a suppression on the publication of images of Mr McDonald; the names and content of the affidavits tendered at the hearing on 16 April of six alleged victims; and the material in the affidavit of one of the victims referring to the use and sale of drugs. The magistrate’s reason for the suppression of the order was to protect an alleged victim from potential hardship.

Advertiser Newspapers Ltd (the appellant) opposed the making of the suppression orders in the Adelaide Magistrates Court. It has appealed seeking orders revoking the orders made by the magistrate and substituting for them an order suppressing from publication the name and any material which might identify the six alleged victims.

Debelle J indicated that, even though there had been much publicity surrounding the circumstances of McDonald, the principle of a fair trial remains (at [23]). Therefore the publication of the unsubstantiated allegations (contained in the affidavit) is such a serious threat to the fair trial of McDonald that an order should be made suppressing that publication (at [25]).

Justice Debelle ordered that the confidentiality of the affidavits be maintained and additional orders to suppress the details of alleged victims be maintained (at [25]- [26]).

**JENSEN V QUEENSLAND**

In *Jensen v Queensland* [2007] QDC 87 the plaintiff was injured at work on 3 December 2003 when a refrigerator fell on his abdomen. He developed abdominal pain and attended upon a general practitioner the following day. He was diagnosed with acute appendicitis and referred to the Logan Hospital (at [1]).

The plaintiff, suffering from pain the general abdominal area, was concerned about the diagnosis and sought a further opinion from another general practitioner. He was referred for abdominal ultrasound. The ultrasound was performed later that day and indicated a grossly thickened appendix which was typical of acute appendicitis (at [2]).

According to Rafter J’s judgment, the plaintiff presented at the Emergency Department at the Logan Hospital at about 4:30 pm on 4 December 2003. By that stage he had developed generalised abdominal pain that was worse on movement. He had no diarrhoea or vomiting. The doctor noted the result of the abdominal ultrasound. He performed a full blood count and diagnosed that it was unlikely that the plaintiff had appendicitis. The plaintiff was discharged on 5 December 2003. The discharge letter stated that his presenting complaint was abdominal pain and that no diagnosis was made (at [4]).

The plaintiff’s pain persisted and four days later he went to his general practitioner who noted that the pain persisted, but that it was improving. Two weeks passed and the plaintiff returned, indicating the pain persisted (it was worse while driving). The general practitioner ordered another ultrasound and planned to review the results with the patient.

Two days later, 22 December, the plaintiff was admitted to the Emergency Department of Logan Hospital. In the operating theatre a laparotomy was performed which revealed a large appendiceal phlegmon, a large amount of purulent fluid free in the peritoneal space, oedematous mesentery and small bowel, and numerous fibrous adhesions. The adhesions were broken down and 800 ml of pus was drained from an abscess in the pelvis.

As a result of a failure to diagnose appendicitis and the eventual perforation of his appendix, the plaintiff suffered peritonitis; sepsis; small bowel necrosis; multiple organ failure; intra-peritoneal adhesions; small bowel obstruction; a serious wound infection; a painful and unsightly scar on the abdomen; and an incisional hernia which required mesh repair.

The plaintiff required extended hospitalisation, including several additional operations. There were three laparotomies to drain pus, wash out the infection and resect a portion of the small bowel. He has a wide scar to the abdomen which is 29 cm long and occupies most of the length of the anterior abdominal wall. He was left with a significantly increased lifelong risk of bowel obstruction because of the adhesions. There is also a risk of recurrence of incisional hernia ([20]).
Liability by the hospital and the general practitioner was admitted with general and special damages agreed. The body of the judgment required Rafter J to assess damages for past and future economic loss and future treatment (at [10ff]). He ordered $111,750.53 be paid to the plaintiff in damages (at [62]).

**Drug and Alcohol Treatment Act 2007 (NSW)**

In his second reading speech, the Hon John Hatzistergos (New South Wales Attorney General and Minister for Justice) described the *Drug and Alcohol Treatment Act 2007* (NSW) as fundamental to the “new direction the NSW Government is taking in the treatment of a particular group of people who are in extreme situations of long term and entrenched substance abuse”.

The Act provides the legal basis for a two-year trial of short-term involuntary care and treatment during which this group would undergo detoxification, rebuild their health and be linked in a planned and considered way to longer-term rehabilitation and support.

Part 1 of the Act sets out the objects of the legislation which include improving the health and safety of persons with a severe substance dependence through the provision of involuntary treatment. This Part also incorporates important principles to safeguard the rights of persons who are detained and treated under the Act, emphasising that this is an intervention of last resort and the interests of the person are paramount. Minors are excluded from the trial under this Part.

The s 5 definition includes the important threshold issue of what is “severe substance dependence”. The definition of severe substance dependence also brings in the concept that to be eligible for involuntary care the person must have lost the capacity to make decisions about their substance use and personal welfare due primarily to their dependence on the substance.

Part 2 sets out the process of involuntary detention and treatment. Section 6 provides that there is a qualified prohibition on involuntary detention:

- A person must not be detained in a treatment centre under this Act unless an accredited medical practitioner has issued a dependency certificate in relation to the person.

“Accredited medical practitioners” appointed by the Director-General of the New South Wales Department of Health (pursuant to s 7) may detain and treat a person under the Act after assessing the person and issuing a “dependency certificate” (s 9 and s 10).

Any medical practitioner may ask an accredited medical practitioner to assess a person under s 9(1). This process recognises that involuntary detention and treatment is essentially a clinical decision. It will not prevent families and other interested parties from approaching any medical practitioner in the catchment area and asking them to formally initiate the process for detention and treatment under the Act.

The assessment criteria to ensure only suitable persons enter the trial are set out in 9(3).

- The accredited medical practitioner must be satisfied the person has a severe substance dependence – as described earlier – and
- needs protection from serious harm
- Treatment is likely to benefit the person but the person has refused treatment.
- There are no other appropriate and less restrictive means of dealing with the person.

The fundamental object of the Act is to provide for the involuntary treatment of persons with a severe substance dependence with the aim of protecting their health and safety. It reflects a new direction the New South Wales Government is taking in the treatment of a particular group of people who are in extreme situations of long-term and entrenched substance abuse.

*SJ and TF*