IN THE HIGH COURT OF NEW ZEALAND
AUCKLAND REGISTRY

I TE KŌTI MATUA O AOTEAROA
TĀMAKI MAKAURAU ROHE

CIV-2023-404-1604
[2023] NZHC 2128

UNDER	the Declaratory Judgments Act 1908
IN THE MATTER OF	HEALTH NEW ZEALAND Plaintiff
AND	
IN THE MATTER OF	ALVIN ARVIN MAHARAJ
BETWEEN	MOVEENA MAHARAJ, KAVITA BHARDWAJ AND DARSHEEKA SHARMA Applicants
AND	TE WHATU ORA OF AUCKLAND Respondent

Hearing: 8 August 2023

Appearances: D S McGill and K J Rowe for Applicants
P N White for Respondent

Judgment: 9 August 2023

ORAL JUDGMENT OF EATON J

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[1] I begin as I did yesterday by acknowledging and expressing the Court's sympathy to the family of Alvin Maharaj. I am also cognisant of the stress and strain cases of this nature place on the treating clinicians and hospital staff. It is no easier being asked to make legal judgments in such a case.

[2] On 20 July 2023, Alvin Maharaj suffered a heart attack. Mr Maharaj presented at Auckland Hospital with a hole torn in the muscular wall that divides the heart's chambers into left and right halves so as to ensure that the blood flows in the correct direction through the heart. Such a condition is a rare but lethal complication of a heart attack. Mr Maharaj was placed on a life support system known as Veno-arterial Extra Corporeal Membrane Oxygenation (VA ECMO) as a "bridge to a decision" to allow the clinicians time to assess whether there were any interventional options available.

[3] On 3 August 2023, Mr Maharaj's family was advised of a decision to remove Mr Maharaj from life support, there being no surgical or interventional options available to save Mr Maharaj's life and the concern that other patients with survivable conditions will have to be turned away in order to keep Mr Maharaj alive. The clinicians proposed taking Mr Maharaj off life support on 4 August.

[4] Mr Maharaj's family had not understood his condition to be so grave. They were concerned there might be alternative treatments that ought to be explored.

[5] On 4 August, Mr McGill, on behalf of the family, wrote to Te Whatu Ora – Health New Zealand (Te Whatu Ora) confirming the family did not consent to the removal of life support and asking for at least five days to allow the family to obtain independent medical advice.

[6] Late on 4 August 2023, two applications were filed. Te Whatu Ora filed a statement of claim under the Declaratory Judgments Act 1908, seeking an order that it is lawful for Mr Maharaj's treating clinicians to turn off his VA ECMO machine with the effect that it will cause his death (and any ancillary orders appropriate or necessary). Mr Maharaj's sisters[1] filed a notice of an interlocutory application for an

[1] I will refer more broadly to Mr Maharaj's family as they share a common position.

interim injunction seeking orders that Te Whatu Ora refrain from turning off the life support machine and continue to provide medical care as required until an independent medical opinion had been obtained and the family had carried out religious duties.

Subsequent process

[7] On the evening of Friday 4 August 2023, Peters J convened two telephone conferences with counsel but declined to make the orders sought. On the morning of 7 August 2023, Peters J issued a minute observing that no affidavit evidence had been filed in support of either application and that the jurisdictional basis upon which the orders were sought was unclear.

[8] The proceedings were then referred to me as Duty Judge. At 4 pm on 7 August 2023, I convened a telephone conference with counsel. By then, Te Whatu Ora had filed affidavits from three of the clinicians involved in Mr Maharaj's care. Mr Maharaj's sister had filed an affidavit in support of the application for the interim injunction and Te Whatu Ora had filed a further affidavit in response.

[9] Mr McGill advised that the family had sought medical opinions from a number of overseas specialists and that meetings with experts based in Australia and America would take place on 8 August 2023. Mr White, on behalf of Te Whatu Ora, agreed the status quo should prevail in order to allow the family the opportunity to seek independent advice. Mr McGill indicated that if that advice was consistent with the advice provided by the Auckland Hospital Clinicians, it was likely the dispute would be resolved.

[10] A hearing was scheduled before me at 3 pm on 8 August 2023 to determine the applications if necessary.

[11] The dispute was not resolved, and I heard argument from counsel. Given the urgency of the matter, I have resolved to provide brief reasons. I begin by summarising the evidence.

The evidence

Tobias Michael Merz

[12] Dr Merz is an Intensive Care Specialist employed in the Cardiothoracic and Vascular Intensive Care and High Dependency units (CVICU and CVHDU) at Auckland Hospital. He has been working there since 2018 and is responsible for the medical care and treatment of Mr Maharaj.

[13] The CVICU provides intensive care for cardiology patients over 15 years of age and other patients requiring support from ECMO. ECMO is an extracorporeal technique of providing prolonged cardiac and respiratory support to patients whose heart and lungs cannot provide adequate gas exchange or perfusion. It is usually a last resort.

[14] ECMO support is extremely invasive and expensive to run. Therefore it is typically only used if a patient has a survivable condition.

[15] Mr Maharaj was admitted into CVICU on 20 July 2023 following a heart attack which resulted in a hole being torn in the muscular wall dividing the heart. Such a tear is rare but lethal. The heart attack was so severe that the tissue in the muscular wall became necrotic due to lack of blood supply, leaving a large hole.

[16] Mr Merz goes on to say Mr Maharaj was offered ECMO, given his relative youth (46),, as a "bridge to decision". He was placed on it on 20 July.

[17] Three interventional cardiologists and two cardiac surgeons extensively considered the matter but concluded there were no available options to repair the hole. A heart transplant is not an option for Mr Maharaj because he is currently on ECMO, is classified as Intermacs 1 due to low blood pressure and decreasing perfusion to organs (confirmed by worsening acidosis and lactate levels), and is receiving treatment for ventilator-associated pneumonia and a possible urinary tract infection. There is no medical or therapeutic benefit to be gained by continuing to maintain Mr Maharaj on ECMO, according to Dr Merz.

[18] This information was relayed to Mr Maharaj's family over several meetings. Members of Mr Maharaj's family were updated five times in July in respect of his condition. On 2 August, a family meeting was held explaining the lack of interventional or surgical options and the futility of ECMO. The family requested a second opinion which was arranged for on 3 August.

[19] He says On 3 August, a meeting taking over an hour was held between the family and Dr Andrew McKee (CVICU Intensivist), Dr Parma Nand (cardiac surgeon), Dr Maurice Hogan, and a nurse specialist, Phillipa Neal. The circumstances and lack of viable options, including transplant, were explained. The family he described as despondent throughout the meeting.

[20] Dr Merz has met with the family each day since 4 August. He has made his contact details available to discuss Mr Maharaj's situation with any clinician the family sought an opinion from.

[21] The CVICU is often at full capacity, he says, and a patient on ECMO requires considerable staffing resources.

Peter Mark Alison

[22] Dr Alison is a Cardiothoracic Surgeon employed at Auckland Hospital. He was consulted alongside Dr Parma Nand on surgical options for Mr Maharaj.

[23] Dr Alison provides further detail as to Mr Maharaj's condition, explaining that the right ventricle is mildly dilated and severely impaired. Mr Maharaj has a significant left to right shunt which means a large volume of blood, instead of being directed to the body, is diverted back through his right heart to the lungs. This causes the right heart to fail from volume overload and the lungs to also fail from excessive circulation.

[24] Closing the hole in the muscular wall within the heart, surgically or percutaneously, usually faces challenges due to the large size of the muscle, the large hole, and critical multi-organ failure. Placing Mr Maharaj on ECMO provided the

team with time to assess options and also provided hope the dead muscle would form scar tissue which may hold stitches during high risk intervention.

[25] Dr Alison canvasses the following options:

(a) Surgical patch: A patch of the hole involves stopping the heart, cutting through the dead muscle, then stitching a large artificial patch to cover the hole and surrounding area, then trying to come off support. However, he says there is unlikely to be scar tissue which would enable the stitches to hold the patch in place. This is aggravated by Mr Maharaj lacking sufficient remaining viable myocardium (heart muscle), narrowed coronary arteries, and a generally deteriorating condition. Such a repair, in his experience, would be futile. He has never seen successful closure in such a case.

(b) Left ventricular assist device: This is a device surgically implanted in the heart to act as a mechanical pump. It helps the left ventricle pump blood to the rest of the body. It was deemed not appropriate because the hole would have to be closed, which is not considered viable for the reasons above.

(c) Heart transplant: Heart transplants are contingent on strict criteria. Mr Maharaj has been on ECMO too long to meet the criteria. This is exacerbated by ventilator-associated pneumonia and urinary tract infection. It would be, in his opinion, an inappropriate use of a donated heart given the likely futility of the operation.

[26] In summary, Dr Alison considers he and Dr Nand thoroughly explored all possible surgical options and concluded nothing can be done to repair the hole or wean Mr Maharaj off ECMO.

Peter Robert Barr

[27] Dr Barr is an Interventional Cardiologist employed at Auckland Hospital.

[28] He and two colleagues were consulted in relation to interventional options for Mr Maharaj. He gives evidence of only one option, that being percutaneous repair of the hole in Mr Maharaj's heart. This repair would involve the delivery of a nitinol mesh covered with polyester material across the hole using percutaneous central arterial and venous access under fluoroscopic and transoesophageal echocardiographic guidance. The device must straddle the hole and anchor against stable tissue rims on both sides. He says Mr Maharaj is not suitable for this repair due to the location and size of the hole. The technique would not be successful and would likely worsen matters by traumatising the region.

[29] Dr Barr considers he and his colleagues have explored all reasonable interventions.

Kavita Kavirashree Bhardwaj

[30] An affidavit was filed by Mr Maharaj's sister, Kavita Bhardwaj. That affidavit is also relied on in support of the family's application for interim relief. Ms Bhardwaj is Mr Maharaj's sister and is authorised by the other applicants and the rest of the family to affirm her affidavit in support of the application for an interim injunction.

[31] She explains that, on the day of Mr Maharaj's admission, the family went to see him and were met by Dr Tobias Gozenbach. He explained Mr Maharaj had had a heart attack and was on ECMO. She says they were told Mr Maharaj would be monitored for 10-14 days before carrying out surgery to repair the hole in his heart. Scar tissue would need to form, and one of two procedures would be carried out, either a less invasive surgery inserting a device or open heart surgery.

[32] At a later point, she says a doctor advised the family they expected the hole in Mr Maharaj's heart would heal by itself. However, another doctor, who she can only recall as "Mike", advised Mr Maharaj's heart would not heal by itself, leading to confusion.

[33] During his stay, the family has remained present and been told by nurses that Mr Maharaj was stable, which they took to mean his condition was not deteriorating.

[34] On 28 July 2023, Ms Bhardwaj says Dr Bevan Vickery told her parents Mr Maharaj had been stable and would hopefully remain so as to allow them to carry out scans and x-rays on 31 July, with surgery to repair the hole the following Monday, 7 August 2023. She says the family was not advised of the results of the 31 July tests.

[35] She says that, on 1 August, Dr Hogan told her sister the surgical team were looking at an operation on 2 August. Later that afternoon, a doctor asked various questions about Mr Maharaj's circumstances and mentioned he may be a good candidate for a transplant, which was the first time the possibility had been raised.

[36] She says that around 4.30 pm on 2 August, Dr Hogan called a family meeting. The family attended but was not sure what it would be about. She says Dr Hogan advised that the planned surgical intervention was off the table and that ECMO would be discontinued the following day. The family asked about other options available, to which Dr Hogan mentioned open heart surgery and heart transplant. The family were devastated as this went against their expectations. They advised Dr Hogan a second opinion would be sought, to which he suggested a meeting with the medical team.

[37] From this point, Ms Bhardwaj says the hospital reduced the number of nurses caring for Mr Maharaj in the CVICU from two to one.

[38] Ms Bhardwaj's account of the 3 August meeting is as follows. The family met with Dr McKee, Dr Nand, Dr Hogan, and a senior nurse. This was the first meeting with the whole medical team. They were advised Mr Maharaj's lungs had fluid in them, and his kidneys were not functioning well. She says this was shocking as they were not aware his health had been deteriorating and did not understand why this was the case. She says little explanation was provided for why they would not perform surgery and intended to turn his machine off within 24 hours. Her evidence is the team had made their mind up and quotes Dr McKee as saying: "You can't change our mind and we can't change yours."

[39] She says there was a lack of compassion shown to the family nor consideration for Mr Maharaj's youth and fatherhood of a special needs son. At no point did the staff say Mr Maharaj's case was hopeless. The hospital staff, she says, made faces

throughout the meeting as if they were confused as to the family's eagerness to keep Mr Maharaj alive and discomfort with the prospect of him being shortly taken off ECMO. When they advised the team they would seek a second opinion, they were told they had 24 hours to obtain that.

[40] From there, she says, the doctors arranged for a cardiologist to talk with the family. That specialist advised that scar tissue takes four to six weeks to form and was a prerequisite to operation. This confused the family given the 14-day timeline they had previously been given.

[41] Ms Bhardwaj says it became more difficult to get information out of nurses, though one said it was protocol for patients to only stay on ECMO for 14 days. The family struggled getting further medical opinions and legal advice while the hospital was providing a deadline for a further meeting on 4 August before taking Mr Maharaj off ECMO. Ms Bhardwaj says they have not been provided by the medical team with information around second opinions from within or outside New Zealand and whether similar surgery has been performed by the doctors in the past. They have also not been told about whether Mr Maharaj can be transported, other patients moved, or additional beds sourced.

[42] There was to be a 2 pm meeting on 4 August. The family engaged Mr McGill of Duncan Cotterill who contacted the hospital's lawyer, Ms Tune, at approximately 1.20 pm. Ms Tune advised the hospital would not take immediate action. Ms Bhardwaj says no one from the hospital attended the scheduled 2 pm meeting. The hospital contacted Mr McGill to explain it would seek a declaration to legally take Mr Maharaj off ECMO to which they instructed Mr McGill to file an interim injunction.

[43] The family wants Mr Maharaj's treatment to continue to facilitate religious duties and the seeking of a second opinion. She sets out the family's extensive efforts to seek a second opinion including contacting medical staff in Singapore, Canada, Melbourne, Sydney, Daly City, New Delhi, and Bengaluru as well as doctors from the Victorian Cardiovascular Services, Alfred Health, John Muir Health, the Asian heart

and Research Centre, and the Medanta Heart Institute. Some preliminary responses have been received.

[44] Ms Bhardwaj also gives evidence of concerns around the standard of care provided to Mr Maharaj. This concerns the amount of nurse-monitoring occurring, errors in reading of temperature, and an IV line leaking blood.

[45] At the hearing, Mr McGill filed an updated affidavit from Ms Bhardwaj confirming further requests have been made of overseas experts and detailing the formal responses received to date

Andrew McKee

[46] The other affidavit I have received and considered is from Andrew McKee. Dr McKee, a Cardiothoracic Anaesthetist and Intensive Care Specialist at Auckland Hospital, is the clinical director of CVICU. His affidavit responds to Ms Bhardwaj's first affidavit.

[47] He considers, having read her evidence, that communications between the team and the family were not ideal. He cannot say exactly what was said to the family at early stages as he was not involved. However, he notes it can be difficult to communicate the severity of a patient's condition, and uncertainties in prognoses, while also not giving false hope or an overly optimistic outlook.

[48] He explains that the term "stable" is used in an ICU context to refer to a patient being maintained on maximum support, reflecting their critical condition. A ward round note from 21 July, which refers to ECMO as a bridge to "scarring/surgery/intervention" is explained as being what is hoped to be achieved, not what can definitely be achieved. He also produces a note from a family meeting with an intensivist on 24 July indicating Mr Maharaj was unlikely to survive.

[49] In a ward note from 31 July, it was noted Mr Maharaj was starting to suffer complications in respect of his lungs and kidney. The note also records discussion with family about that deterioration and potential for it to continue and complicate closure of the hole in his heart.

[50] Consultation with interventional cardiologists and cardiothoracic surgeons had occurred by 2 August. They had concluded the hole could not be closed.

[51] Dr McKee says the view was formed that continuing ECMO would be futile. It is used to sustain life in the hope of a procedure. Once such procedures are unavailable, Dr McKee says continuing ECMO is not in Mr Maharaj's interests and could result in the hospital having to turn away patients with potentially survivable conditions. He says the team tries to be compassionate when dealing with families in such difficult situations.

[52] He explains the 3 August meeting as intended to explain the situation further after the family did not accept what they were told on 2 August. He attaches a note from the meeting which indicates it took place for over an hour, involved an explanation of all treatment efforts, the lack of availability of such efforts elsewhere in New Zealand (which meant Mr Maharaj would have already passed away had he been treated in another locale), and that no option currently existed to repair the hole in Mr Maharaj's heart. It was also noted that it was explained Mr Maharaj was not a transplant candidate. Dr McKee says he explained that ECMO was only initiated in the slim hope a procedure might be possible. Repeated questions on this topic were answered. He states the family remained despondent and disappointed and that sympathies were expressed.

[53] He rejects Ms Bhardwaj's evidence that why Mr Maharaj's health had deteriorated was not covered. Deterioration on ECMO is not unexpected, and he says the family indicated they were aware of the possibility of complications. He says the team had to repeatedly convey the unfortunate position that there was nothing more that could be done.

[54] Dr McKee refers to the evidence of steps the family have taken to seek overseas opinion. He views these efforts as unrealistic. The few responses there are note that this is a high risk situation with poor prognosis. Overseas transport on ECMO with a full medical team would be required. This would be immensely expensive, would not be funded, he says Mr Maharaj may not survive the flight, and there is no certainty any treatment in another country would succeed.

[55] Dr McKee says the hospital is constantly operating near capacity, and a situation could arise at any time where they would have to turn away patients from CVICU beds.

The respective positions

[56] I then summarise the parties' positions.

Te Whatu Ora

[57] Mr White, for Te Whatu Ora, submits there is nothing to be done to treat the hole in the septum of Mr Maharaj's heart. Continuing ECMO is no longer appropriate. Ordinarily, ECMO support would be withdrawn after consultation and agreement with the family, but this has not occurred in this instance. A declaration is therefore sought.

[58] Mr White cites *Auckland Area Health Board v Attorney-General* as providing the relevant test Te Whatu Ora would have to satisfy to avoid seeking a declaration in relation to ceasing life support treatment:[2]

> (a) the doctors responsible for the patient, taking into account a responsible body of medical opinion, conclude that there is no reasonable possibility of that patient ever recovering from their present clinical condition;
>
> (b) there is no therapeutic or medical benefit to be gained by continuing to maintain the patient on support, and to withdraw that support accords with good medical practice, as recognised and approved within the medical profession; and
>
> (c) the relevant ethics committee and family concur with the decision to withdraw support.

[59] Mr White says the evidence from Dr Merz, Dr Barr, and Dr Alison makes it clear that there is no reasonable possibility of Mr Maharaj recovering, and there is no

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2 *Auckland Area Health Board v Attorney-General (NZ)* [1993] 1 NZLR 235 (HC) at 255.

further therapeutic benefit to continuing support. There was extensive consultation and unanimous agreement among the medical staff that there are no further interventions available to Mr Maharaj. There is insufficient myocardium, accompanied by narrowed coronary arteries, and a deteriorated condition. Furthermore, the fact that Mr Maharaj has now acquired ventilator-associated pneumonia, a possible urinary tract infection, and multiorgan failure confirm a clinical deterioration on ECMO.

[60] Mr White acknowledges there has been no communication with the ethics committee, but this is irrelevant given the lack of interventions available to assist Mr Maharaj off ECMO. He says there is simply no question for an ethics committee to address. He notes efforts have been made to gain the consent of the family, but this has not been successful.

[61] Where consent has not been obtained, Mr White says the case *Auckland Area Health Board* makes it clear that a declaration is required from the Court to assure clinicians they would not be criminally culpable for the death of Mr Maharaj should ECMO be discontinued.

[62] For the reasons I have summarised above, Mr White submits ongoing ECMO is futile and risks other patients being barred from life-preserving treatment. He says patients with survivable conditions have been turned away from CVICU.

[63] Mr White notes Te Whatu Ora does not come to the Court in a situation like this lightly, and doing so has placed a further burden on already overburdened clinicians.

[64] He cites several policy considerations in support of Te Whatu Ora's position. Allowing the lack of family consent to prevent the withdrawal of ECMO or other similar therapies would disincentivise clinicians from placing patients onto such therapies where there is not a high expectancy of survival. This compromises clinicians' ability to explore options for patients. Further, he submits Te Whatu Ora is committed to providing equitable care. However, there is an unequal distribution of knowledge and resources enabling some families to pursue legal challenges to

withdrawal of treatment decisions, but not others. To that end, Mr White reiterates his submission that the ethics committee has no place in circumstances such as this where there is no ethical question to consider; there are no available treatment options for Mr Maharaj. Ethics committees are useful when there is a clinical dilemma to resolve — no such dilemma arises here. While it is preferential for consent to be granted, he accepts, clinicians should not have to seek court approval every time there is family dissent.

[65] These factors combine, Mr White submits, to support the granting of the declaration. He says clinicians should be authorised to make the decision to withdraw support provided:

(a) there has been consultation with other suitable clinicians who confirm the lack of a possibility of the patient recovering;

(b) the responsible doctors consider there is no therapeutic or medical benefit to be gained by continuing invasive life-preserving treatment, and that withdrawal accords with good medical practice as recognised and approved by the profession;

(c) the views of the patient, if known, and the views of the patient's family and other suitably interested persons, if known, are taken into account.

[66] There is no need in this process for consultation with an ethics committee.

[67] Finally, Mr White addresses the family's sought injunction. He says the law cannot countenance a general position that a family can require treatment irrespective of the clinical judgement of doctors involved.[3] The initial application sought an injunction for at least five days. He observes that four days have since passed, and it is inappropriate for the situation to continue, for an uncertain period of time, in the hope Mr Maharaj's family might find an opinion from an overseas person, uninvolved in Mr Maharaj's care and unable to provide care, that they then seek to follow. While

[3] Citing *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 (CA) at 443.

such opinion is being sought, there is an ongoing potential for people who might benefit from life sustaining therapy to be deprived of that opportunity.

The family's position

[68] The applicants seeking injunctive relief are Mr Maharaj's sisters. Mr McGill, on behalf of the family, stresses that the family seeks further time to enable a second opinion to be obtained from a suitably qualified expert. The original application sought an interim injunction for five days. Mr McGill submits that was overly optimistic, given that time period included a weekend. The five-day period expires this evening. He seeks an additional "day or two" to secure the second opinion. As regards the relevant legal framework, Mr McGill submits there is a serious question to be tried between the parties, namely, whether the hospital can turn off Mr Maharaj's VA ECMO machine and end his life against his family's wishes and before they can obtain a second opinion regarding Mr Maharaj's prospects.

[69] Mr McGill relies on s 8 of the New Zealand Bill of Rights Act 1990 (NZBORA), submitting that the exceptions within that right have not yet been triggered because there has not been sufficient and reasonable time to obtain a second opinion. He submits that there is not a "full responsible body" of medical opinion that sufficiently proves Mr Maharaj's heart rupture cannot be repaired. Mr McGill does not accept that the unanimous opinion of the Auckland Hospital clinicians, that it is appropriate to remove life support, reflects a "reasonable body" of medical opinion. He says that because those clinicians are employed by the Health Board, there is an appearance of bias and that a decision as significant as one to withdraw treatment that will result in a patient's death ought not be determinative absent an "independent" opinion.

[70] Mr McGill accepts that the courts are appropriately reluctant to interfere in clinical decisions but submits that a decision that a particular patient's case is hopeless and that life-preserving treatment should be discontinued would only be made if there is a sound body of medical opinion to support that conclusion. He relies on the decision of Thomas J in the *Auckland Area Health Board case*, where the patient's prognosis was described as hopeless and overseas second opinions had been obtained

some 10 months prior to the decision.[4] He further relies on *Shortland v Northland Health Ltd*, where the Court refused an application to direct the Northland Health Board to continue dialysis for a patient who would die without a kidney transplant.[5] Mr McGill highlights that in that case, the Northland Health Board had completed widespread consultation with appropriate specialists and followed guidelines to unanimously conclude the patient was unsuitable for long-term dialysis.

[71] He submits that both the balance of convenience and overall justice in this case favour the granting of the interim injunction because the applicants only seek a short time to secure a second opinion and submits there is insufficient medical evidence to support an assertion that Mr Maharaj's case falls within the "hopeless" category. He stresses that Mr Maharaj will die if life support is withdrawn.

[72] Mr McGill submits that it was only on Thursday, 3 August 2023, that the family clearly understood that the clinicians had formed the view that a surgical repair was not an option. He submits that to allow the family five or six days to secure a second opinion is in the interests of justice.

Overview of the evidence

[73] I then deal with an overview of the evidence on particular factual matters.

Communication issues

[74] I accept the evidence of Ms Bhardwaj that it was really only on Thursday, 3 August 2023, that the family understood the clinicians had resolved there was no surgical remedy for Mr Maharaj. From 20 July until 2 August 2023, the family had understood that Mr Maharaj was "stable" and that the VA ECMO was a mechanism to preserve the situation pending a decision made by the clinicians as to the appropriate surgical intervention.

[75] I accept that the advice of the clinicians, proposing taking Mr Maharaj off VA ECMO on 4 August 2023, came as a shock and caused much distress to

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4 *Auckland Area Health Board v Attorney General (NZ)*, above n 2.
5 *Shortland v Northland Health Ltd*, above n 3.

Mr Maharaj's family. Whilst I acknowledge that there was a communication breakdown, I accept the evidence of Mr McKee, the clinical director of the CVICU, that it is hard to communicate the severity of a patient's condition and uncertainties on their prognosis to families while at the same time not giving false hope or an overly optimistic outlook.

[76] It seems it was the shock of learning there were no surgical interventions proposed that led Mr Maharaj's family to lose confidence in the medical advice of the clinicians. If they had understood from the outset that surgical intervention was merely a possibility, given the severity of Mr Maharaj's condition, the decision to withdraw life-support would unlikely have given rise to that loss of confidence. The decision to obtain legal advice and to issue legal proceedings was, I find, a direct consequence of the loss of confidence.

[77] The family has since had several days to come to grips with the medical opinion. In that period, they have anxiously sought, from a variety of sources, a second opinion. To date, no such opinion has been forthcoming.

Mr Maharaj's prognosis

[78] Regrettably, I am of the view, based on the detailed medical evidence from a range of specialist clinicians, that Mr Maharaj's prognosis is hopeless. The heart attack he suffered on 20 July 2023 has caused irreparable damage to his heart muscle, resulting in the necrosis of part of the septum between his two heart ventricles. That, in turn, has created a hole between those ventricles, causing a shunt of blood between the two chambers which has in turn caused the right heart to fail from volume overload and damage to his lungs. I accept that, but for the VA ECMO he is receiving, he would be deceased. Notwithstanding VA ECMO, his condition is deteriorating. The VA ECMO is avoiding the pressure on his heart and is, therefore, prolonging his life. But the overwhelming opinion of the clinicians is that there is no therapeutic cure for Mr Maharaj. There is no option that would allow him to function off VA ECMO, and the clinicians are unanimously of the opinion that it is no longer medically appropriate for him to receive VA ECMO. I acknowledge Mr Maharaj's family have reached out to other international medical experts for a second opinion but, even if a second

opinion offered a glimmer of hope as to a surgical repair, I see no prospect of that opinion leading to a change of view within the treating clinicians. It would not be reasonable to require suitably qualified and experienced clinicians to put on hold what they consider to be appropriate treatment regimes on the basis of a possibility raised by another clinician who has not been involved in the treatment of Mr Maharaj. In a case where other patients' lives are put at risk by delays in withdrawing the VA ECMO from Mr Maharaj, it is not reasonable to require the treating clinicians to respond to treatment options that amount to no more than mere possibilities.

[79] It is for those reasons I accept that it is, regrettably, appropriate to describe Mr Maharaj's prognosis as "hopeless".

[80] I accept without question that a decision to withdraw life support from a patient should never be made without consultation amongst suitably qualified clinicians. I am satisfied there has been significant consultation amongst appropriate clinicians and, as I have indicated, I am satisfied that the opinions offered are independent and appropriately categorised as being made by a responsible body of clinicians in light of relevant medical opinion.

Interests of other patients

[81] I accept that the hospital is constantly operating near capacity, and a situation could arise at any time where they would have to turn patients away from CVICU beds, and since the decision that there are no treatment options for Mr Maharaj, patients with survivable conditions have been turned away from the CVICU. Other patients have been and will continue to be compromised as a consequence of Mr Maharaj remaining on life support. It has been good fortune that the demands on the CVICU have been manageable since 4 August, however that situation could change at any minute.

The essence of the dispute

[82] Both parties seek orders under the Declaratory Judgments Act 1908 as to the lawfulness of Mr Maharaj's treating clinicians discontinuing the VA ECMO treatment. However, the contest as to legality is far narrower. The family does not suggest that

to cease the VA ECMO treatment would be unlawful of itself, rather, that it would be unlawful to do so until the family have had a reasonable opportunity to obtain an alternative medical expert opinion and an ethics committee has been consulted. The application for interim relief seeks a period of at least five days to obtain a second medical opinion. In oral submissions, Mr McGill suggested that period was overly ambitious and suggested a further one or two days.

Legal Principles

[83] The general principles in determining whether an interim injunction should be ordered are settled. First, there must be a serious question to be tried in a proceeding.[6] Second, the Court must consider where the balance of convenience lies.[7] Third, the Court must consider the overall justice.[8]

[84] As Mr White submits, the considerations relevant for a declaration in relation to ceasing life support were addressed by Thomas J in the *Auckland Area Health Board* case.[9]

[85] There, an application had been made by doctors at Auckland Hospital and by the Auckland Area Health Board for a declaration determining whether they would be guilty of culpable homicide if they withdrew a life support system which maintained the breathing and heartbeat of a patient suffering from an extreme case of Guillain-Barré acute syndrome. On the withdrawal of life-support, it was acknowledged that death would be instantaneous but painless.

[86] Thomas J held that the life-support system could be withdrawn without those responsible bearing criminal liability. It was held that the discontinuance of a life support system would not be unlawful if the discontinuance was in accordance with "good medical practice". Ultimately, Thomas J found that "good medical practice" was established if the process began with bona-fide decision-making on the part of the attending doctors as to what was in the best interests of the patient, encompassing

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6 *American Cyanamid Co v Ethicon Ltd* (1975) AC 396, [1975] 1 All ER 504 (HL).
7 Above n 6.
8 *Klissers Farmhouse Bakeries Ltd v Harvest Bakeries Ltd* [1985] 2 NZLR 140 (CA).
9 *Auckland Area Health Board* [1993] 1 NZLR 235.

prevailing medical standards, practices, procedures and traditions which command general approval within the medical profession. The Judge observed that all relevant tests would need to be carried out and that specialist opinions and agreement would be required, and that extended consultation was likely to be appropriate. A court will need to be satisfied a reasonable body of medical opinion leads the responsible clinician to conclude there is no reasonable possibility of the patient ever recovering. The Judge considered that consultation with the medical profession's recognised ethical body was critical and that the patient's family must be fully informed and freely concur in what was proposed.

[87] In *Shortland v Northland Health Ltd*,[10] the Court of Appeal referred to the *Auckland* case, observing that the criteria identified by Thomas J were framed for a particular factual situation and were not necessarily applicable to a different situation.

[88] Finally, in relation to legal principles, I acknowledge the sanctity of life. Section 8 of NZBORA 1990 provides:

> **8 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.

Discussion

[89] I have regard to the test outlined by Thomas J in *Auckland* but observe that any decision considering whether it is appropriate to make a declaration as to the lawfulness of the decision to withdraw the life-support of a patient must turn on its own facts. The facts of the present case do not mirror those that arose in *Auckland*.

[90] First, unlike the scenario described by Thomas J in *Auckland*, the clinicians treating Mr Maharaj do not express concern that they might be exposed to a criminal prosecution as a consequence of their medical assessment. The clinicians are content to implement their collective decision to withdraw ECMO. The proceedings were a response to the proposed injunction.

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10 *Shortland v Northland Health Ltd,* above n 3.

[91] Further, I am satisfied on the evidence presented that the lives of other patients who might otherwise survive heart attacks will be lost if Mr Maharaj is to remain on ECMO. That is the harsh reality of a limited resource. As Mr White submits, if Mr Maharaj had suffered his heart attack anywhere within New Zealand outside of Auckland, it is almost inevitable he would have died on that day. While I acknowledge that Mr Maharaj's family simply seek time to secure a second opinion as opposed to a position of absolute refusal to consent to the withdrawal of life-support, the ongoing risk to the lives of other patients is a highly relevant consideration.

[92] Third, there is no challenge to the lawfulness of the decision to withdraw the EMCO, rather the alleged unlawfulness is the denial of what is said to be a reasonable opportunity to secure a second opinion.

[93] I am quite satisfied a reasonable body of medical opinion has concluded there is no possibility of Mr Maharaj ever recovering. Mr McGill submits that the evidence filed on behalf of Te Whatu Ora is not from an appropriate "body of medical opinion", but rather from clinicians sharing the same employer and who are, therefore, not truly independent. I do not accept that submission. Each of the clinicians is subject to their Hippocratic Oath, and I am satisfied they have reached their opinions independently, albeit through an appropriate process of consultation. That each of the clinicians expresses an opinion that life support should be withdrawn does not reflect an absence of independence but the strength and validity of the medical opinion.

[94] I acknowledge that an ethics committee has not been consulted. Mr McGill did not advance submissions specific to the issue of referral to an ethics committee. I accept Mr White's submission that in circumstances, where on the medical evidence there is simply no alternative medical intervention available, there is no issue to be resolved by an ethics committee.

[95] Further, and by reference to the factors identified in *Auckland*, I am not persuaded that the family's lack of consent to the proposed withdrawal, in the circumstances of this case, could render the decision to withdraw life support unlawful. As I have found, the position taken by the family is, in large part, a reflection of their shock at learning that there is no medical treatment available that will save

Mr Maharaj's life, having previously understood he was on life support whilst the appropriate remedial procedure was determined, as opposed to an informed disagreement with the clinicians.

[96] As the Court of Appeal observed in *Shortland*,[11] to require the consent of the patient's family to the cessation of a particular form of treatment, or to a decision not to give the patient a particular form of treatment, gives the family the power to require the treatment to be given or continued irrespective of the clinical judgment of the doctors involved. The law cannot countenance such a general proposition.

[97] As Thomas J recognised in *Auckland*, it is only in rare cases that the Court might see fit to make a declaration of the nature sought by Te Whatu Ora.

[98] In my view, this is not an appropriate situation for the Court to make such an order, given the very narrow nature of the alleged unlawfulness and that the clinical decisions made in relation to the treatment of Mr Maharaj have very serious and life-threatening consequences for other patients.

[99] In those circumstances, I am not persuaded that this is a case where the Court should act as the arbiter of clinical decisions. The unanimous opinion of the clinicians who have consulted widely, albeit amongst those employed at Te Whatu Ora, is that it is futile for Mr Maharaj to continue on the VA ECMO machine. In my view, the provision of second opinions and the interests of other patients who are impacted by the clinical decisions relevant to Mr Maharaj are not matters that the Court ought to determine. Those are matters solely for the clinicians, in consultation with the family, to consider and determine. For those reasons, the application made by Te Whatu Ora for declaratory orders is declined.

[100] I am also not satisfied that this is a case where the Court ought to intervene by way of an order for interim relief to allow the family further time to possibly secure a second opinion. Grounds have not been established to justify the granting of injunctive relief. The balance of convenience does not favour placing other patients' lives at risk in circumstances where there is unanimous clinical opinion that

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[11] *Shortland v Northland Health Ltd,* above n 3, at 443.

Mr Maharaj will not survive, in the hope that an expert outside of New Zealand might take a contrary view.

[101] I am not persuaded that the provision of additional time and a second opinion that proffers the possibility of a surgical intervention would lead to any reconsideration by the treating clinicians, given any such second opinion will inevitably be based on limited information and made by persons who have not examined Mr Maharaj.

[102] Relevant to both applications I adopt full-heartedly the observation of the Court of Appeal in *Shortland* that "it is not for the courts to be the arbiters of the merits in cases of this kind".[12]

Result

[103] The application made by Te Whatu Ora is dismissed as is the family's application for injunctive relief.

[104] The Court has every sympathy for Mr Maharaj and his family and the predicament they now face. No doubt lessons will be learnt in terms of ensuring that a family is not given false hope as to the likely outcomes when a loved one is being kept alive by medical intervention. I strongly encourage the family to communicate directly with the responsible clinicians in order that a time can be agreed upon and which the family may, if they so elect, be present when the ECMO is disconnected.

Appeal

[105] Counsel, I have anticipated the possibility of appeals, have you taken instructions in that regard Mr McGill.

[Mr McGill indicates he has no further instructions]

[106] Recognising that time remains of the essence, what I propose doing, subject to hearing from you, Mr White, is to extend the interim injunction until 5 pm this evening to allow the family the opportunity, or indeed Te Whatu Ora, to file an appeal against

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12 *Shortland v Northland Health Ltd,* above n 3 at 134.

my decision. If an appeal is filed, it will be for the appellant to obtain an extension of the interim injunction pending determination of the appeal.

[Mr White indicates he has no further instructions]

[107] The interim injunction I made yesterday will remain in force until 5 pm this evening.

[108] Thank you counsel. I wish the family well.

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Eaton J

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