Queensland Guardianship and Administration Tribunal Decisions

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⇦ SAJ ⇨, re [2007] QGAAT 62 (11 September 2007)

Last Updated: 7 January 2008

GUARDIANSHIP AND ADMINISTRATION TRIBUNAL, QUEENSLAND

CITATION:	⇦ **SAJ** ⇨, Re [2007] QGAAT 62
APPLICATION CONCERNING:	Application for Directions
PARTIES:	**In the matter of ⇦ SAJ ⇨**
FILE NO:	14936
MATTER NUMBER:	2007/2480
ORIGINATING COURT:	Guardianship and Administration Tribunal
DATE OF HEARING:	8 June 2007
DATE OF ORDER:	8 June 2007
DATE OF REASONS:	11 September 2007
TRIBUNAL MEMBERS:	L Clarkson Presiding Member Prof L Willmott Member Dr R Stafford Member
CATCHWORDS:	DECLARATION-GENERAL PRINCIPLES-HEALTH CARE PRINCIPLES-LIFE-SUSTAINING MEASURE-ARTIFICAL HYDRATION-BEST MEDICAL PRACTICE-86 year old in an unresponsive and pre-morbid state following multiple strokes-Where Tribunal considered action of Guardian
CASES QUOTED:	*Re HG [2006] QGAAT 26* *Guardianship and Administration Act 2000* (Qld) Schedule 1, 2 and 4

ORDER

DECLARATION

1. The Tribunal declares that the continuation of artificial hydration to **SAJ** is inconsistent with good medical practice.

APPLICATION FOR DIRECTIONS

2. The application for directions is dismissed.

REASONS FOR DECISION

HISTORY OF THE APPLICATION

[1] At the time this application was heard, **SAJ** was an 83 year old man who experienced a stroke in November 2006, and a subsequent stroke or an extension on or about 16 May 2007.

[2] Prior to his first stroke **SAJ** resided with his spouse.

[3] **SAJ** has two daughters, namely BS and WV. On 16 February 2007, the Tribunal heard separate applications by **SAJ**'s two daughters, each seeking appointment of themselves as his sole guardian and administrator. WV was granted leave at the hearing to withdraw her applications.

[4] The Tribunal appointed the Adult Guardian as guardian for **SAJ** in relation to decisions about his accommodation, health care, and the provision of services, and The Public Trustee of Queensland as his administrator for all financial matters.

[5] **SAJ** was admitted to a Nursing Home where he remained until 21 May 2007.

[6] On 21 May 2007, **SAJ** was admitted to the Hospital with a provisional diagnosis of an extension of cerebrovascular accident.

[7] On 6 June 2007, the Adult Guardian made a decision to instruct the removal of artificial hydration (by way of subcutaneous fluids) to **SAJ**.

[8] On 7 June 2007, **SAJ**'s daughter, BS (the applicant), applied to the Tribunal seeking a stay of this decision of the Adult Guardian.

[9] On 8 June, Counsel for the applicant amended the relief sought and, in effect, asked the Tribunal either to:

(a) Direct the Adult Guardian to order the reinstatement of artificial hydration to **SAJ** as its continuation was not inconsistent with good medical practice; or

(b) Declare that the continuation of the artificial hydration to **SAJ** was not inconsistent with good medical practice.

[10] The Tribunal heard the application on 8 June 2007.

THE PARTIES

[11] The following persons attended the hearing as active parties:

(a) BS - the applicant
(b) MS (by telephone) - **SAJ**'s spouse, (assisted by an interpreter)
(c) Ms Dianne Pendergast - the Adult Guardian.

[12] Attending the hearing as interested parties were:

(a) ES (by telephone) - **SAJ**'s granddaughter
(b) representatives from the Office of the Adult Guardian
(c) Dr S - Medical Registrar at the Hospital.

[13] RC, Ethicist, attended the hearing to assist the applicant.

[14] KW of Counsel was granted leave to appear and represent the applicant.

[15] The Tribunal requested the following medical practitioners to attend the hearing to assist in the matter. Dr D attended the hearing by telephone, and A/Prof P attended in person for part of the hearing.

[16] The Tribunal had the benefit of three suitably qualified and experienced persons in the area of medical ethics to assist with submissions on relevant aspects. They were:

(a) RC, teacher of medical ethics, current director of Queensland Bioethics Centre, and previously Co-ordinator of Christ Formation within the Archdiocese of Brisbane. RC

has presented papers on various topics in the field of Bioethics in Australia and New Zealand.
(b) Dr D, full-time specialist palliative care physician at the Hospital, previously Medical Director of the Wesley Hospital Palliative Care Service. Dr D has particular expertise and a long standing interest in end-of-life care.
(c) A/Prof P, general practitioner with 30 years experience. He is an Associate Professor of Medical Ethics at the University of Queensland and teaches subjects including law and ethics to undergraduate medical students.

THE ISSUES AND THE LEGISLATION

[17] The essential issues for the Tribunal included:

(a) Did **SAJ** have capacity for decisions in relation to the withdrawal of artificial hydration?
(b) Is the Adult Guardian's decision to withdraw artificial hydration a decision about "health care" within the meaning of the *Guardianship and Administration Act 2000* (the Act)? In deciding this issue, it must be considered whether continuing the artificial hydration is inconsistent with good medical practice.

[18] Counsel for the applicant does not challenge the decision of the Adult Guardian to withdraw artificial hydration from **SAJ** on the basis that she has not applied the General Principles or Health Care Principle as required by the *Guardianship and Administration Act 2000*. Further, on the facts before it, the Tribunal could see no grounds for any such submission. Accordingly, the Tribunal did not make a determination about whether the Adult Guardian's consent to withdraw treatment complied with such principles.

[19] Relevant legislation included Schedule 1 of the *Guardianship and Administration Act 2000* relating to the General Principles and the Health Care Principle; sections 5, 5A & 5B of Schedule 2 in relation to the definitions of "health care", "life-sustaining measure", and "good medical practice" respectively; and the definition of "capacity" in Schedule 4 of the *Guardianship and Administration Act 2000*.

DOES SAJ HAVE CAPACITY TO MAKE A DECISION IN RELATION TO THE WITHDRAWAL OF ARTIFICIAL HYDRATION?

[20] Capacity is defined in Schedule 4 of the *Guardianship and Administration Act 2000* as follows:

***"capacity"**, for a person for a matter, means the person is capable of –*
(a) understanding the nature and effect of decisions about the matter; and

(b) freely and voluntarily making decisions about the matter; and
(c) communicating the decisions in some way.

[21] At the hearing on 16 February 2007, in light of the unchallenged medical evidence about **SAJ**'s lack of understanding and inability to communicate, the Tribunal found that he had impaired capacity for decisions about personal and financial matters.

[22] At the hearing on 8 June 2007, BS stated that since her father's most recent admission to hospital, he had regained consciousness, had some communication with her and had held her hand.

[23] However, apart from this assertion, the medical evidence was again unchallenged. It was to the effect that **SAJ** suffered a stroke on 19 November 2006 and either an extension or a new cardio embolic stroke on 16 May 2007. Since that time **SAJ** has remained unresponsive and unable to communicate in any way.

[24] Dr S told the Tribunal that he spoke on behalf of **SAJ**'s treating team, which consisted of himself, Dr Y (general physician, endocrinologist, Visiting Medical Officer), and Dr C. His evidence was to the following effect:

(a) As a result of his second stroke, both of **SAJ**'s cerebral hemispheres have been affected.
(b) **SAJ** has been verbally and non-verbally unresponsive for 24 days and has consistently shown a Glasgow Coma Scale (GCS) score of 3/15.
(c) **SAJ**'s premorbid state was one of severe impairment.
(d) Dr S specifically instructed nursing staff to record in the Progress Notes any change in **SAJ**'s condition, for example, regaining consciousness. The nursing staff reported that **SAJ** opened his eyes once (for about a second), but apart from this event, the Progress Notes do not record anything to indicate that **SAJ** regained consciousness at any time since his admission.

CONCLUSION

[25] On the weight of the evidence, the Tribunal was satisfied that **SAJ**'s cognitive impairment and his ability to communicate have deteriorated since the initial hearing in February 2007, and that **SAJ** continues to have impaired capacity for decisions about personal matters. The Tribunal found in particular that **SAJ** lacks capacity to make a decision about the withdrawal of artificial hydration.

DOES THE DECISION TO WITHDRAW ARTIFICIAL HYDRATION CONSTITUTE A DECISION ABOUT "HEALTH CARE" UNDER THE ACT?

[26] The Tribunal's order of 16 February 2007 conferred power on the Adult Guardian to make decisions for **SAJ** on a range of personal matters, including decisions about health care.

[27] "Health care" is defined in section 5 of Schedule 2, and under section 5(2), health care includes "... withdrawal of a life-sustaining measure for the adult if the ... continuation of the measure for the adult would be inconsistent with good medical practice". Due to the particular wording of section 5(2), the Tribunal should thus consider:

(a) Is artificial hydration a life-sustaining measure in this case?
(b) If so, in the circumstances, is the continuation of artificial hydration inconsistent with good medical practice?

IS ARTIFICIAL HYDRATION A LIFE-SUSTAINING MEASURE IN THIS CASE?

[28] A "life-sustaining measure" is defined in section 5A of Schedule 2 as "health care intended to sustain or prolong life and that supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation". Section 5A(2)(c) provides that artificial hydration is a life-sustaining measure.

[29] The artificial hydration in this case was delivered by way of subcutaneous fluids. **SAJ**'s unresponsive state clearly rendered his bodily functions incapable of independent operation to the extent that he cannot take in the fluids necessary to sustain his life without this procedure. Therefore, artificial hydration is a life-sustaining measure on the facts of this case.

IS THE CONTINUATION OF ARTIFICIAL HYDRATION TO SAJ INCONSISTENT WITH GOOD MEDICAL PRACTICE?

[30] "Good medical practice" is defined in section 5A of Schedule 2 as "good medical practice for the medical profession in Australia having regard to –

(a) the recognised medical standards, practices and procedures of the medical profession in Australia; and
(b) the recognised ethical standards of the medical profession in Australia".

[31] The following evidence was received on the issue of good medical practice.

[32] Dr S (Medical Registrar, the Hospital):

(a) **SAJ** was admitted to the Hospital in an unresponsive state.

(b) Artificial hydration was initially commenced in order to prevent acute renal failure and to give **SAJ** the opportunity to improve.
(c) The continuation of artificial hydration may mean that **SAJ** could live for up to 3 months, whereas without it, he might survive for 7 to 14 days.
(d) In the event that **SAJ** survives for up to 3 months, he will likely develop the following symptoms: he will be in a "starvation state"; his muscles will wither; there is a high probability of developing deep vein thrombosis, aspiration pneumonia, urinary tract infection; without constant turning he will develop pressure sores which could become infected and painful.
(e) Taking into account his premorbid state, the consistent GCS score of 3/15, and the almost certain consequences that will flow from continuing artificial hydration, this treatment was not in the best interests of **SAJ**.
(f) For these reasons he had recommended to the Adult Guardian the withdrawal of artificial hydration.
(g) In his view the continuation of artificial hydration will harm **SAJ** and its continuation is inconsistent with good medical practice.

[33] Dr D (specialist palliative care physician at the Hospital):

(a) He saw **SAJ** twice in the last 24 hours.
(b) Apart from his visits, Dr D relied on the notes in **SAJ**'s medical chart.
(c) **SAJ** has suffered severe strokes, he has a low GCS score, and is presently in a vegetative state. In essence, **SAJ** is in the dying process.
(d) Without artificial hydration, **SAJ** is likely to die within the next 14 days.
(e) The cessation of oral intake is a normal part of the dying process, and in **SAJ**'s case, the emphasis should now be on nursing care to ensure his comfort, dignity and the absence of pain. This result will not be achieved if artificial hydration is continued.
(f) The burden of continuing treatment and the resulting complications will far outweigh any potential benefit to **SAJ**.
(g) The only benefit of continuing artificial hydration is the prolonging of **SAJ**'s life. It will only lengthen the dying process, but the numerous side-effects will lessen his quality of life.
(h) Continuing artificial hydration in these circumstances is inconsistent with good medical practice.

[34] KW stated that she did not challenge the medical evidence about **SAJ**'s present condition or the likely consequences to him of continuing artificial hydration. KW submitted that artificial hydration by way of subcutaneous fluids would not be as burdensome to **SAJ** as the provision of artificial nutrition by way of gastronomic tube. Artificial hydration had benefited **SAJ** to this point, and the Tribunal might consider a short term extension of the treatment to give **SAJ** a further opportunity to recover.

[35] Dr D disagreed with the submission that artificial hydration had benefited **SAJ**.

Further, while the process of artificial hydration might not in itself be burdensome, the effects of the process would be harmful and burdensome.

[36] A/Prof P (Associate Professor of Medical Ethics at the University of Queensland):

(a) He placed significant weight on the professional opinion of Dr D.
(b) On the material he has seen, including the Progress Notes, the course of **SAJ** 's illness and his continuous lack of response, **SAJ** is in the dying process.
(c) Continued artificial hydration is likely to be harmful to **SAJ**. It will cause physiological harm and will be detrimental to his general comfort.
(d) The concept of good medical standards has elements of medical and ethical components.
(e) Medical standards include statements of principle from the Australian Medical Association (AMA) and the recognised legal standards of care under relevant Queensland legislation.
(f) Ethical standards include the AMA Code of Ethics and other statements concerning dying and terminally ill patients. While there is no specific guidance, there is a focus on the well-being of patients and on the prevention of harm to them.
(g) In this case the continuation of artificial hydration is not ethical. The reason for this view is that the procedure has no possible benefit to **SAJ**, and in fact will likely cause him harm. The treatment is clinically futile.
(h) On weighing up the benefits against the burden of continuing artificial hydration, in A/Prof P's view, its continuation is inconsistent with good medical practice.

[37] KW queried that, given the provision of subcutaneous fluids was not comparatively burdensome for **SAJ**, might there not be ethical considerations for continuing the process and thus extending his life for a relatively short period.

[38] A/Prof P responded that the only benefit is extending **SAJ**'s life at its current quality. It was impossible to state from a clinical perspective when the stage is reached that **SAJ** is being burdened by continuing artificial hydration.

[39] RC (teacher in Medical Ethics):

(a) In a given situation, depending on the particular individual's circumstances, there could be more than one position that is ethically acceptable.
(b) In cases such as these, there are two fundamental principles:

(i) action should not be taken to deliberately shorten a person's life; and

(ii) futile or overly burdensome treatment should not be continued.

(c) RC queried the description of artificial hydration as futile, given that it was achieving its purpose – that is, maintaining **SAJ**'s life.
(d) RC accepted the testimony of the medical practitioners in relation to the likely

consequences to **SAJ** of continuing artificial hydration, and the burdensome nature of this process.
(e) Nevertheless, because of the fact that other medical practitioners might in similar

circumstances reach a different conclusion, RC did not accept the proposition that the continuation of artificial hydration would be contrary to good medical practice.

[40] The following evidence and submissions were received from the applicant and her counsel, KW, respectively.

[41] Evidence from BS:

(a) Her father was a strong willed person whose philosophy was not to give up without trying, even if the chances were one in a million against recovery.
(b) **SAJ** would prefer to die from old age or a disease, that is, a natural death. He would not want to die as the result of withdrawal of subcutaneous fluids.
(c) BS stated that her father had not been given a chance to live.
(d) She referred to the possibility of transferring **SAJ** to Mount Olivet Hospital where other treatments may be considered. She does not intend to give up on her father.
(e) BS is the only person who has spent many hours with her father at the hospital, and has noticed certain improvements in him. He recovered consciousness on a number of occasions while she was there. **SAJ** swallowed twice on her instructions and she believes he understood things she was saying to him because of his eye contact, and on one occasion he grabbed her hand.
(f) BS acknowledged that artificial hydration and any possible future artificial nutrition would be a burdensome procedure for her father.

[42] The possibility of **SAJ** recovering consciousness and listening to his daughter speaking to him was raised with Dr S and A/Prof P. Dr S's view was that it would not be possible for **SAJ** to listen to a conversation in his clinical state. A/Prof P also indicated that, in the circumstances, he would be surprised if **SAJ** regained consciousness to the extent described by BS.

[43] KW's final submissions on good medical practice:

(a) KW referred to this Tribunal's decision in *Re HG [2006]* QGAAT 26 (5 May 2006) in relation to whether the Adult Guardian's decision relates to a health matter, and the concept of good medical practice. KW submitted that while **SAJ**'s condition was moving towards the risks associated with prolonging treatment, that stage had not yet been reached.
(b) It is likely that, at the current stage, there would be alternative options acceptable to the medical profession – that is, either to continue or to withdraw artificial hydration.
(c) In line with the views of the Tribunal expressed in *Re HG*, the requirement for

continuing the measure to be inconsistent with good medical practice could not be satisfied if there was evidence of two medically and ethically acceptable treatment options for **SAJ**.

[44] In response to questions from the Tribunal, KW advised that she could not produce medical evidence that, on the facts of this case, the continuation of artificial hydration was consistent with good medical practice.

[45] Ms Pendergast (Adult Guardian):

(a) Ms Pendergast gave evidence to the Tribunal that the decision to withdraw artificial hydration was very difficult for her to make. The decision was made on the basis of medical advice from **SAJ**'s treating team and after visiting **SAJ** in hospital.
(b) In Ms Pendergast's view, the continuation of artificial hydration would simply extend the opportunity for **SAJ** to suffer the downside of the likely after-effects of treatment, including experiencing pain.
(c) The likely detriment clearly outweighed any possible benefit to **SAJ**. The withdrawal of artificial hydration was consistent with good medical practice, and in her view a continuation of the procedure was in this case ethically unsustainable.

DISCUSSION OF THE EVIDENCE

[46] In this case the medical evidence is largely unchallenged and the Tribunal makes the following findings of fact:

(a) **SAJ** is dying, and he may already have died if not for the intervention of the provision of subcutaneous fluids.

(b) **SAJ** has no reasonable prospect of recovery.

(c) The continuation of artificial hydration will have no effect other than to lengthen **SAJ**'s life in his present unresponsive condition for a matter of months.

(d) The continuation of artificial hydration will almost certainly be severely detrimental to the well being of **SAJ** – with consequences consistently outlined by all the medical practitioners who gave evidence at the hearing.

(e) The suffering to be endured by **SAJ** (the burden) as the result of continuing artificial hydration far outweighs any benefit he might receive by continuing the process.

[47] On the basis of these objective considerations, the Tribunal had no difficulty in finding that withdrawing artificial hydration is consistent with good medical practice.

[48] However, as has been stated, consistency with good medical practice is not sufficient for the withdrawal of artificial hydration to fall within the definition of health care in section 5(2) of Schedule 2 of the *Guardianship and Administration Act 2000*. The essential question is whether *the continuation of treatment is inconsistent with good medical practice.*

[49] RC submitted that **SAJ**'s circumstances could properly lead a medical practitioner to recommend withdrawing artificial hydration, but that another medical practitioner might equally properly conclude and recommend otherwise. This scenario was supported by KW. If these submissions are correct, then it cannot be said that either treatment option is contrary to good medical practice.

[50] However, the evidence of all the attending medical practitioners was consistently to the effect that continuation of artificial hydration in **SAJ**'s case would be inconsistent with good medical practice. Dr S's evidence was significant in that, in addition to his own views, he was also expressing the views of **SAJ**'s treating team. Also of critical importance was the evidence of A/Prof P and Dr D. Their expertise and experience was of significant assistance to the Tribunal and their insightful and consistent testimony was compelling.

[51] The passage in *Re HG* (para [64]) cited by KW refers to "*evidence that there were two medically and ethically acceptable treatment options*". However, in **SAJ**'s case, there was no medical evidence to suggest that providing artificial hydration was consistent with good medical practice.

CONCLUSION

[52] In all the circumstances, the Tribunal concluded that the continuation of artificial hydration to **SAJ** would be inconsistent with good medical practice. The Adult Guardian's decision to withdraw artificial hydration was therefore a decision about health care within the meaning of section 5(1) and (2) of Schedule 2.

[53] An order dismissing the application for directions was made accordingly.

[54] It is pertinent to comment that in a number of previous cases involving end-of-life decisions, reference has been made to the relationship between the Act and the criminal law. This Tribunal has, in previous cases, referred to this difficulty and has made certain recommendations. It is not intended to canvass these issues again. However, due to the fact that the application may have been dismissed on grounds other than a finding that the decision was not a decision about health care, the Tribunal took the view that a declaration outlining the reason for its decision may assist all parties, including legal and medical practitioners, in the future.

[55] A declaration that the continuation of artificial hydration to **SAJ** is inconsistent with good medical practice was made accordingly.