TABLE OF CONTENTS

- Majority of HC adopted the distinction between treatment which has the 'purpose of curing some disease or malfunction of the body' (**'therapeutic treatment'**) and that which is proposed for other reasons (**'non-therapeutic treatment'**).
- Where non-therapeutic treatment is proposed for minors, parents don't have power to consent → court or tribunal consent is mandatory.
- The majority based this decision on the seriousness of the proposed treatment and the risks involved in parents making such decisions.
    - The sterilisation procedure was described by the court as invasive and irreversible.
    - Invasiveness and irreversibility did not on their own justify the finding of mandatory authorisation + the addition of factors as the gravity of the operation and the risk of a wrong decision
    - It was said that the risk of a wrong decision was increased by the great difficulty and complexity of the issues, the tendency for the medical profession to 'medicalize' the decision and the tendency for the interests of others, such as relatives, to be confused with or override the interests of the incompetent.

Court as an uber-parent

- *Marion's* a departure from the traditional understandings of the role of the court.
    - In the past the court's power was one of supervision and review if parent's were making bad decisions / disappeared
    - Court would exercise the same powers as traditional powers
- *Marion's case* changed that fundamentally by making the court an *uber*-parent – a parent who can decide issues that other parents cannot.
- John Seymour, 'The Role of the Family Court of Australia in Child Welfare Matters' (1992-1993) 21(1) *Federal Law Review* 1.

Issues: therapeutic vs non-therapeutic

- Over time, this distinction was collapsed
- *Re B (A Minor)(Wardship: Sterilisation)[1988]*
    - The distinction between therapeutic and non-therapeutic treatments proved difficult from the start. The majority recognised that the therapeutic/non-therapeutic distinction was imprecise (noting that the House of Lords had already rejected the distinction for this reason).
    - Brennan J and Deane J both highlighted the difficulties of the distinction in their dissents.
    - Deane J was also quick to point out that it was still within the power of parents to consent to 'plastic surgery… for purely cosmetic purposes' and 'male circumcision for perceived hygienic — or even religious — reasons', even though he believed both to be non-therapeutic.

<u>After *Marion's case*</u>

- After *Marion's case*, cases began to emerge which showed that decision as to whether court authorisation was mandatory had more to do with a general feeling of judicial unease, rather than a rational employment of the therapeutic/non-therapeutic distinction.
- A pattern of contradictory cases has emerged. Even though all the judges in *Marion's case* recognise that there may be cases of therapeutic sterilisation, there are numerous examples where the judges' feelings of trepidation or discomfort with sterilisation seem to push the court into finding treatments to be non-therapeutic.

- It did approve tests from earlier cases, which adopted the suggestion that gross negligence describes cases where the defendant has shown such disregard for the life and safety of others as to deserve punishment.

R v Misra [2004] EWCA Crim 2375

Facts:

- Two doctors appealed convictions for manslaughter after their patient died from toxic shock syndrome after routine knee surgery.
- Both doctors had been responsible for the post-operative care of the patient and had failed to realise that the patient was suffering from a post-operative infection.
- The doctors appealed on the basis that the law regarding negligent manslaughter was unclear and a breach of the *Human Rights Act 1998* (UK).

Ruling:

ROL:

- In our judgment the law is clear.
- The ingredients of the offence have been clearly defined, and the principles decided in the House of Lords in *Adomako*. They involve no uncertainty. The hypothetical citizen, seeking to know his position, would be advised that, assuming he owed a duty of care to the deceased which he had negligently broken, and that death resulted, he would be liable to conviction for manslaughter if, on the available evidence, the jury was satisfied that his negligence was gross.
- A doctor would be told that grossly negligent treatment of a patient which exposed him or her to the risk of death, and caused it, would constitute manslaughter. (at [64])

Bawa-Garba v R [2016] EWCA Crim 1841

Facts:

- Junior doctor specialising in paediatrics returning14 months of maternity leave.
- Employed in the Children's Assessment Unit of the hospital which would receive patients from Accident and Emergency or from direct referrals by a GP.
- Its purpose was to assess, diagnose and (if appropriate) then treat children, or to admit them onto a ward or to the Paediatric Intensive Care Unit as necessary
- Jack, 6 yo with Downs Syndrome, fell ill and his GP referred him to hospital
- Susceptible to coughs, colds and resulting breathlessness.
- Jack arrived and was admitted at about 10.15 am - unresponsive and limp - initially treated for acute gastro-enteritis (a stomach bug) and dehydration – later treated for a chest infection (pneumonia) with antibiotics.
- The responsible staff were Dr Bawa-Garba and her two co-accused nurses.
- Later it was found that Jack had pneumonia which caused his body to go into septic shock.
- Jack had organ failure and his heart failed at 7.45 pm
- CPR was administered but the defendant stopped CPR thinking he was child with a DNR (do not resuscitate order)
- CPR was reinstated very quickly afterwards after but Jack died
- Jury found Dr and one nurse guilty of manslaughter
- Prosecution points

  i) a history of diarrhoea and vomiting for about 12 hours;
  ii) a patient who was lethargic and unresponsive;
  iii) a young child who did not flinch when a cannula was inserted (to administer fluids);
  iv) raised body temperature (fever) but cold hands and feet;

- *Washington v Glucksberg* 521 US 702 (1997)
- *Vacco v Quill* 521 US 793 (1997)
- Oregon: Death with Dignity Act (1994)
- Washington: Death with Dignity Act (2008)
- Vermont: Patient Choice at End of Life Act (2013)
- California: End of Life Option Act (2015)
- Colorado: End-of-Life Options Act (2016)
- District of Columbia: Death with Dignity Act (2017)
- Hawaii: Our Care, Our Choice Act (2018)
- Maine: Death with Dignity Act (2019)
- Baxter v Montana 224 P 3d 1211 (2009)

R (Pretty) v Director of Public Prosecutions [2002] 1 AC 800.

Facts:

- Diane Pretty suffered from motor neurone disease and was unable to commit suicide without assistance.
- Pretty wished for her husband to aid her suicide but requested that the DPP undertake not to prosecute him for breaching the *Suicide Act 1961* (UK).
- The Director refused to give such an undertaking. She then brought an application for judicial review of the decision of the Director.
- Pretty argued that under the *Human Rights Act 1998* (UK) she had a right to aid in dying, the effect of which would be to protect her husband from being charged for assisting her suicide.
- Pretty's main arguments were that her right to assisted suicide was based on the right to life (contained in Article 2), the prohibition of torture (Article 3), the right to respect of private and family life (Article 8), freedom of thought, conscience and religion (Article 9), and the prohibition of discrimination (Article 14).

Ruling:

The House unanimously agreed that she failed on all counts.

ROL:

- With respect to the right to life, it was found that while the state had no obligation to keep Pretty alive against her will, the state did not have to recognise her right to commit suicide.
  - The right to life enjoined the state from killing and also imposed on it a duty to safeguard life. It did not include a right to kill.
  - Moreover, such a recognition would conflict with the deeply embedded principles of the common law which distinguish between killing and letting die
- The argument based on the prohibition of torture was also dismissed. The "negative" prohibition against torture did not include a "positive" right to die.
  - Nor was there any positive action on the part of the state to inflict pain or a failure to properly treat Pretty's condition.
- Pretty's arguments about her right to freedom of thought, conscience and religion were given short shrift, Lord Steyn stating that Article 9 did not give individuals a right to perform any acts in pursuance of whatever beliefs they might hold.
- With regards to the discrimination argument, Article 14 can only be invoked if other Articles have been offended. Given the findings of the House on the other claims, the claim based on discrimination failed.
  - Even so, the Lords considered that there was no discrimination on any account as the criminal law applied to all equally, whether the victims of an assisted suicide were able-bodied or not.
- An appeal to the European Court of Human Rights was also unsuccessful – difficult balance, should be left up to particular member states

(4) providing guidance, advice and support (including emotional support) to all midwives; this is only covered insofar as it relates to guidance, advice and support directly connected with the care of a particular patient undergoing a termination, such as whether to administer another round of drugs, as opposed to the ordinary monitoring of any patient on the ward;
(5) accompanying the obstetricians on ward rounds; this would not be covered by the conscience clause as interpreted above, except to the patients undergoing terminations; but there would be little that a midwife with conscience objections could contribute to such a ward round for patients undergoing a termination;
(6) responding to requests for assistance, including responding to the nurse call system and the emergency pull; responding by itself is not covered; it would depend upon the assistance requested whether it was part of the treatment for a termination;
(7) acting as the midwife's first point of contact, if the midwife is concerned about how a patient is progressing; in itself, this is not covered; but the assistance required may be, depending upon what it is; and if assistance is required with the course of treatment leading to a termination, the Labour Ward Co-ordinator should refer to someone else who does not share her conscientious objection to assisting;
(8) ensuring that midwives on duty receive break relief, which may mean that the Labour Ward Co-ordinator provides the break relief herself; ensuring break relief is not covered but providing it oneself is covered;
(9) being present to support and assist if medical intervention is required, for example, instrumental delivery with forceps; this is covered by the conscience clause as interpreted above;
(10) communicating with other professionals, eg paging anesthetists; this is a managerial task which is not covered by the conscience clause as interpreted above;
(11) monitoring the progress of patients to ensure that any deviations from normal are escalated to the appropriate staff level, eg an obstetrician; responding to and passing on the judgment of the treating midwife is an administrative task not covered by the conscience clause as interpreted above; however, forming the judgment personally would be taking part in the treatment;
(12) directly providing care in emergency situations; this is covered by the conscience clause, unless falling within section 4(2) as it normally would;
(13) ensuring that the family are provided with appropriate support; this is not covered by the conscience clause as interpreted above. It is not treatment authorised by the Act as it has never been unlawful. However, as with helping with arrangements after the baby is delivered, it may be reasonable to expect an employer to accommodate an employee's objections, in the interests of providing the family with the most effective service.

- N.b. not directly appropriate to refer that back to NSW/Qld/Vic legislation
- Obligation only goes to providing referrals (point of request)

Topic 7: Duty of Care

Negligence

1. Is there a duty of care?
    a. Reasonable foreseeability - neighbourhood principle (Donoghue v Stevenson)
    b. Proximity – circumstantial, relationship, causal

- She was not told about the risks of her experiencing mechanical problems during labour - that risk was 9-10% in the case of diabetic mothers.
- Treating Dr accepted that this was a high risk
    - But common practice was not to spend time discussing potential risks of shoulder dystocia
- Risk to baby was small and if the condition was mentioned, "most women will actually say, 'I'd rather have a caesarean section'" - "everyone would ask for a caesarean section, and it's not in the maternal interests for women to have caesarean sections"
- At 30 weeks M expressed concerns about the size of the baby – again failure to warn
- Baby had shoulder dystocia and ended up having forceps delivery after attempted symphysiotomy
- Umbilical cord occluded and child had cerebral palsy and Erb's palsy
- Negligent advice?

Ruling:

ROL:

Lord Kerr and Lord Reed at [83]

- The former role is an exercise of professional skill and judgment: what risks of injury are involved in an operation, for example, is a matter falling within the expertise of members of the medical profession.
- But it is a *non sequitur* to conclude that the question whether a risk of injury, or the availability of an alternative form of treatment, ought to be discussed with the patient is also a matter of purely professional judgment.
- The doctor's advisory role cannot be regarded as solely an exercise of medical skill without leaving out of account the patient's entitlement to decide on the risks to her health which she is willing to run (a decision which may be influenced by non-medical considerations).
- Responsibility for determining the nature and extent of a person's rights rests with the courts, not with the medical professions.

Lady Hale:

- A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the "natural" and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby. She may place great value on giving birth in the natural way and be prepared to take the risks to herself and her baby which this entails.
- The medical profession must respect her choice, unless she lacks the legal capacity to decide (*St George's Healthcare NHS Trust v S*). There is no good reason why the same should not apply in reverse, if she is prepared to forgo the joys of natural childbirth in order to avoid some not insignificant risks to herself or her baby.
- She cannot force her doctor to offer treatment which he or she considers futile or inappropriate. But she is at least entitled to the information which will enable her to take a proper part in that decision.

Civil Liability Act

5O Standard of care for professionals

(1) A person practising a profession does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that was widely accepted in Australia by peer professional opinion as competent professional practice.

(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

- Brereton J also rejected a defence under s 5I – only applies where D could have avoided injury through own reasonable care & skill. Here, the risk was relevant to the surgeon not Cooke
- Paul appealed to the NSWCA; Cooke appealed the rejection of s 5I

Leeming JA on the **policy of s 5I** at [53]:

- If a case can conveniently be decided under s 5I, it should be. The language of s 5I reflects the elements of liability which the plaintiff needs to establish. That is why it is framed in terms of the broader causal language of "as a result of", reflecting the language of s 5A(1) rather than of s 5D(1), and why its opening words are "A person is not liable in negligence". That is reinforced by s 5I(3), which carves out from the operation of the section "to exclude liability" a class of liability connected with a duty to warn.
- Section 5I does not deny s 5D causation; rather it answers the implicit question posed by the "claim" contemplated by s 5A(1) negatively: the defendant is not liable for that claim for damages for harm resulting from negligence.
    - I.e. can be applied when causation is proved

Leeming JA on whether s 5I is concerned with **the occurrence of injury or the risk of occurrence** at [67]:

- The question posed by the statute is whether the "**risk** of something occurring", ie the "risk of intra-operative rupture followed by stroke" (not the occurrence itself) could have been avoided by the exercise of reasonable care and skill.
- That had to be determined from Ms Paul's position *before* she underwent surgery. There was always a small but unavoidable risk of intra-operative rupture followed by stroke. In those circumstances, s 5I applies.

Leeming JA rejects Brereton J's reasoning on limiting the section to the D's reasonable care and skill at [76]:

- Put simply, whether or not Dr Cooke exercised reasonable care, Ms Paul always faced the risk of intra-operative rupture if she chose to undergo surgery. Either way, the whole of the harm suffered by Ms Paul was as a result of the materialisation of the risk in 2006 she chose to run on the operating table. It is no answer to say that she would have, but for Dr Cooke's negligence, chosen to run that risk (or for that matter a slightly different risk) in 2003.
- Either way, Ms Paul faced an unavoidable risk once she chose to undergo a procedure following the diagnosis of her aneurysm. That is exactly the circumstance to which s 5I applies. Her harm resulted from the materialisation of a risk which could not be avoided by the exercise of reasonable care and skill.

Complications from negligence?

- It follows that the view which I favour does not detract from the well-established principle that a defendant is liable not merely for injuries caused by his or her negligence, but also for complications (whether negligent or non-negligent) from any resulting medical treatment. Mr Kirk SC gave the example of a driver whose negligence causes a pedestrian to be hospitalised needing a general anaesthetic. The unavoidable anaesthetic risk in that case is not an "inherent risk" within the meaning of s 5I, because the occasion for administering an anaesthetic was created by the defendant's negligence. It would be inaccurate and incomplete to describe the pedestrian's harm as resulting from the materialisation of the unavoidable anaesthetic risk.
- The example given by Basten JA at [9] of a patient being harmed by the materialisation of an unavoidable risk from treatment which the patient only underwent by reason of a negligent

- To deny such recovery is to provide a zone of legal immunity to medical practitioners engaged in sterilisation procedures that is unprincipled and inconsistent with established legal doctrine

Gleeson CJ in dissent at [39]:

- Case involves pure economic loss – involve difficulties with assessment
- The liability sought to be imposed is indeterminate. It is difficult to relate coherently to other rules of common law and statute. It is based upon a concept of financial harm that is imprecise; an imprecision that cannot be concealed by an arbitrary limitation of a particular claim in subject matter or time. It is incapable of rational or fair assessment.
- Furthermore, it involves treating, as actionable damage, and as a matter to be regarded in exclusively financial terms, the creation of a human relationship that is socially fundamental. The accepted approach in this country is that "the law should develop novel categories of negligence incrementally and by analogy with established categories". The recognition of the present claim goes beyond that, and is unwarranted.

Reform

- 3 days later, 3 states changed legislation
- Codified law of McFarlane into NSW → CLA s 70/71

Wrongful Birth

Failure to diagnose condition in child

Veivers v Connolly [1995] 2 QdR 326

- Failure to diagnose an infection or disease in the pregnant woman
- Lost opportunity to lawfully terminate rubella infected pregnancy
- Found the defendant doctor should have appreciated that this plaintiff was a responsible person who would not abandon a disabled child suffering from rubella embryopathy and would undertake normal maternal responsibility for her upbringing which would necessarily involve substantial additional cost and personal loss

Failure to diagnose pregnancy

CES v Superclinics Pty Ltd (1995) 38 NSWLR 47

Facts:

- Pregnancy test produced false negative
- Clinic gave wrong results afterwards
- Loss of opportunity to abort

Ruling:

- Kirby ACJ and Priestley agreed to limit damages to medical expenses and lost income for period of pregnancy

ROL:

- Kirby rejected the application of the benefits rule in this particular case
    - I see no other reason, grounded in public policy, to prevent a full recovery by the appellants of the damages which were claimed to compensate the appellants for the damage incurred, physical, psychological and economic
    - Ending up agreeing with Priestley due to the 3 way split
- Priestley JA would have allowed damages but rejected costs of raising the child after the time when the child could have been adopted - keeping the child beyond that point was a failure to mitigate loss
    - Rejected in *Veivers v Connelly*
    - Rejected in ***Armellin***

- This represented an error of law either in the interpretation of s 68(1)(a)–(d) or in the application of those statutory criteria. Therefore, in the case of PBU, common grounds 1 and 2 and ground 3(a) will be upheld.

NJE:

- VCAT found that NJE did not satisfy the criterion in para (c) because '[t]o *use and weigh* requires a person to carefully consider the advantages and disadvantages of a situation or proposal before making a decision' (emphasis in original).
- VCAT went on to say that NJE refused to give consent for ECT 'without prior consideration of the advantages and disadvantages' and 'she could not be persuaded that the information was relevant to her'.
- VCAT's decision was erroneous because it:
    - (1) it focused upon whether NJE had *actually* considered the advantages and disadvantages of the decision, not *whether she had the ability* to use or weigh relevant information; and
    - (2) it *applied a threshold of capacity* that required the person 'to carefully consider the advantages and disadvantages of the situation or proposal', *which was too high*.