

Re BWV; Ex parte Gardner

Supreme Court of Victoria
Common Law Division
Morris J
20–22, 29 May 2003
(2003) 7 VR 487; [2003] VSC 173

Morris J.

[1] The plaintiff is the Public Advocate of Victoria. This position is a statutory position created by s 14 of the Guardianship and Administration Act 1986.

[2] By reason of s 16(1)(a) of that Act the public advocate may be appointed by the Victorian Civil and Administrative Tribunal (“the tribunal”) to be a guardian, whether plenary or limited, of a person who needs representation.

[3] On 28 February 2003 the tribunal appointed the public advocate to be a limited guardian of BWV, a woman aged 68 years who suffers from dementia. The appointment constituted the public advocate as a limited guardian of BWV with powers and duties to make decisions concerning her medical treatment.

[4] BWV suffers from a progressive and fatal form of dementia, probably Pick’s Disease. She has not appeared conscious, or to have any cortical activity, for approximately three years. She appears to have no cognitive capacity at all and has no bodily functions, other than those which are reflexive. Further, she appears to have no conscious perception of input from any of her sensory pathways.

[5] BWV receives fluid and nutrition, via a percutaneous endoscopic gastrostomy (“PEG”), which process keeps her alive.

[6] BWV requires full nursing care: she is doubly incontinent; she receives regular pressure care; she is moved into a shower by a hoist; and she receives medications, as well as nutrition and hydration, through the PEG.

[7] Although the brain stem of BWV continues to function normally, the medical evidence is that the damage to the cortex is irreparable. There is no prospect of any recovery, or improvement of any kind in BWV’s condition.

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[8] The evidence of the three medical witnesses who examined BWV is that the provision of nutrition and hydration, via the PEG, is futile, in the sense that it has no prospect whatever of improving her condition.

[9] It is in these circumstances that the plaintiff seeks declarations from the court that:

- (a) provision of nutrition and hydration via a PEG to BWV constitutes “medical treatment” within the meaning of the term in the Medical Treatment Act 1988; and
- (b) refusal of further nutrition and hydration administered via a PEG to BWV constitutes refusal of “medical treatment”, rather than refusal of “palliative care”, within the meaning of the Medical Treatment Act.

[10] The significance of the distinction between “medical treatment” and “palliative care”, in the context of the Medical Treatment Act, revolves around the provisions of

ss 3, 4 and 5B of that Act, which effectively allows a guardian, on behalf of a patient, to refuse medical treatment, but not to refuse palliative care.

[11] If the declarations sought are made, the public advocate, on behalf of BWV, intends to refuse further medical treatment in the form of the provision of nutrition and hydration via the PEG (subject to satisfying certain other conditions required by the Act). If this occurs BWV will die within one to four weeks of the withdrawal of such nutrition and hydration.

Parties and amici curiae

[12] The application was made by way of an originating motion, without naming any defendant.

[13] On 13 May 2003 Master Kings ordered that the Attorney-General for the State of Victoria be given leave to intervene. Counsel for the Attorney-General subsequently explained to the court that the application to intervene had been made to ensure that there was a proper contradictor; and, also, to ensure that certain matters concerning the public interest were considered by the court.

[14] On 14 May 2003 I considered an application by Right to Life Australia Inc to be joined as a party to the proceeding and be given leave to intervene in the proceeding. I refused this application. I considered that Right to Life Australia Inc could not demonstrate any legal interest which would entitle it to be made a party or be given leave to intervene. Further, I indicated that I would have refused to give leave for Right to Life Australia Inc to be joined as a party as a matter of discretion.

[15] None the less I did decide that Right to Life Australia Inc should be given leave to appear before the court as amicus curiae; subject to the condition that, subject to any further order, its participation in the hearing be confined to making written submissions and oral submissions (confined to one hour) concerning the interpretation of the Medical Treatment Act in the context of the application for declarations in the case.

[16] The Most Reverend D J Hart, Catholic Archbishop of Melbourne, and Catholic Health Australia Inc also appeared before me on 14 May 2003. These persons did not seek to be joined as parties, or be given leave to intervene in the proceeding; but they did apply to be given leave to appear as amici curiae. I granted such leave, on the same basis as that set out above in relation to Right to Life Australia Inc.

[17] In refusing the application of Right to Life Australia Inc to be joined as a party, and in granting the applications for leave to appear as amici curiae, I had regard

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to the comments of Brennan CJ and Kirby J in *Levy v Victoria*.¹ It is unusual for the status of amicus curiae to be given to a person in a hearing before the Trial Division of this court. However, it struck me that the nature of the proceeding, the novelty of the issues raised, the possible implications of any decision and the uncertainty about the precise role that the Attorney-General might play in the proceeding all justified this course. (As matters transpired, the Attorney-General played a substantial role in the hearing and made submissions contrary to those of the public advocate.)

Evidence

[18] The public advocate has given evidence to the court that he has obtained information in relation to BWV's current condition from four medical practitioners, being:

- Dr Michael Woodward, MBBS, FRACP, consultant physician in geriatric medicine and general medicine and rehabilitation;
- Dr Noel G Whitty, BWV's treating general practitioner;

- Professor Michael Ashby, MD, MRCP, FRCR, FRACP, FACHPM, Head of Palliative Care Unit at the Monash Medical Centre; and
- Professor Malcolm Horne, MBBS, PhD, FRACP, Director of Neurological Sciences at the Monash Medical Centre.

[19] The public advocate has also given evidence to the court that he has consulted with the family of BWV, which consists of the husband of BWV and six adult sons and daughters of BWV. By reference to these matters, the public advocate has formed the view that it would be contrary to the wishes of BWV to continue to receive nutrition and hydration through the PEG and that the continuation of these measures constitutes a continuing denial of her wishes. Further, the public advocate has formed the view, after consultation with the medical practitioners and the members of BWV's family, that BWV would, after giving serious consideration to her health and well-being, consider that the medical treatment she is receiving is unwarranted and unreasonable.

[20] The affidavit of the public advocate also set out statements of the family of BWV as to what they knew of BWV's wishes if she was ever to be in her current condition. It was argued that this part of the public advocate's evidence was inadmissible as hearsay; and I expressly reserved ruling on this question until the giving of judgment. As matters transpired it has become unnecessary for me to make any ruling as my decision can be made without relying on this evidence.

[21] Dr Ashby, who is highly qualified in the field of palliative medicine, visited BWV on 14 April 2003 and subsequently provided a report to the public advocate. He expressed the opinion that BWV is slowly dying of advanced dementia. In his view it is in accordance with good medical practice, and in particular good palliative care, for the PEG to be removed and for the provision of fluids and nutrition to cease. He believes the present nutrition and hydration regime does not accord with the "reasonable provision of food and water" because it is only having the effect of prolonging the natural dying process.

[22] Professor Horne is a highly qualified expert in neuroscience. He saw BWV on 13 April 2003, made investigations and subsequently provided a report to the public advocate. His report, which provides a basis for the findings set out earlier in this judgment, concludes by stating that BWV has no prospect of any recovery, or any improvement of any kind.

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[23] Dr Michael Woodward, a consultant physician in geriatric medicine, also provided a report to the public advocate. This report offers further support to the findings set out earlier in this judgment. However Dr Woodward's report did differ in that he stated that, in his opinion, the maintenance of hydration and nutrition is not generally regarded as medical treatment. By this he meant that the actual administration of the nutrition and hydration, through the PEG, is not regarded as medical treatment. In his oral evidence Dr Woodward shifted from this view and he told the court that he would certainly regard the provision of food and fluid, via a PEG, as an example of a medical procedure, if not medical treatment.

[24] However, in my opinion, medical opinion as to whether or not the administration of nutrition and hydration through a PEG is, or is not, medical treatment is not directly relevant in the context of the Medical Treatment Act, because the expression "medical treatment", when used in the Act, carries a special, statutory meaning.

[25] Evidence was also given to the court by Dr Peter John McCullagh. Dr McCullagh is now retired, but has previously worked in medical research and has been the President of the National Brain Injury Foundation. The circumstances in which Dr McCullagh gave evidence were somewhat unusual. In December 2002, prior to the VCAT hearing, an officer of the public advocate had contacted Dr McCullagh seeking information about the

circumstances in which artificial nutrition and hydration, via a PEG, might be refused. Dr McCullagh had apparently written a book, which had not then been published, on questions relating to brain injuries. Dr McCullagh provided a short series of comments on 15 December 2002 in relation to the withdrawal of PEG feeding. The matter was left there and would have remained there, but for the fact that Dr McCullagh decided to attend the first day of the hearing. On that day counsel for Right to Life Australia Inc raised a concern that the public advocate was not being candid with the court because he was not calling Dr McCullagh to give evidence. Subsequently the public advocate explained that he did not have any personal knowledge that Dr McCullagh had been contacted by a junior officer in his employ. I accept that evidence. None the less, in order to remove any possible concern, Mr Burnside QC, who appeared with Dr Freckelton for the public advocate, called Dr McCullagh to give evidence.

[26] Although I have found reading the transcript of Dr McCullagh's evidence informative and helpful in relation to some of the issues I am called upon to decide, his evidence cannot be regarded as being in the same category as the evidence of Dr Ashby, Professor Horne or Dr Woodward. Dr McCullagh has not examined BWV and, really, he is in no position to give evidence about her condition.

[27] Having regard to what was put to me, I do wish to record that I am satisfied that the public advocate has displayed candour with the court. It was suggested at one stage that I was having the wool pulled over my eyes. If that is the case, I certainly have not detected it.

Submissions

[28] Essentially the public advocate submitted that the matter before the court was governed by the Medical Treatment Act. It was submitted that the administration *7 VR 487 at 493* of nutrition and hydration via a PEG was (what I will call) *prima facie medical treatment* because it was either the administration of a substance like a drug or some other medical procedure. Further it was submitted that such administration, or procedure, did not constitute palliative care, whether by reference to the natural meaning of the words "palliative care", or any of the included words. In relation to para (b) of the definition of palliative care, it was submitted that the proper meaning of the expression "the reasonable provision of food and water" was the ordinary provision of food or water, being food or water provided for oral consumption. Alternatively it was submitted that, if the provision of food and water by artificial means, through a PEG, was embraced by the words in para (b) of the definition of palliative care, then this was not "reasonable" in all the circumstances.

[29] Counsel for the Attorney-General took issue with a number of elements of this argument. Ms Tate SC, who appeared with Ms Brophy for the Attorney-General, questioned whether the administration of artificial nutrition and hydration to BWV could be regarded, *prima facie*, as within the definition of medical treatment. Further, it was submitted that such a process could constitute palliative care, as being the reasonable provision of food and water, which would result in it failing to be regarded as medical treatment under the Act. The Attorney-General submitted that the court should consider whether to exercise its power within the *parens patriae* jurisdiction of the court and make an order, or give a consent, which would provide a remedy in the circumstances of this case, without impacting upon the operation of the Medical Treatment Act.

[30] The public advocate responded to this argument by contending that the Parliament had put in place the Guardianship and Administration Act 1986 and the Medical Treatment Act to deal with guardianship issues and issues relating to the refusal of medical treatment, including by agents and guardians on behalf of other persons. He contended that it was the intention of Parliament that these statutes largely govern the circumstances which arise in this case. Counsel for the public advocate did not deny the

continued existence of the *parens patriae* jurisdiction, but submitted that it should be reserved for extraordinary circumstances. None the less, it was submitted that, should the application in relation to the Medical Treatment Act fail, it would be appropriate in those circumstances for the court to ultimately make an order in its *parens patriae* jurisdiction.

[31] Written and oral submissions were made on behalf of the Most Reverend Hart, Catholic Archbishop of Melbourne, Catholic Health Australia Inc and Right to Life Australia Inc, all as *amici curiae*, in relation to the interpretation of the Medical Treatment Act in the context of the application for declarations. These submissions were comprehensive and thought provoking and have assisted the court in its task.

Key issues

[32] The key issues in this case which the court must address are:

- what is the meaning of the words used in the definitions of medical treatment and palliative care in the Act;
- whether, having regard to the meaning of the defined terms and the facts, it is appropriate to make the declarations sought by the public advocate or decline to make such declarations, either absolutely or because it would be better for the court to exercise its powers within the *parens patriae* jurisdiction of the court.

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Legal context

[33] In 1988 the Victorian Parliament passed the Medical Treatment Act, with the intention of clarifying the law relating to the right of patients to refuse medical treatment. Subsequently, in 1990, the Act was amended to enable an agent or guardian to make decisions about medical treatment on behalf of an incompetent patient.

[34] The present application arises in the context of the Medical Treatment Act; it is not an application which relies upon the common law right of a person to refuse medical treatment; nor, for that matter, is it an application in which the plaintiff calls in aid the court's *parens patriae* jurisdiction. At least three things follow from this.

[35] First, decisions in other jurisdictions which were made by reference to common law principles, whilst of general assistance, are not directly relevant.

[36] Secondly, the court is in a position where the Parliament has turned its mind to the circumstances where an agent or guardian may refuse treatment on behalf of a patient. This issue is of public interest and will inevitably involve different views, having regard to the nature of the philosophical, legal, moral and social issues involved. But I must emphasise: the Medical Treatment Act is part of the law of Victoria; it is the role of a judge of this court to discharge his or her office according to law; and in giving its judgment the court should be taken as giving effect to the will of Parliament, not making new law.

[37] Thirdly, in the interpretation of provisions of the Medical Treatment Act, a construction that would promote the purpose or object underlying the Act should be preferred to a construction that would not promote that purpose or object. This will require consideration of the whole of the Act, so that particular provisions can be interpreted in their context. Further, in seeking to interpret particular provisions of the Act, consideration may be given to relevant documents that form part of the legislative history, including reports of proceedings before the Legislative Assembly and Legislative Council and reports of parliamentary committees.

Medical Treatment Act

[38] In order that this decision can be understood in its full legal context, it is necessary to set out substantial extracts from the Medical Treatment Act. It is convenient to set out the relevant extracts in the same order as they are contained in the Act:

Preamble

The Parliament recognises that it is desirable —

- (a) to give protection to the patient’s right to refuse unwanted medical treatment;
- (b) to give protection to medical practitioners who act in good faith in accordance with a patient’s express wishes;
- (c) to recognise the difficult circumstances that face medical practitioners in advising patients and providing guidance in relation to treatment options;
- (d) to state clearly the way in which a patient can signify his or her wishes in regard to medical care;
- (e) to encourage community and professional understanding of the changing focus of treatment from cure to pain relief for terminally-ill patients;
- (f) to ensure that dying patients receive maximum relief from pain and suffering.

1. Purpose

The purposes of this Act are —

- (a) to clarify the law relating to the right of patients to refuse medical treatment;
- (b) to establish a procedure for clearly indicating a decision to refuse medical treatment;
- (c) to enable an agent to make decisions about medical treatment on behalf of an incompetent person.

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...

3. Definitions

In this Act —

...

“medical treatment” means the carrying out of —

- (a) an operation; or
- (b) the administration of a drug or other like substance; or
- (c) any other medical procedure —

but does not include palliative care;

“palliative care” includes —

- (a) the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or
- (b) the reasonable provision of food and water;

...

4. Other legal rights not affected

(1) This Act does not affect any right of a person under any other law to refuse medical treatment.

(2) This Act does not apply to palliative care and does not affect any right, power or duty which a registered medical practitioner or any other person has in relation to palliative care.

(3) This Act does not —

- (a) affect the operation of section 6B(2) or 463B of the **Crimes Act 1958**;² or

- (b) limit the operation of any other law.

(4) A refusal of medical treatment under this Act does not limit any duty of a registered medical practitioner or other person —

- (a) to advise and inform the patient or the patient’s agent or guardian; or
- (b) to provide medical treatment, other than medical treatment that has been refused.

5. Refusal of treatment certificate

(1) If a registered medical practitioner and another person are each satisfied —

- (a) that a patient has clearly expressed or indicated a decision —
 - (i) to refuse medical treatment generally; or
 - (ii) to refuse medical treatment of a particular kind —

for a current condition; and

- (b) that the patient’s decision is made voluntarily and without inducement or compulsion; and
- (c) that the patient has been informed about the nature of his or her condition to an extent which is reasonably sufficient to enable the patient to make a decision about whether or not to refuse medical treatment generally or of a particular kind (as the case requires) for that condition and that the patient has appeared to understand that information; and
- (d) that the patient is of sound mind and has attained the age of 18 years —

the registered medical practitioner and the other person may together witness a refusal of treatment certificate.

...

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(3) For the purposes of sub-section (1)(a), the patient may clearly express or indicate a decision in writing, orally or in any other way in which the person can communicate.

5A. Agents and guardians

(1) A decision about medical treatment of a person may be made in accordance with this Act —

- (a) if the person has appointed an agent in accordance with this section, by that agent; or

...

- (b) if the person is a represented person and an appropriate order has been made under the **Guardianship and Administration Act 1986** providing for decisions about medical treatment, by the person’s guardian.

5B. Refusal of treatment certificate by agent or guardian

(1) If a registered medical practitioner and another person are each satisfied —

- (a) that the patient’s agent or guardian has been informed about the nature of the patient’s current condition to an extent that would be reasonably sufficient to enable the patient, if he or she were competent, to make a decision about whether or not to refuse medical treatment generally or of a particular kind for that condition; and
- (b) that the agent or guardian understands that information —

the agent or guardian, on behalf of the patient —

- (c) may refuse medical treatment generally; or
- (d) may refuse medical treatment of a particular kind —

for that condition.

(2) An agent or guardian may only refuse medical treatment on behalf of a patient if —

- (a) the medical treatment would cause unreasonable distress to the patient; or
- (b) there are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and well-being, would consider that the medical treatment is unwarranted.

(3) Where a refusal is made by an agent or a guardian, a refusal of treatment certificate must be completed in the form of Schedule 3.

...

6. Offence of medical trespass

A registered medical practitioner must not, knowing that a refusal of treatment certificate applies to a person, undertake or continue to undertake any medical treatment to which the certificate applies, being treatment for the condition in relation to which the certificate was given.

Penalty: 5 penalty units.

7. Cancellation or cessation of certificate

...

(3) A refusal of treatment certificate ceases to apply to a person if the medical condition of the person has changed to such an extent that the condition in relation to which the certificate was given is no longer current.

...

9. Protection of registered medical practitioners

(1) A registered medical practitioner or a person acting under the direction of a registered medical practitioner who, in good faith and in reliance on a refusal of treatment certificate, refuses to perform or continue medical treatment which he or she believes on reasonable grounds has been refused in accordance with this Act is not —

- (a) guilty of misconduct or infamous misconduct in a professional respect; or
- (b) guilty of an offence; or
- (c) liable in any civil proceedings —

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because of the failure to perform or continue that treatment.

[39] The effect of these provisions in this case is that the public advocate, as guardian of BWV with the power to make decisions concerning her medical treatment, may refuse “medical treatment” of a particular kind for the current condition of BWV, if:

- the medical treatment would cause unreasonable distress to BWV; or
- there are reasonable grounds for believing that BWV, if competent, and after giving serious consideration to her health and well-being, would consider that the medical treatment is unwarranted.

[40] However the public advocate cannot refuse treatment pursuant to the Act, on behalf of BWV, if that treatment is not “medical treatment”. Further, if a procedure or practice constitutes palliative care, it cannot be refused pursuant to the Act, because it would then be excluded from the definition of medical treatment.

Purposes of Medical Treatment Act

[41] The inclusion of a preamble to the Act and the matters set out in s 1 of the Act make it relatively easy to discern the purposes of the Act. In the context of the present case, two purposes stand out:

- to both clarify and give legal effect to the right of a patient to refuse unwanted medical treatment; and
- to enable an agent (including a guardian) to make a decision about medical treatment on behalf of an incompetent patient.

[42] Much was said during the hearing about the sanctity of life. There is no doubt that this is a fundamental principle of every civilised society, although I believe that the principle is better referred to as the inviolability of life. But as Hoffmann LJ observed in *Airedale National Health Service Trust v Bland*:³

But the sanctity of life is only one of a cluster of ethical principles which we apply to decisions about how we should live. Another is respect for the individual human being and in particular for his right to choose how he should live his own life. We call this individual autonomy or the right of self determination. And another principle, closely connected, is respect for the dignity of the individual human being: our belief that quite irrespective of what the person concerned may think about it, it is wrong for someone to be humiliated or treated without respect for his value as a person.

[43] In *Bland* the English courts adopted an approach which sought to balance these competing values and which established a common law position, in that country, which revolves around what is said to be in the “best interests” of the patient. It is unnecessary to decide whether that same principle applies as part of the common law in Victoria. None the less it is important to note that, both legally and ethically, it will always be necessary to achieve some accommodation between different moral principles. In this respect, I agree with Hoffmann LJ, in *Bland* when he said:⁴

I do not suggest that the position which English law has taken is the only morally correct solution. Some might think that in cases of life and death, the law should be more paternalist even to adults. The point to be emphasised is that there is no morally correct solution which can be deduced from a single ethical principle like the sanctity

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of life or the right of self determination. There must be an accommodation between principles, both of which seem rational and good, but which have come into conflict with each other.

[44] The Medical Treatment Act, combined with the Guardianship and Administration Act, seeks to achieve an appropriate accommodation between these principles in Victoria. This does not mean that the Act articulates the only morally correct solution. But it is the solution which forms part of the law in this State.

Legislative history

[45] This is a case where it is appropriate to have regard to the legislative history in carrying out the task of interpreting the provisions of the Medical Treatment Act, particularly the definitions of medical treatment and palliative care.

[46] The legislative history of the Act is unusual, and requires some background.

[47] Victoria has two houses of Parliament, the Legislative Assembly and the Legislative Council. The Legislative Assembly is the lower house and, in 1988, consisted of 88 members. The majority party in the lower house forms the government. During the relevant period the Australian Labor Party formed the majority in the Legislative Assembly and constituted the government. In 1988 the Legislative Council consisted of 44 members. Twenty-two members were drawn from the Australian Labor Party; and 22 members were drawn from conservative political parties (the Liberal Party of Australia and the National Party). Of course, for legislation to be approved, it needed to be carried by both houses of Parliament.

[48] In 1988 the President of the Legislative Council was a member of the Australian Labor Party. As president, this member did not have a deliberative vote, but could only cast a vote if the number of votes for and against were the same. This effectively meant that the government of the day could only get its legislation through both houses of

Parliament if at least one member of the conservative parties in the Legislative Council voted for a proposed Act or abstained from voting.

[49] On 17 December 1985 the Social Development Committee of the Parliament was asked to conduct an inquiry and make recommendations to the Parliament in relation to a number of matters which were subsequently described as options for dying with dignity. The members of the committee were drawn from all political parties and from both the Legislative Council and the Legislative Assembly. The chairperson of the committee was the Hon J L Dixon, a member of the Australian Labor Party and of the Legislative Council. The committee conducted an extensive inquiry and subsequently produced at least two reports.

[50] In April 1987 the second and final report of the committee was published and was titled "Inquiry into Options for Dying with Dignity". Amongst other things, the committee concluded⁵ that:

... the primary mechanism for clarification of the common law right to refuse medical treatment is by means of legislation. Such legislation should verify the right of a competent adult to refuse medical treatment or *life support systems*, thereby protecting the individual concerned, their relatives or care-givers, and the medical team caring for the individual. [Emphasis added.]

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[51] In the course of its discussions the committee also discussed the concepts of a "right to die" and a "right to die with dignity". The committee reported:⁶

The Committee found that, while opinions were divided on definitions on a "right to die", there appeared to be considerable common ground as to what a "right to die peacefully with human dignity" means, in a practical, every day sense among the major religious and philosophical traditions in our community.

In essence, there appears to be common ground among these traditions that a dying person has a basic right to die with dignity. From a moral perspective such a basic right is comprised of two elements:

- (a) that it is morally acceptable to forego medical treatment which is "disproportionate" or "extraordinary" or "burdensome"; and
- (b) that it is morally acceptable to administer pain-killing medication with the intention of relieving pain and suffering, even though the medication may shorten life.

[52] The drafting of a Bill to give effect to the committee's recommendations proved to be no easy task. According to Hansard debates the final version was in fact the ninth draft. However, for present purposes, it is sufficient to refer to the last three drafts.

[53] On 27 October 1987 a Bill was introduced into the Legislative Council, known as a Bill for the Medical Treatment Act 1987. This Bill did not contain any definition of "palliative care". However the definition of medical treatment was as follows:

"Medical Treatment" means the carrying out of —

- (a) an operation; or
- (b) the administration of a drug or other substance; or
- (c) any other medical procedure —

except for the purposes of relief of pain, suffering or discomfort.

This Bill was not proceeded with.

[54] On 23 March 1988 the Hon E H Walker, on behalf of the Hon J H Kennan, (both members of the government) moved that the Medical Treatment Bill (No 2) be read for a second time. This Bill contained a different definition of "medical treatment" and a new definition of "palliative care", as follows:

"Medical Treatment" means the carrying out of —

- (a) an operation; or
- (b) the administration of a drug or other like substance; or
- (c) any other medical procedure —

but does not include palliative care.

“Palliative Care” means a medical procedure for the purposes of relief of pain, suffering or discomfort, including the provision of food or water (or other medical care) which is not burdensome to the patient.

[55] It is to be observed that the Bill introduced in 1988 differed from that introduced in 1987, not only by introducing the definition of palliative care, but also by specifically referring to the provision of food or water as part of palliative care (and, hence, not part of medical treatment). This is of potential significance as part of the task facing the court is to give effect to Parliament’s will in relation to the meaning of the words “the provision of food and water”.²

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[56] In the course of his second reading speech, Mr Walker referred to the fact that a definition of palliative care had been included in the Bill. He then said:⁸

The definition of “palliative care” covers treatment for the relief of pain, suffering or discomfort and specifically includes the provision of food or water or other medical care which is not burdensome to the patient. The inclusion of non-burdensome treatment within the definition is intended to meet concerns that the Bill as originally drafted addressed only the medical, pain relieving aspect of treatment and did not recognise necessary *non-medical care, especially in the area of physical sustenance*. [Emphasis added.]

[57] The conservative parties strongly opposed the Medical Treatment Bill (No 2). This opposition was led by the Hon B A Chamberlain, a senior and respected member of the Council. He was supported in the debate by other members of the conservative parties, though, interestingly, not by the Hon R I Knowles or the Hon R M Hallam who, with Mrs Dixon, had been members of the inquiry into options for dying with dignity.

[58] Mr Chamberlain was strongly critical of some of the concepts employed in the Bill, stating that it was possible “to drive a truck through the concepts”. In describing the Bill Mr Chamberlain commenced by saying:⁹

The scheme of the Bill is as follows: firstly, the Act does not apply to pain relieving care and the ordinary provision of food; those are items which cannot be refused under a refusal of treatment certificate.

[59] The Hon Judy Dixon made a lengthy speech in support of the Bill. During the course of this speech she distributed a list of amendments that the government proposed to make when the Bill was considered in its committee stage. One of these amendments was to alter the definition of “palliative care” so it would read:

“Palliative care” includes —

- (a)
 - the provision of reasonable medical procedures for the relief of pain, suffering and discomfort; or
- (b)
 - the reasonable provision of food and water.

[60] In the course of her speech Mrs Dixon said:¹⁰

I shall foreshadow important amendments that the government will move during the Committee stage. The amendments concern palliative care, which was an issue raised by Mr Chamberlain. The subject is difficult and all honourable members acknowledge that the consultative process has been long and trying. We were very concerned to make sure that no one was ever in the situation where he or she would be refused, or where

anyone could refuse on his or her behalf, food and water. Working out that particular definition was difficult. Honourable members have before them the definition of "palliative care". That definition will resolve the problem. It means that palliative care is now divided into two separate elements; the first is the provision of reasonable medical procedures for the relief of pain and suffering and discomfort; and the second is the reasonable provision of food and water.

This definition will overcome confusion that has arisen because of the use of the term "medical procedures" as one which embraced the provision of food and water. I shall not go into further detail because the subject will be explained during the committee stage. [Emphasis added.]

Unfortunately the matter was not further explained during the committee stage.

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[61] Another speaker during the second reading debate was the Hon J V C Guest, a member of the Liberal Party and a former barrister. In the course of his contribution he said:¹¹

I turn now briefly to what will be the ninth version of the Bill. Mrs Dixon referred to the care taken, and the amendments made or proposed, to ensure that a patient cannot refuse food and drink. At least two further questions arise from that: one is whether that means that the food will be forced into the mouth of a patient. Is it yet another case of the government not having thought the matter through? Does this really mean that the patient cannot refuse any food and drink?

A number of cases that were not commented on adversely which were related in the Committee's report were of old people who simply refused to eat. Will those people suffering from the terminal illness of old age have their mouths levered open and food shoved into them? Possibly this is not just a failure of the government to think clearly but also a failure to bite the bullet. If the patients are not fed orally, will they have tubes inserted into their veins so that they obtain the nutrients compulsorily? The government has failed to spell out the detail of the proposed legislation that would help members of the medical profession in this respect as well as other drafting problems referred to by Mr Chamberlain.

[62] The speaker who followed Mr Guest was the Hon M A Lyster, who later became Minister for Health in the Kirner government. In the course of her speech she referred to the rider to the definition of medical treatment, namely that it did not include palliative care. In relation to patients choosing palliative care rather than medical treatment Mrs Lyster said:¹²

They may not use those words, quite obviously, but what they want is to be able to die with dignity. That is where the palliative care issue becomes so important. Clause 3 of the Bill defines palliative care as "a medical procedure for the purposes of relief of pain, suffering or discomfort, including the provision" — for those who imagine for some reason that we are in some cruel, barbaric, uncivilised State — "of food or water". I have heard people say that this Bill will preclude the provision of food and water to people with terminal illness. I do not know where that view could possibly come from.

After an interjection, she continued:

I cannot imagine what sort of barbaric thinking would lead anybody to imagine that this government would even contemplate including that in legislation; and, worse still, I do not know how anybody who had known of the effort, the compassion, concern and sensitivity that have gone into the Social Development Committee's Inquiry could contemplate in any way that members of that committee would support proposed legislation that talked about not providing food and water to a person who was dying. There are some very sick minds around.

[63] The comments of Mr Walker, Mr Chamberlain and Mrs Lyster appeared to have been made in relation to the original version of the Bill debated on 19 April 1988. By contrast, the comments made by Mrs Dixon and Mr Guest appeared to have been directed to the definitions foreshadowed by Mrs Dixon (which ultimately became part of the Act). However all of these contributions would seem to be relevant in ascertaining what the Parliament ultimately meant when it enacted a definition of palliative care that included the reasonable provision of food and water.

[64] The second reading in the Legislative Council was adjourned and resumed on 3 May 1988. During the course of this debate the Hon A J Hunt, a former leader

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of the Liberal Party in the Legislative Council, indicated that he intended to abstain from voting so that the Bill would be read a second time and proceed to the committee stage. Subsequently, when a division was called, the vote was 21 in favour and 21 against; which enabled the President of the Legislative Council to exercise a casting vote in favour of the motion to read the Bill a second time.

[65] When the Legislative Council came to debate the clauses of the Bill in committee the Minister for Health moved the amendment to the definition of palliative care previously foreshadowed by Mrs Dixon. Mr Chamberlain spoke against the amended form of cl 3 and criticised the lack of precision in the concepts being employed. The Hon D R White, Minister for Health, replied by stating:¹³

The common law is vague and attempts no definition of medical treatment. The Bill gives structure where none exists in common law.

Interestingly, notwithstanding that Mr Chamberlain announced that the Opposition would oppose the clause, the Legislative Council agreed to the clause without dividing.

[66] Subsequently, during the committee stage, the Legislative Council defeated those parts of the Bill which would have allowed an agent or guardian to refuse medical treatment on behalf of a patient. This was an important change. Following this change the Legislative Council carried a motion to read the Bill for a third time, at which stage it was sent to the Legislative Assembly.

[67] In presenting the second reading speech in the Legislative Assembly on 5 May 1988 the Attorney-General, Mr McCutcheon, read a similar speech to that which had been read by Mr Walker (on behalf of Mr Kennan) in the Legislative Council. There was one significant change. By contrast to what has been set out previously, Mr McCutcheon said:¹⁴

A definition of "palliative care" is included in the Bill. The definition of "palliative care" covers treatment for the relief of pain, suffering or discomfort and specifically the reasonable provision of food or water.

[68] The debate in the Legislative Assembly, where the government had the numbers, provides fewer clues as to the meaning of the legislation than the debate which was held in the Legislative Council. None the less it can be noted that the lead speaker for the Liberal Party, Mr John, adopted a similar approach to Mr Chamberlain in describing the main provisions in the Bill, stating:¹⁵

Firstly, it does not apply to pain relieving care and the ordinary provision of food.

[69] The Legislative Assembly approved the Bill, reinstating provisions which would have allowed an agent or guardian to refuse medical treatment on behalf of a patient. However, when this was sent back to the Legislative Council, the Council stood its ground and refused to approve legislation that would permit such a course. The Legislative Assembly then reluctantly accepted the position which the Council had taken.

[70] Thus the key definitions with which the court is concerned were originally contained in an Act which did not permit an agent or guardian to refuse medical treatment on behalf of a patient; although they were inserted in the context of a

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Bill whereby the government hoped to invest agents or guardians with the power to refuse medical treatment on behalf of a patient.

[71] On 3 May 1989 the Medical Treatment (Enduring Power of Attorney) Bill was first debated in the Legislative Council. Essentially, this Bill sought to re-introduce, in a much revised form, the provisions which the Legislative Council had rejected in 1988. The revisions that had been made were designed to ensure that satisfactory safeguards were in place to prevent the abuse, by agents or guardians, of the power to refuse medical

treatment on behalf of some other person. The lead speaker on behalf of the Opposition in the Legislative Council was Mrs Tehan, who announced that the Liberal Party would not oppose the Bill, subject to certain amendments. She said:¹⁶

The Bill will have the full support of the three parties in this chamber, will eventually be passed and become law in Victoria.

Mrs Tehan proved correct. The Legislative Council subsequently passed numerous amendments, and then the whole Bill, without division. When the matter was then considered by the Legislative Assembly it was overwhelmingly supported with 65 members in favour and 16 against.

Medical Treatment Act – method of approach

[72] Having regard to the framework of the Medical Treatment Act, it is convenient to first consider whether the provision of nutrition and hydration to BWV, via a PEG, falls within paras (a), (b) or (c) of the definition of medical treatment; and, secondly, if it does fall within any of these paragraphs, to then consider whether it falls within the definition of palliative care. It is convenient to describe an action which falls within paras (a), (b) or (c) of the definition of “medical treatment” as being “prima facie medical treatment”.

[73] This approach acknowledges that there is some overlap between prima facie medical treatment and palliative care. So much is clear, not only from para (a) of the definition of palliative care, but also from the final words in the definition of medical treatment. The extent to which the concepts overlap and, in particular, whether there is any overlap between prima facie medical treatment and para (b) of the definition of palliative care are important matters which I will come to later in this judgment.

Prima facie medical treatment

[74] It is clear that the administration of artificial nutrition and hydration in this case is not an operation. It is thus necessary to consider whether it is a medical procedure or the administration of a drug or other like substance.

[75] In my opinion, a medical procedure can generally be described as a procedure that is based upon the science of the diagnosis, treatment or prevention of disease or injury, or of the relief of pain, suffering and discomfort. It is not a simple matter to say what is and what is not a medical procedure. Some procedures, such as blood letting, might once have been regarded as medical procedures but may no longer be regarded as such. Other procedures, such as applying dressings to wounds, might be medical procedures in some contexts, but not in other contexts (such as applying a band-aid to a grazed knee). I think there is some force in Mr Burnside’s submission that whether or not a procedure is a medical procedure

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depends upon whether the medical knowledge upon which it is based has become so widespread within the community that it might now be regarded as common knowledge, not medical knowledge.

[76] It is not necessary to explore all the circumstances which might be said to constitute a medical procedure: because, unquestionably in my judgment, the use of a PEG for artificial nutrition and hydration, or for that matter any form of artificial feeding, is a “medical” procedure. Artificial nutrition and hydration involves protocols, skills and care which draw from, and depend upon, medical knowledge. Artificial nutrition and hydration will inevitably require careful choice of and preparation of materials to be introduced into the body, close consideration to dosage rates, measures to prevent infection and regular cleaning of conduits. These are not matters of common knowledge. In this regard, I particularly rely upon the evidence given to the court by Dr Woodward, Professor Ashby and Professor Horne.

[77] In my opinion, the claim that artificial nutrition and hydration, via a PEG, can be performed in the home by an informed lay person does not mean that this procedure is not a medical procedure. Quite apart from the fact that the evidence is that such artificial nutrition and hydration must necessarily be performed under regular medical and nursing supervision, such a procedure involves skills and protocols which the lay person would need to specifically obtain by drawing upon medical knowledge.

[78] I also find that the administration of artificial nutrition, via a PEG, to BWV is the administration of a substance like a drug: and, hence, is also within the meaning of the words in para (b) of the definition of medical treatment. The nutrition administered to BWV consists of Osmolite, which is said to be a high nitrogen isotonic liquid nutrition. Mr Burnside emphasised that Osmolite consists of a number of specified minerals, vitamins and other constituents. However, as I observed in argument, the same could be said of a banana. None the less Osmolite is quite different to most foods in that it is intended to provide complete, balanced nutrition, without the need for any other food whatsoever. Osmolite is included in the 1998 edition of the Australian Prescription Products Guide and in the 2002 MIMS Annual (which claims to be the byword for accurate, reliable, comprehensive and independent drug information). Both publications emphasise that Osmolite provides complete, balanced nutrition and that it is suitable for both oral feeding and tube feeding. The label on the can of Osmolite specifies that it should be used under the supervision of a physician. Indeed, when Professor Horne was asked whether Osmolite fitted more closely into the category of a drug or a food, he answered that it fitted more closely into the category of a drug because it was formulated in concentrations that one would not normally expect in a food and would have consequences if it was administered in an inappropriately high or inappropriately low dosage. Having regard to these characteristics of Osmolite I find that it is within the meaning of the words "other like substance" in para (b) of the definition of "medical treatment".

[79] Of course, that is not the end of the exercise: it is now necessary to consider whether the artificial nutrition and hydration in this case would also fall within the definition of "palliative care". This not only involves consideration of the words used in that definition, but also consideration of the extent of overlap between prima facie medical treatment and palliative care.

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Palliative care – natural meaning

[80] The definition of "palliative care" must first be considered by reference to its natural meaning, in the context of the Act. This context includes the right of a person, or a person's agent or guardian, to refuse medical treatment. Such a right would be worthless if the Parliament meant the expression "palliative care", standing alone, to encompass most medical procedures. Further, the context includes the preamble to the Act. Having regard to this context, in my opinion the expression "palliative care", standing alone, means care, not to treat or cure a patient, but to alleviate pain or suffering when a patient is dying. Indeed, palliative care extends to care for the relatives of the dying patient. In its second and final report "Inquiry Into Options For Dying With Dignity", the Social Development Committee of the Parliament discussed the meaning of the expression "palliative care" in its natural sense.¹⁷ Various explanations are given of the nature of palliative care. The report quotes various submissions, including a submission from Right to Life Victoria, which emphasises that when death has become inevitable, treatment should be adjusted, since the patient's best interest would then be served by treatment that emphasised relief, rather than futile attempts to cure.¹⁸

[81] I find that the administration of artificial nutrition and hydration, via a PEG, cannot be regarded as palliative care, where that expression is used in its natural sense. Such a procedure is, in essence, a procedure to sustain life; it is not a procedure to manage the dying process, so that it results in as little pain and suffering as possible.

The provision of food and water

[82] The Medical Treatment Act makes it clear that the reasonable provision of food and water is not to be regarded as medical treatment. But what did the Parliament mean when it referred to the provision of food and water? Did it mean making food and water available, to be consumed naturally, that is orally? Or should it be taken to have meant any nourishment, or water, which is put into the body? Dictionary definitions are of limited assistance. And cases, in other contexts, provide little guidance.¹⁹

[83] There may be some significance in the use of the words “food” and “water”, rather than “nutrition” and “hydration”. However I do not think that this choice of words is decisive. It is necessary to also consider the language used in para (b) of the definition of palliative care compared with the language used in para (a) of that definition and the language used in the definition of medical treatment. It is also necessary to consider what would appear to be the purpose of para (b) in the definition of palliative care. And, in seeking to discern the intent of Parliament, the legislative history and parliamentary debates ought to be considered.

[84] After carefully studying the definitions in the Medical Treatment Act, I have concluded that para (b) of the definition of palliative care is not intended to be

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understood so as to overlap with what I have called prima facie medical treatment. In this respect I draw attention to the different language used in para (a) to that used in para (b) of the definition of palliative care; the legislative history leading to the separation of para (b) from para (a); and the comments of Mr Walker and Mrs Dixon in this regard. Indeed, I am persuaded by the argument put by Mr Santamaria QC that there is no overlap between prima facie medical treatment and para (b) of the definition of palliative care. Of course, when he put this argument he was seeking to persuade the court that the consequence of such a conclusion was that the expression “medical procedure” in para (c) of the definition of medical treatment should be confined. But his contention also means that if the provision of artificial nutrition and hydration is a medical procedure (as I have found) it should not be regarded as being within the concept of the provision of food and water.

[85] In my opinion, the intent of Parliament in excluding the provision of food and water from the concept of medical treatment was to ensure that a dying person would have food and water available for oral consumption, if the person wished to consume such food or water. It can hardly have been the Parliament’s intention that dying patients would be forced to consume food and water. Further, in my opinion, the extension of the concept to artificial nutrition and hydration would produce odd results, contrary to the purpose of the legislation to allow patients, or agents or guardians on their behalf, to choose to refuse medical treatment and to die with dignity. In this respect, I agree with the analysis of the Canadian author Dr Margaret Somerville, the founding director of the McGill Centre for Medicine, Ethics and Law, in her recent book *The Ethical Canary, Science, Society And The Human Spirit*:

One such request by patients that healthcare professionals and families often find difficult to respect — and which some people vehemently oppose implementing — is that to withdraw artificial hydration and nutrition when a person’s life is dependent on them. Images of a person dying of dehydration and starvation come to mind. This situation can be viewed differently, however, if we think of the terminally ill person as suffering from a failed alimentary system and the withdrawal of artificial hydration and nutrition as withdrawal of artificial alimentary system support. In short, respecting a refusal of this type of treatment is no different from accepting a person’s refusal of respiratory support for a failed respiratory system. We have tended to see these situations differently because of the values and symbolism attached to the provision of food and drink for those in our care, especially babies and young children. We have wrongly equated artificial hydration and nutrition (a medical life-support treatment) with natural food and drink and, thereby, have mistakenly equated the withholding of them. I hasten to add that I am not suggesting we are always justified in withholding or withdrawing artificial hydration and nutrition. Rather, the basis on which this decision should be made is the ethics of the withholding or withdrawal of artificial life-support treatment, not that of food and water.²⁰

[86] The parliamentary debates set out above assist the court in ascertaining the intent of Parliament when it referred to the provision of food and water. These

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debates make it clear that the Parliament was intending to refer to the ordinary, non-medical provision of food and water. This is especially evident in the speeches of Mr Walker, Mr Chamberlain, Mrs Dixon, Mr Guest, Mrs Lyster and Mr John.

[87] It is also useful to consider the position immediately after the Medical Treatment Act came into operation on 1 September 1988. At that time only a patient, not an agent or guardian, could refuse medical treatment. One might imagine a lucid patient suffering from throat cancer who had lost the ability to swallow. The prognosis might be that the patient had one week to live; but, if a PEG was installed to provide artificial nutrition and hydration, the prognosis might be three months. In my opinion, it cannot have been the case that the Parliament was enacting a law whereby the patient could not have refused to have a PEG installed. But, if the provision of food and water included artificial nutrition and hydration, it would not have been open for the patient to have refused such an operation pursuant to the Act unless it could be shown that such provision of nutrition and hydration was not reasonable.

[88] Of course, it is said that different considerations arise when the decision to refuse medical treatment is being made by an agent or guardian, rather than a patient. But it is most unlikely that the meaning of the words "the ... provision of food and water" changed when the Medical Treatment Act was amended by the Medical Treatment (Enduring Power of Attorney) Act 1990 on 6 August 1990. On the contrary, there is every indication that the Parliament intended to put the patient's agent or guardian in exactly the same position as the patient, when it came to refusing medical treatment, provided that the safeguards added into the Act by the Medical Treatment (Enduring Power of Attorney) Act were complied with. These safeguards include a formal process for the appointment of an agent (s 5A(2)), the provision of information to the agent or guardian about the nature of the patient's current condition (s 5B(1)), a right to refuse treatment only in limited circumstances (s 5B(2)), the requirement that a formal refusal of treatment certificate be completed (s 5B(3)), the ability for the Victorian Civil and Administrative Tribunal to suspend or revoke the appointment of an agent (s 5C(1)), which might be done on the application of either the public advocate or a person who has a special interest in the affairs of the donor of the power (for example, the treating medical practitioner) (s 5C(2)), penalties for procuring or obtaining the execution of a certificate by deception, fraud, misstatement or undue influence (s 5F), and the inapplicability of a refusal of treatment certificate if the medical condition of the patient changes to the extent that the condition in relation to which the certificate was given is no longer current (s 7(3)). These safeguards have the effect of substantially reducing the risk of an agent or guardian acting unlawfully, or even criminally, in refusing medical treatment on behalf of another person.

[89] Mrs Morrish, on behalf of Right to Life Association Inc, emphasised the possibility that the Medical Treatment Act may be abused by an agent or guardian. In this respect, she relied upon a number of cases decided in contexts other than the Medical Treatment Act, such as the criminal law. For my part, I believe the safeguards that have been put in place will prove to be appropriate in the overwhelming number of situations that will arise. It must be remembered that most agents of dying patients will be loving relatives who have been trusted by the patient to make life and death decisions on the patient's behalf. In any event, what is more important, is that the Parliament has decided upon the

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appropriate safeguards and, indeed, that an agent or guardian can make the decision to refuse medical treatment on behalf of some other person.

[90] I note that my conclusion that artificial nutrition and hydration is medical treatment, not palliative care, pursuant to the Medical Treatment Act is consistent with the approach of other courts where artificial nutrition and hydration has been considered in the context of the natural meaning of the expression “medical treatment”. Thus in *Bland* Lord Goff noted that the effect of discontinuing the artificial feeding of Anthony Bland would be that he would inevitably die within one or two weeks. Lord Goff then said:²¹

Objection can be made to the latter course of action on the ground that Anthony will thereby be starved to death, and that this would constitute a breach of the duty to feed him which must form an essential part of the duty which every person owes to another in his care. But here again it is necessary to analyse precisely what this means in this case of Anthony. Anthony is not merely incapable of feeding himself. He is incapable of swallowing, and therefore of eating or drinking in the normal sense of those words. There is overwhelming evidence that, in the medical profession, artificial feeding is regarded as a form of medical treatment; and even if it is not strictly medical treatment, it must form part of the medical care of the patient. Indeed, the function of artificial feeding in the case of Anthony, by means of a nasogastric tube, is to provide a form of life support analogous to that provided by a ventilator which artificially breathes air in and out of the lungs of a patient incapable of breathing normally, thereby enabling oxygen to reach the bloodstream.

[91] In the Irish case of *Re a Ward of Court*²² the Supreme Court of Ireland found that artificial nutrition and hydration through a nasogastric tube constituted “medical treatment” and not merely “medical care”.²³ Dame Elizabeth Butler-Sloss reached a similar conclusion in *National Health Service Trust; A v M*.²⁴ The issue was also addressed by Schreiber J of the Supreme Court of New Jersey, United States of America, in the matter of *Re Conroy*²⁵ where he considered a possible distinction between the termination of artificial feedings and the termination of other forms of life sustaining medical treatment. He offered the view:²⁶

Certainly, feeding has an emotional significance. As infants we could breathe without assistance, but we were dependent on others for our lifeline of nourishment. Even more, feeding is an expression of nurturing and caring, certainly for infants and children, and in many cases for adults as well.

Once one enters the realm of complex, high technology medical care, it is hard to shed the “emotional symbolism” of food. However, artificial feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle feeding or spoon feeding — they are medical procedures with inherent risks and possible side effects, instituted by skilled health care providers to compensate for impaired physical functioning. Analytically, artificial feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own.

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Furthermore, while nasogastric feeding and other medical procedures to ensure nutrition and hydration are usually well tolerated, they are not free from risks or burdens; they have complications that are sometimes serious and distressing to the patient.

The “reasonable” provision of food and water

[92] Having regard to my conclusion that the Parliament did not intend the words “the ... provision of food and water” to include artificial feeding or artificial hydration (for example, by way of a PEG), it is unnecessary to resolve what is meant by the word “reasonable” in order to make the declarations sought by the public advocate. But as the matter was argued before me, it may be desirable that I make a few observations.

[93] In *Mounsey v Lafayette*²⁷ Nettle J considered the meaning of the expression “reasonable” in the context of the steps which must be taken for purchase of a ticket to travel on public transport. After referring to a number of cases, he observed that the essential idea is what a reasonable person would regard as being reasonable in the circumstances. In one sense this does not take us very far. However it does indicate that the concept of what is “reasonable” is a practical concept which depends upon the circumstances and which calls in aid the everyday judgment of a fair-minded person. In my opinion, this is the manner in which the word “reasonable” is employed in paras (a) and (b) of the definition of palliative care in the Medical Treatment Act. It must also be kept in mind that the reasonableness of the provision of, for example, food and water

must be determined in the context that such provision is for the purpose of palliative care.

[94] An example of the application of this concept, in the context of the provision of food and water, might be where food or water is not provided to a dying patient in circumstances where it is not being requested and, when provided on previous occasions, has not been consumed. This could be a case of the carer paying heed to what Professor Ashby told the court was a Latvian proverb that “he or she has put down the spoon”, meaning that the patient no longer wished to eat or drink but wished to die peacefully.

[95] If my conclusion as to the meaning of the expression “the ... provision of food and water” is wrong, and instead this expression includes the provision of artificial nutrition or hydration, the question would then arise whether, in the circumstances of BWV, the continued provision of artificial nutrition and hydration was “reasonable”. If I was required to answer this question, I would find that the further provision of artificial nutrition or hydration was not reasonable in all the circumstances. In forming this view I would rely upon the evidence of the medical witnesses who observed BWV, the view of her guardian that it would be contrary to her wishes to continue to receive nutrition and hydration through the PEG, her existing condition, the period for which she has been in her existing condition, her prognosis and the fact that continued feeding is doing no more than merely postponing the natural dying process.

The parens patriae alternative

[96] I now turn to the submission made on behalf of the Attorney-General that, if the court considers that there is uncertainty as to whether the administration of artificial nutrition and hydration via a PEG is medical treatment under the Medical Treatment Act, the most appropriate course would be for the court to

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proceed, on a case by case basis, to consider whether it should grant authority for the cessation of such a procedure using its parens patriae jurisdiction. It was common ground, and I accept, that the court does possess a parens patriae jurisdiction.²⁸

[97] In a comprehensive submission, Ms Tate SC explained the history and nature of the parens patriae jurisdiction. She referred the court to the statement by Lord Brandon in *Re F (Mental Patient: Sterilisation)*²⁹ where he said the parens patriae jurisdiction:

... is an ancient prerogative jurisdiction of the Crown going back as far perhaps as the 13th Century. Under it the Crown as parens patriae had both the power and the duty to protect the persons and property of those unable to do so for themselves, a category which included both minors (formerly described as infants) and persons of unsound mind (formerly described as lunatics or idiots).

The nature of the jurisdiction has been further discussed by the High Court of Australia in *Marion's Case*.³⁰

[98] Ms Tate submitted that the court could exercise the parens patriae jurisdiction of its own motion, provided that there was a matter before the court. She argued that this followed from the fact that the jurisdiction was based upon a duty and was to be exercised in the public interest. I do not doubt this submission, but it is unnecessary to determine it. The public advocate agreed that if the court was to proceed in its parens patriae jurisdiction (instead of making the declarations sought) the case would need to be adjourned and a further application could be made, supported by further evidence.

[99] Although the parens patriae jurisdiction of the court is of considerable historical interest, I doubt if it should play any current role in the day to day administration of guardianship matters. Victoria has comprehensive laws in relation to guardianship and administration matters.³¹ These laws have established the statutory office of public advocate, with roles and responsibilities somewhat akin to those which might once have

been adopted by the court. A wide jurisdiction is also vested in the Victorian Civil and Administrative Tribunal to resolve disputes concerning guardianship matters and to consider applications where there is some perceived threat to the integrity of the guardianship system. The Medical Treatment Act sets out Parliament's intent in relation to the procedure whereby a person may refuse medical treatment; and, further, the procedure whereby an agent may make a decision about medical treatment on behalf of an incompetent person.

[100] In my opinion, the court would be failing to give effect to the will of Parliament if it refused to make the declarations sought by the public advocate in this case by reference to some discretionary consideration. The fact that a type of reserve power exists provides no logical justification for bypassing the Guardianship and Administration Act and the Medical Treatment Act.

[101] It is clearly *not* the intention of Parliament that the usual method whereby an agent might refuse medical treatment on behalf of a patient who is dying be one where the agent seeks to invoke either the common law jurisdiction or the *parens patriae*

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jurisdiction of the Supreme Court. The Parliament has set in place a careful statutory scheme whereby such decisions can be made by agents or guardians, subject to safeguards to prevent abuse. Further, the parliamentary debates demonstrate that recourse to the Supreme Court was seen as problematic: for reasons of cost, delay and emotional trauma to the families concerned.

[102] It is apparent from my judgment that I do not regard there to be any uncertainty as to whether the administration of artificial nutrition and hydration via a PEG is medical treatment under the Medical Treatment Act. Hence the basis for the submission made on behalf of the Attorney-General falls away. In any event, for the reasons set out above, I do not believe it to be desirable for the court to make an order in its *parens patriae* jurisdiction in lieu of making the declarations sought by the public advocate.

Declarations

[103] This is an appropriate case for the making of the declarations sought by the public advocate. The circumstances of BWV are real, not hypothetical. The issues have been fully and competently argued. The court has formed the firm conclusion that artificial nutrition and hydration is medical treatment within the meaning of the Medical Treatment Act. The making of the declarations will remove any doubts that the public advocate may have had in relation to the decisions open to him, in relation to BWV, under the Act; and will enable the public advocate to decide, on behalf of BWV, whether it is now time to allow her to die with dignity.

[104] Accordingly, I declare that:

- 1. the provision of nutrition and hydration via a percutaneous endoscopic gastrostomy ("PEG") to BWV constitutes medical treatment within the meaning of the Medical Treatment Act; and
- 2. the refusal of further nutrition and hydration, administered via a PEG, to BWV constitutes refusal of medical treatment, rather than refusal of palliative care, within the meaning of the Medical Treatment Act.

Declarations made accordingly.

Solicitors for the plaintiff: Office of the Public Advocate.

Solicitor for the intervenor: *James Syme*, Victorian Government Solicitor.

Solicitors for the first and second amici curiae: *Corrs Chambers Westgarth*.

Solicitors for the third amicus curiae: *Cooper Randles & Co Pty Ltd*.

[1](#) (1997) 189 CLR 579 at 600–5 and 650–2; see also the comments of Kirby P in *Breen v Williams* (1994) 35 NSWLR 522 at 532–3.² These provisions are concerned with inciting, or aiding or abetting, another person to

commit suicide; and using force to prevent the commission of suicide.³ [1993] AC 789 at 826.⁴ At 827.⁵ At p 140.⁶ At p 89.⁷ For some reason, which is not apparent, the reference to the provision of food or water was subsequently altered to a reference to the provision of food and water.⁸ Hansard, Legislative Council, 23 March 1988, p 335.⁹ Hansard, Legislative Council, 19 April 1988, p 684.¹⁰ Hansard, Legislative Council, 19 April 1988, p 705.¹¹ Hansard, Legislative Council, 19 April 1988, pp 711–12.¹² Hansard, Legislative Council, 19 April 1988, p 718.¹³ Hansard, Legislative Council, 5 May 1988, p 1263.¹⁴ Hansard, Legislative Assembly, 5 May 1988, p 2167.¹⁵ Hansard, Legislative Assembly, 6 May 1988, p 2243.¹⁶ Hansard, Legislative Council, 5 September 1989, p 140.¹⁷ See pp 201–4.¹⁸ See p 203.¹⁹ *Bristol-Myers Co Pty Ltd v Commissioner of Taxation* (1990) 23 FCR 126 (Sustagen Gold is a beverage, not a food, in the sales tax context); *Customs and Excise Commissioners v Beecham Foods Ltd* [1972] 1 WLR 241 (Ribena is not a drug or medicine in a sales tax context); *Diet Tea Co Ltd v Attorney-General* [1986] 2 NZLR 693 (in its natural and ordinary meaning, the word “food” did not include tea); *James v Jones* [1894] 1 QB 304 (baking powder is not an article of food).²⁰ See the chapter “Terminating Life Support Without Consent”, at p 163. In his book *Culture of Death: the Assault on Medical Ethics in America*, Wesley J Smith notes that: “In the decade since the Supreme Court implied that tube feeding could be considered a form of medical treatment that can be withdrawn or withheld like kidney dialysis or chemotherapy (a position made more concrete in a subsequent case), this country has substantially lost its revulsion against removing food and water from helpless people. But to state that an act is ‘legal’ isn’t the same thing as saying it is right.” (At p 223.)²¹ [1993] AC 789 at 869–70.²² [1995] 2 ILRM 401.²³ At 428 per Hamilton CJ.²⁴ [2001] Fam 348.²⁵ 486 A 2d 1209 (NJ 1985).²⁶ At 1236.²⁷ [2002] VSC 342.²⁸ This would seem to flow from s 85 of the Constitution Act 1975 and the Judicature Act 1874.²⁹ [1990] 2 AC 1 at 57.³⁰ *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218. See also the Canadian decision of *Re Eve* [1986] 2 SCR 388 at 407–17.³¹ The Guardianship and Administration Act 1986, which runs to well over 100 pages, makes detailed provision in relation to such questions.