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IN THE HIGH COURT OF NEW ZEALAND
AUCKLAND REGISTRY
ex Whangarei

M.75/97

IN THE MATTER of the Judicature Amendment Act 1972

BETWEEN JAMES FREDERICK SHORTLAND of Moerewa, Farmer

Applicant

AND NORTHLAND HEALTH LIMITED of Whangarei, Crown Health Enterprise

Respondent

Hearing: 19 September 1997

Counsel: G. J. Mathias and B.P.C. Carter for Applicant
G. Winter and M. Casey for Respondent

Judgment: 20 September 1997

ORAL JUDGMENT OF SALMON, J.

Solicitors: Thomson Wilson, Whangarei for Applicant

Gerard Winter Associates, Whangarei for Respondent

The applicant has applied for review under the Judicature Amendment Act 1972 of a decision of the respondent to discontinue dialysis treatment for Rau Williams. The grounds set out in the statement of claim for seeking to review that decision are that the decision is a breach of the

duty owed by the respondent to Mr Williams pursuant to its obligations under the Health Disabilities Act 1993. Paragraph 5 of the statement of claim sets out those obligations as follows:

> "In exercising its statutory powers of decision the Respondent is bound to:
>
> (i) Provide health and disability services;
> (ii) Secure for the people of the Whangarei area the best health and the best care and support for those in need of health and disability services.
> (iii) To exhibit a sense of social responsibility by having regard to the interests of the community in which it operates.
> (iv) To uphold any ethical standards generally expected of providers of both health and disability services."

An interim order has been sought to restrain the respondent, Northland Health, its servants, agents and employees from discontinuing dialysis treatment for Mr Rau Williams until further order of the Court or, alternatively, in the event that dialysis treatment has been discontinued, requiring the respondent through its servants, agents and employees to resume dialysis treatment for Mr Williams. The standard grounds relating to interim injunctions are relied on to support the interim order sought.

An affidavit has been filed by the applicant in support of the application for interim order. Mr Shortland deposes that he is a nephew of Mr Williams and that Mr Williams is aged 64 and is currently receiving dialysis treatment. Mr Shortland records that he has authority on behalf of Mr Williams and from his family to apply for the relief sought in these proceedings. The affidavit records Mr Williams'

relevant medical history as follows.

In October 1996 while on jury service Mr Williams fainted and was admitted to hospital where he was diagnosed as a diabetic. Within two or three days of his admission to hospital he suffered renal failure and that resulted in him being given dialysis treatment. At the time the treatment was initiated in October 1996 the family was advised that Mr Williams did not qualify for dialysis treatment but a threat of legal action at that time, resulted in him being placed on the dialysis treatment programme and given treatment.

Mr Shortland goes on to say that following receipt of the treatment there was an immediate recovery which resulted in Mr Williams returning home within two weeks and he lived at home from October 1996 to June 1997 without requiring further dialysis treatment. In June of this year Mr Williams' health deteriorated and he was readmitted to Whangarei Base Hospital and began receiving further dialysis treatment. During the course of the treatment Mr Williams suffered peritonitis and this resulted in complications with the result that he has been unable to fully care for himself.

On 3 September 1997 the respondent wrote to the applicant advising that Mr Williams did not meet the Northern Regional Health Authority Guidelines for acceptance onto the renal placement programme and that dialysis treatment would be discontinued as at Thursday, 17 September 1997. (Presumably the date referred to was intended to be either Wednesday, 17

or Thursday, 18 September.)

The applicant, acting on behalf of the family, sought further information from Northland Health and received that information by letter dated 5 September. The applicant was given a copy of the Northland Regional Health Authority's Guidelines for entry into the Northern Region's End Stage Renal Failure Programme.

The applicant records his understanding that without dialysis treatment Mr Williams will die within a short period of time, probably some two to three weeks. He states that Mr Williams enjoys quality of life and is not experiencing pain and that with treatment he could expect to live for some time. He states that Mr Williams has indicated to him and to other members of his family that he does not wish to die, he enjoys seeing his family. The affidavit concludes by recording that the respondent is trading profitably and that there appears to be no reason why a continuation of the dialysis treatment could not be made available to enable Mr Williams to be given the best care and support in the circumstances.

Three affidavits have been filed on behalf of the respondent. Dr L. V. Henneveld, is the chief medical advisor to the respondent. He is responsible for the medical staff and he sets out Mr Williams' case history. His affidavit describes the efforts made to establish home-based peritoneal dialysis. He says that although there were grave concerns of Mr Williams suitability, on the whanau's insistence an attempt

was made to train Mr Williams in the use of peritoneal dialysis. He says this was attempted over a period of several weeks, June/ July 1997. Mr Williams was unable to learn the basic concepts of this system despite very intensive and repeated teachings. His affidavit says that it proved impossible to ensure a whanau member to take responsibility for Mr Williams' care. Mr Williams pulled out his catheter on two occasions, causing life threatening peritonitis, which is an infection of the intra-abdominal membrane.

The consequence of what has just been recorded, is that the only dialysis possible is hospital based and Mr Williams has reached what is called, end stage renal failure, where there is no prospect of a cure. A renal transplant is the only possibility for such people, but there is a long waiting list for such transplants and the affidavit records that it can take up to seven years to receive a transplant.

In paragraph 10 of his affidavit Dr Henneveld describes the process of dialysis. He said that peritoneal dialysis is a 24 hour process heavily reliant on active patient participation. And he goes on to describe the precision and cleanliness that are essential and generally the process involved.

He then describes how attempts are made to evenly distribute the resources that are available and he refers to the Guidelines for Entry into the Northern Region's End Stage Renal Failure Programme.

In paragraph 13 he describes the assessments that are undertaken to determine whether or not to accept patients on a dialysis programme. He says these assessments are, "required to be able to make a judgment of the patient to benefit from the treatment and to ascertain that the compliance potential is positive and that the patient is able to co-operate with an active therapy". He notes that dialysis treatment is very demanding on patients and their care-givers.

His affidavit goes on to describe the assessment that was made in Mr Williams' case. There was a psychiatric review, and a psychological assessment, and the unanimous conclusion was reached that Mr Williams falls into the category of moderate dementia that puts him under Group A of the Guidelines and consequently, the affidavit says, Mr Williams is not suitable for treatment of end stage renal failure.

In his conclusion Dr Henneveld says:

> "A duty of a doctor is to act in the best interests of the patient when the patient is incompetent. When there is no prospect of cure or the progression of the disease cannot be halted. Regrettably Mr Williams cannot be cured and withholding dialysis treatment is the best decision and duty of his physicians at this time when he nears the end of his life."

The next affidavit filed on behalf of the respondent is that of Dr J. A. Walker, a Renal Physician. She makes recommendations as to the appropriate medical management of patients, bearing in mind the Guidelines produced by the

Regional Health Authority. She describes in her affidavit the efforts that were made to provide Mr Williams with dialysis at home, and she says this:

> "Mr Williams was discharged to outpatient follow up but had to be re-admitted to the hospital on 20/6/97. At this stage he was failing to cope at home, had no food in the house and his mentation was very slow."

She describes the tests that were performed as part of the assessment of Mr Williams for on-going dialysis and concludes in this way:

> "In summary I feel that Mr Williams is incapable of performing any form of home dialysis. He is incapable of living independently. I therefore believe he falls outside the guidelines for entry into the Northern regions end stage renal failure programme as published by the Northern Regional Health Authority on 24/7/96.
>
> It is my belief that Mr Williams fails to comply with the CNS/mental function requirements in Group A categories as detailed on Page 9 of the guidelines. The basis of this is that the patient is required to have the ability to co-operate with active therapy.

And in the last paragraph of her affidavit she notes that the dialysis treatment was discontinued as at 17 September, as notified to Mr Williams and his family.

The final affidavit is that of Mr Peter Dawson, who is a senior psychologist. He describes the interviews that he had with Mr Williams, the tests that he administered and his conclusion is that:

> "Mr Williams is showing evidence of organic dementia, that is a global impairment of intellect, memory and personality but without impairment of consciousness."

I have made reference to the procedures and guidelines for entry into the Northern Region's End Stage Renal Failure

Programme. The section of the Guidelines relied upon by the respondent is at page 9 of that document. It will be recalled that both Dr Henneveld and Dr Walker consider that Mr Williams' comes within Group A of those Guidelines. That section reads:

> "**Group A**
> Factors which in isolation are likely to determine that an individual is not suitable for treatment of End Stage Renal Failure.
>
> **CNS/Mental function**
> Dementia (moderate to severe), very low IQ, a disabling psychiatric disorder which is unlikely to respond to further therapy, previous major stroke with persisting severe functional disability. [Obviously, those are all possibly alternatives.]
>
> Basis: There must be the ability to co-operate with active therapy."

That then is the evidence that has been presented in relation to this application.

The applicant's argument presented by Mr Mathias refers to provisions of the Health and Disability Services Act 1993. The respondent company is incorporated pursuant to the provisions of that Act. Mr Mathias relies on the provisions of s.4 of that Act which sets out its purpose and I read s.4(a):

> "4. **Purpose** - The purpose of this Act is to reform the public funding and provision of health services and disability services in order to -
> (a) Secure for the people of New Zealand -
> (i) The best health; and
> (ii) The best care or support for those in need of those services; and
> (iii) The greatest independence for people with disabilities -
> that is reasonably achievable within the amount of funding provided."

He then referred to the objectives of Crown Health Enterprises, which include to assist in meeting the Crown's objectives under s.8 by the provision of services. Subsection (3) of s.8 effectively repeats what I have already read as being the purpose of the Act and it will be noted that in each case what is required is qualified by the reference to being "reasaonably achievable within the amount of funding provided".

Mr Mathias submits that the respondent is failing to meet these objectives by refusing to place Mr Williams on its End Stage Renal Failure Programme. He seeks interim relief to maintain the status quo relying on the conventional principles as set out in decisions such as ***American Cyanamid Co. v Ethicon Limited*** [1975] AC 396, ***Eng Mee Yong v Letchumanan*** [1980] AC 331 and the New Zealand decision of ***Klissers Farmhouse Bakeries Limited v Harvest Bakeries Limited*** [1985] 2 NZLR 140.

Mr Mathias' submissions were summarised in the final paragraph when he said that:

> "The decision to deny him [Mr Williams] treatment is one which is arguably contrary to the direction of the Act such being designed to secure the best health and the best care and support for those in need of health services. A service is available that will provide him with a continuation of life. The refusal to provide that service, or its withdrawal, whatever the situation, will of necessity result in the termination of his life."

Mr Mathias submits that if the respondent has the means and someone needs treatment then the respondent must provide it. But as will become apparent, I do not accept this

argument. There is no such absolute duty. The general obligations that are set out in the Act are subject to clinical judgment.

For the respondent, Mr Winter, raised questions as to the applicant's status to bring these proceedings. He points out that there is provision for the appointment of people to represent a person not able to look after themselves, and that that has not been done in this case.

Given the urgency of the application I am prepared to accept the applicant's unchallenged statement in paragraph 4 of his affidavit, that he has the authority of Mr Williams and Mr Williams' family to bring the proceedings. And I note in that regard that the respondent accepted Mr Shortland as representing the family in correspondence annexed to the applicant's affidavit.

Mr Winter raised the question as to whether the Court should order the respondent to do something which its clinical employees have decided is inappropriate, and he relied heavily on a decision of the Court of Appeal in England, ***In Re J (A Minor)*** [1992] 3 WLR 507.

After much careful consideration, and being very conscious of the enormous importance of the decision in this case to Mr Williams, Mr Shortland, and other family members, and indeed, of course, to the respondent, I have decided that it is appropriate, and indeed, unavoidable, that I should

follow the same approach as was followed by the Court of Appeal in ***In Re J.*** (supra). That case was concerned with whether an infant should be taken off mechanical ventilation. An interim order was made that the Health Authority should cause such measures (including artificial ventilation) to be applied as were capable of prolonging the child's life. The Health Authority appealed. There are passages in the appeal judgment that exactly express what I consider to be the appropriate approach for this Court to adopt in this case.

Lord Donaldson said this at page 516:

> "Let me say at once that in a matter of this nature, there is absolutely no room for the application of the principles governing the grant of interlocutory relief which were laid down by Lord Diplock in ***American Cyanamid Co. v Ethicon Ltd*** [1975] A.C. 396, 408. The proper approach is to consider what options are open to the court in a proper exercise of its inherent powers and, within those limits, what orders would best serve the true interests of the infant pending a final decision. There can be no question of "balance of convenience." There can be no question of seeking, simply as such, to preserve the status quo, although on particular facts that may well be the court's objective as being in the best interests of the infant. There can be no question of "preserving the subject matter of the action." Manifestly there can be no question of considering whether damages would be an adequate remedy.
>
> The fundamental issue in this appeal is whether the court in the exercise of its inherent power to protect the interests of minors should ever require a medical practitioners or health authority acting by a medical practitioner to adopt a course of treatment which in the *bona fide* clinical judgment of the practitioner concerned is contra-indicated as not being in the best interests of the patient. I have to say that I cannot at present conceive of any circumstances in which this would be other than an abuse of power as directly or indirectly requiring the practitioner to act contrary to the fundamental duty which he owes to his patient. This, subject to obtaining any necessary consent, is to treat the patient in accordance with his own best clinical judgment, notwithstanding that other practitioners who are not called upon to treat the patient may have formed a quite different judgment or that the court, acting on expert evidence, may disagree with him."

Then later referring to an earlier decision Lord Donaldson

said:

> "The decision whether to treat is dependent upon an exercise of his own professional judgment..."

Lord Donaldson also referred to the problem of limited resources in this passage of his judgment:

> "Furthermore it was, in my judgment, erroneous on two other substantial grounds, only slightly less fundamental than that to which I have just adverted. The first is its lack of certainty as to what was required of the health authority. The second is that it does not adequately take account of the sad fact of life that health authorities may on occasion find that they have too few resources, either human or material or both, to treat all the patients whom they would like to treat in the way in which they would like to treat them. It is then their duty to make choices.
>
> The court when considering what course to adopt in relation to a particular child has no knowledge of competing claims to a health authority's resources and is in no position to express any view as to how it should elect to deploy them. ..."

Lord Donaldson emphasised that the Court decision not to require treatment by the Health Authority in that case left the Authority and its medical staff free to treat the patient in accordance with the best clinical judgment. Balcombe, J. agreed with Lord Donaldson, but went further, and at pages 518 to 519 he said:

> "I find it difficult to conceive of a situation where it would be a proper exercise of the jurisdiction to make an order positively requiring a doctor to adopt a particular course of treatment ... unless the doctor himself or herself were asking the court to make such an order. Usually all the court is asked, or needs, to do is to authorise a particular course of treatment where the person or body whose consent is requisite is unable or unwilling to do so."

He too, referred to the question of resources and concluded by saying:

> "I would also stress the absolute undesirability of the court making an order which may have the effect of compelling a doctor or health authority to make available scarce resources (both human and

> material) ... without knowing whether or not there are other patients to whom those resources might more advantageously be devoted."

For the same reasons as are expressed in that case, I have concluded that it is inappropriate for me to make an order in this case. There is no suggestion that the respondent's medical staff are acting in bad faith. That being the case, they must be allowed to act in accordance with their clinical judgment. It is totally inappropriate for the Court to attempt to direct a doctor as to what treatment should be given to a patient. It must be remembered that the respondent is not refusing to treat this patient rather, it is exercising a professional judgment through its medical staff as to the appropriate treatment to adopt.

The interim order sought is, therefore, refused.

Having come to that conclusion there are some observations which I feel it appropriate to make in relation to the evidence. It is not clear to me whether the decision to cease dialysis was made on the basis of a judgment that it was not in Mr Williams' best interests or whether it was based on an assessment of where scarce resources should best be used. I have no doubt that the respondent will want to ensure that there is absolute clarity as to the reasons for refusing the treatment and so I would commend a careful reconsideration of the conclusion reached with the appropriate clinical steps taken as a result.

Just to make myself quite clear, I refer back again to paragraph 14 of Dr Walker's affidavit. That paragraph, which I read earlier, does not make it clear as to whether she has reached a decision on clinical or resource grounds, that treatment is inappropriate, or whether she was just applying the policy. Each case must, of course, be decided on its merits, referring to the Guidelines for assistance, but not letting those Guidelines dictate the result. To allow the Guidelines to dictate the result would be a reviewable error or law, but is not a matter raised in these proceedings.

Indeed, I am not clear from the evidence, as to how the decision-making process is undertaken by the respondent. That is not surprising in this case, because the proceedings do not attack the decision-making process, rather they claim a right which I have held must be subject to clinical judgment.

It is possible that the decision to refuse treatment was made by the assessment group meeting and reaching a conclusion guided by the Policy and, if that is so, that would be an appropriate course to follow. Indeed, Dr Henneveld's evidence suggests that that is what has happened. But, unfortunately, the matter is not entirely clear. If there has been an error of approach, and as I have said, I am not at all clear as to whether there has been, I am sure that the respondent and its staff would want to readdress the matter immediately, including, of course, if appropriate, the reinstatement of dialysis or any other clinical treatment. However, I cannot in these proceedings make any order relating to that issue,

even if I was certain, which I am not, that the evidence was clear.

Therefore, for the reasons already advanced, I am not prepared to make an order which would direct the respondent as to the form of treatment it should adopt in respect of the applicant.

The question of costs is reserved.