Maharaj v Te Whata Ora of Auckland: Discontinuing Life Support in Aotearoa-NZ: Time for a Rethink?

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Maharaj v Te Whata Ora of Auckland [2023] NZHC 2128

- Mr Maharaj, 46 years, admitted to ICU in a coma after heart attack
- Rare but lethal hole torn in muscular wall dividing chambers of heart
- Placed on ECMO (form of ventilator, invasive & expensive) used as a last resort if patient has survivable condition
- Allowed clinicians to assess if any interventional options available
- Over 3 weeks, 5 expert clinicians assess & conclude that no surgical or other options available to repair the hole; no medical benefit from continuing ECMO

Maharaj (2)

- Several meetings with family, then hour-long family meeting with surgical team. Family told hole could not be closed. Shocked family request second opinion; told 24-hours to obtain it before ECMO discontinued;
- Hospital-arranged cardiologist advised family that scar tissue, a prerequisite to surgery to repair hole, took 4-6 weeks to form.
- Family did not consent to discontinuation, seek 5 days to organise overseas second opinions & to perform funeral rites
- Told by Hospital to seek injunction to prevent cessation of ECMO

Eaton J in High Court at Auckland

- First NZ decision in 25 years (since *Shortland* 1998)
- Makes order that lawful to discontinue life support, despite family disagreement; denied family 5 more days
- "not for courts to be the arbiters of the merits in cases of this kind," which were "solely for clinicians, in consultation with the family"
- Accepted medical evidence that prognosis "hopeless," treatment "futile" & withdrawal in Mr M's best interests
- Clinicians' plan supported by reasonable body of medical opinion (*Bolam)*
- Other patients' lives at risk by delays in withdrawing ECMO
- Court does not decide whether or not Hospital required to seek approval in every "disputed" case

Important issues in *Maharaj*

First NZ decision in 25 years (since *Shortland* 1998)

1. Inter-relationship of common law on withdrawal of life support with medical consent statutes (PPRA, MCA, state & territory statutes)
2. **Judicial definition/assessment of "best interests" at common law**
3. Defence of efficient allocation of scarce resources
4. **Mandatory or not for court to grant approval to discontinue life support in disputed cases? If so, whose role to bring matter before court?**

Can only consider (2) & (4)

See J Manning, "Removal of Life-supporting Treatment in New Zealand: Time for a Rethink?" [2024] NZ Law Review 617-656

Shortland v Northland Health Ltd [1998] 1 NZLR 433 (CA)

- Leading authority is ***Shortland v Northland Health Ltd*** [1998] 1 NZLR 433 (CA)

(1) Bona fide decision by doctors that withdrawal of life support in patient's best interests

(2) Compliance with prevailing medical standards & practices i.e. carrying out all relevant tests & consulting widely with other specialists, who agree

(3) Approval by profession's recognised ethical body

(4) Fully informed consent of family or guardian

- These criteria to be used as guideines

- Model changed from joint medical- family decision to unilateral medical autonomy

Sea change in assessing best interests in UK

- why the UK? Most developed law on the point
- *In re F, HL,* 1990 – wishes and feelings of incapacitated adult woman in forced sterilisation case not worthy of mention; bare best interests model
- Modern position: default position to attach much greater weight to patient's wishes and feelings (if any) or what would want over sanctity of life in assessing best interests
- Mandatory to bring before Court in disputed cases (*An NHS Trust v Y* [2018] UKSC 46)
- line of cases approved in *An NHS Trust v Y* that it is Hospital's role, not family's, to do so

Drivers of change in UK

- Once matter brought to court, court's role, not doctors, to make decision as to patient's best interests,
- Baroness Hale's highly influential statement in *Aintree*
- Most importantly CRPD, article 12, legal capacity is a human right, decisions based on P's will & preferences
- though implications still being worked through ("respect" for wishes & feelings v determinative)
- Modern patient-centred & more empathetic approach emphasises centrality of patient autonomy & importance of past & present wishes, feelings & values, though not a full "substituted judgment" approach

Baroness Hale in *Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67

"The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. … **But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs & values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being**.

This is … still a "best interests" rather than a "substituted judgment" test, but one which accepts that the preferences of the person concerned are an important component in deciding where his best interests lie.

Maharaj

- NZ a best interests, not a "substituted judgment," jurisdiction, *Re G*
- But no special priority or added weight attached to patient's wishes & feelings
- No mention of Mr M's wishes & feelings. What might he have wanted for himself?
- *Baroness Hale in Aintree* not cited
- Family wanted a few more days to observe burial rites. ? religious values that may have been important to him

Maharaj cont'd

- Family forced to bear cost of bringing matter before Court
- Unclear if Hospital obliged to seek court approval in all disputed cases, despite Hospital's argument that it was not
- An *NHS Trust v Y* not cited
- Hospital obligation to bring matter before court should include "dispute" between clinicians & patient's wishes & feelings.
- Shouldn't depend on something as arbitrary as whether or not family & treating health professionals have fallen out