

LEGAL CHALLENGES TO ICU TRIAGE DECISIONS IN THE COVID-19 PANDEMIC: HOW EFFECTIVELY DOES THE LAW REGULATE BEDSIDE RATIONING DECISIONS IN AUSTRALIA?

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The COVID-19 pandemic has raised the difficult question of how to ration scarce intensive care resources when a health system is overwhelmed. Despite substantial ethical scholarship addressing these rationing decisions, little is known about the legal position in Australia. This article considers various legal challenges in response to a clinical scenario denying intensive care admission and a ventilator to a critically ill patient with COVID-19. The article considers key challenges in negligence, criminal law, administrative law, human rights law, and under the parens patriae jurisdiction and guardianship legislation, and how they would apply to this scenario. The article concludes that while there are many obstacles to a successful legal challenge, the law can provide important scrutiny and guidance in the design of decision-making processes and triage policies. To adequately protect individual interests, the article supports calls in the ethical literature to make these policies transparent for public scrutiny.

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I INTRODUCTION

In the initial stages of the novel coronavirus 2019 ('COVID-19') pandemic,¹ Australia was among the few fortunate countries that avoided significant community transmission of the virus.² Initial forecasts predicted Australian intensive care units ('ICUs') would be overwhelmed in April 2020,³ which did not eventuate due to successful public health measures.⁴ By mid-year, most Australian jurisdictions eased restrictions, and as of 1 July 2020, there were 104 COVID-19 deaths nationally, markedly lower than in other countries.⁵ However, from July to October 2020 the Australian death rate increased exponentially,⁶ as Victoria experienced considerable community transmission⁷ and outbreak clusters emerged in New South Wales⁸ and Queensland.⁹ In response, states and territories rapidly reinstated border closures and lockdowns. These outbreaks, and the sobering international experience, illustrate that until there is widespread vaccination or an

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- 1 On 11 March 2020, the World Health Organization officially declared the novel coronavirus 2019 ('COVID-19') outbreak a pandemic: Tedros Adhanom Ghebreyesus, 'WHO Director-General's Opening Remarks at the Media Briefing on COVID-19' (Speech, World Health Organization, 11 March 2020) <<https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>>.
 - 2 Our World in Data, *Australia: Coronavirus Pandemic Country Profile* (Web Page, 13 September 2020) <<https://ourworldindata.org/coronavirus/country/australia?country=~AUS>>.
 - 3 Hamish DD Meares and Michael P Jones, 'When a System Breaks: Queuing Theory Model of Intensive Care Bed Needs during the COVID-19 Pandemic' (2020) 212(10) *Medical Journal of Australia* 470.
 - 4 Nazrul Islam et al, 'Physical Distancing Interventions and Incidence of Coronavirus Disease 2019: Natural Experiment in 149 Countries' (2020) 370 *BMJ* m2743:1–10, 3–7. See also Allan Saul et al, 'Victoria's Response to a Resurgence of COVID-19 Has Averted 9,000–37,000 Cases in July 2020' (2020) *Medical Journal of Australia* (advance, 4 August 2020) <<https://www.mja.com.au/journal/2020/victorias-response-resurgence-covid-19-has-averted-9000-37000-cases-july-2020>>.
 - 5 Our World in Data, 'Australia: What is the Cumulative Number of Confirmed Deaths?', *Australia: Coronavirus Pandemic Country Profile* (Web Page, 13 September 2020) <<https://ourworldindata.org/coronavirus/country/australia?country=~AUS>>. As of 10 January 2021, Australia had 36 cumulative confirmed COVID-19 deaths per million people, more than six times below the world average of 249: Our World in Data, 'Cumulative Confirmed COVID-19 Deaths per Million People', *Coronavirus Pandemic Data Explorer* (Web Page, 12 January 2021) <https://ourworldindata.org/explorers/coronavirus-data-explorer?zoomToSelection=true&pickerSort=desc&pickerMetric=total_cases&hideControls=true&Metric=Confirmed+deaths&Interval=Cumulative&Relative=to+Population=true&Align+outbreaks=false&country=OWID_WRL~AUS>.
 - 6 As of 1 October 2020, there were 890 Australian COVID-19 deaths: Our World in Data, 'Cumulative Confirmed COVID-19 Deaths', *Coronavirus Pandemic Data Explorer* (Web Page, 17 March 2021) <https://ourworldindata.org/explorers/coronavirus-data-explorer?zoomToSelection=true&pickerSort=desc&pickerMetric=total_cases&hideControls=true&Metric=Confirmed+deaths&Interval=Cumulative&Relative=to+Population=false&Align+outbreaks=false&country=OWID_WRL~AUS>.
 - 7 Saul et al (n 4).
 - 8 Ministry of Health (NSW), 'Locally Acquired COVID-19 Cases: A Review of the Last Six Weeks' (In Focus, 13 August 2020) <<https://www.health.nsw.gov.au/Infectious/covid-19/Documents/in-focus-6-week-review.pdf>>.
 - 9 See, eg, Department of Health (Qld), 'Urgent New COVID-19 Measures after Youth Detention Centre Cluster Detected' (Media Release, 22 August 2020) <<https://www.health.qld.gov.au/news-events/doh-media-releases/releases/urgent-new-covid-19-measures-after-youth-detention-centre-cluster-detected>>.

effective treatment for COVID-19, the health system could be overwhelmed. Moreover, there is a heightened awareness that novel disease pandemics or other disasters that threaten the health system are likely to arise in the future.¹⁰

In a pandemic or disaster, when an ICU has more patients than it can accommodate, doctors and nurses must triage patients and make ‘tragic choices’¹¹ about who is admitted, who is discharged and who receives scarce life-sustaining resources, such as ventilators. Internationally, some jurisdictions have faced hospital resource shortages due to COVID-19, leading to otherwise preventable deaths.¹² When individuals are denied treatment from which they would benefit because of a lack of resources, this constitutes ‘rationing’.¹³ Since the start of the pandemic, there has been a significant focus on how to make ICU rationing decisions fairly, and how to protect health workers and vulnerable cohorts. There has been a veritable deluge of literature in Australia,¹⁴ and internationally,¹⁵

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- 10 See, eg, David M Morens, Peter Daszak and Jeffrey K Taubenberger, ‘Escaping Pandora’s Box: Another Novel Coronavirus’ (2020) 382(14) *New England Journal of Medicine* 1293; Department of Health (Cth), ‘Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)’ (Report, 18 February 2020) 27 <https://www.health.gov.au/sites/default/files/documents/2020/02/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19_2.pdf>.
- 11 The phrase ‘tragic choices’ was coined by Calabresi and Bobbitt to describe the moral and ethical dilemmas societies face in allocating scarce resources: Guido Calabresi and Philip Bobbitt, *Tragic Choices* (Norton, 1978). They argue that society must consider how it structures its allocation mechanisms to minimise the tragedy in these choices. Triage is one such mechanism. The word ‘triage’ is derived from the French verb *trier*, ‘to sort’. This is typically used in medicine to mean ‘the sorting of patients for treatment priority in emergency departments (‘EDs’) and in multi-casualty incidents, disasters, and battlefield settings’: Kenneth V Iserson and John C Moskop, ‘Triage in Medicine, Part I: Concept, History, and Types’ (2007) 49(3) *Annals of Emergency Medicine* 275, 275.
- 12 See, eg, Jason Phua et al, ‘Intensive Care Management of Coronavirus Disease 2019 (COVID-19): Challenges and Recommendations’ (2020) 8(5) *Lancet Respiratory Medicine* 506; Giacomo Grasselli, Antonio Pesenti and Maurizio Cecconi, ‘Critical Care Utilization for the COVID-19 Outbreak in Lombardy, Italy: Early Experience and Forecast During an Emergency Response’ (2020) 323(16) *Journal of the American Medical Association* 1545; Daniel Sokol, ‘The NHS Is Not at Risk of Being Overwhelmed: It Already Is’ (2021) 372 *BMJ* n62:1. See also Ontario Office of the Premier, ‘Ontario Declares Second Provincial Emergency to Address COVID-19 Crisis and Save Lives’ (News Release, 12 January 2021) [1] <<https://news.ontario.ca/en/release/59922/ontario-declares-second-provincial-emergency-to-address-covid-19-crisis-and-save-lives>>, which refers to ‘the real and looming threat of the collapse of the province’s hospital system’.
- 13 Rationing can be defined as ‘any implicit or explicit measures that allow people to go without beneficial health care services’: Peter A Ubel and Susan Dorr Goold, ‘“Rationing” Health Care: Not All Definitions Are Created Equal’ (1998) 158(3) *Archives of Internal Medicine* 209, 209.
- 14 See, eg, Angus Dawson et al, ‘An Ethics Framework for Making Resource Allocation Decisions within Clinical Care: Responding to COVID-19’ (2020) 17(4) *Journal of Bioethical Inquiry* 749; Australia and New Zealand Intensive Care Society, ‘Guiding Principles for Complex Decision-Making during Pandemic COVID-19’ (Guidance, 2020) <https://www.anzics.com.au/wp-content/uploads/2020/04/ANZI_3367_Guiding-Principles.pdf>, also published as Stephen Warrillow et al, ‘ANZICS Guiding Principles for Complex Decision-Making during the COVID-19 Pandemic’ (2020) 22(2) *Critical Care and Resuscitation* 98 (‘COVID-19 Guiding Principles’); Melanie Jansen et al, ‘Ethical Considerations for Paediatrics during the COVID-19 Pandemic: A Discussion Paper from the Australian Paediatric Clinical Ethics Collaboration’ (2020) 56(6) *Journal of Paediatrics and Child Health* 847.
- 15 See, eg, Ezekiel J Emanuel et al, ‘Fair Allocation of Scarce Medical Resources in the Time of Covid-19’ (2020) 382(21) *New England Journal of Medicine* 2049; Douglas B White and Bernard Lo, ‘A

advocating for ethical approaches to triage. Most of these ethical frameworks are explicitly utilitarian and aim to maximise the total number of lives saved when the system is overwhelmed.¹⁶ However, disability advocates, bioethicists, and other commentators have questioned this utilitarian focus and have urged more scrutiny and greater transparency in ICU rationing decisions, to protect the rights of vulnerable individuals.¹⁷

Despite the extensive ethical discourse about rationing ICU resources during the COVID-19 pandemic there has been little attention paid in Australia to the law as a mechanism to protect individual interests in this context.¹⁸ Although some international literature has considered the legality of triage decisions,¹⁹ and has

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- Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic' (2020) 323(18) *Journal of the American Medical Association* 1773; Armand H Matheny Antommaria et al, 'Ventilator Triage Policies During the COVID-19 Pandemic at US Hospitals Associated with Members of the Association of Bioethics Program Directors' (2020) 173(3) *Annals of Internal Medicine* 188; Susanne Joebges and Nikola Biller-Andorno, 'Ethics Guidelines On COVID-19 Triage: An Emerging International Consensus' (2020) 24(1) *Critical Care* 201.
- 16 See, eg, Emanuel et al (n 15); Julian Savulescu, Ingmar Persson and Dominic Wilkinson, 'Utilitarianism and the Pandemic' (2020) 34(6) *Bioethics* 620.
- 17 See, eg, Samuel R Bagenstos, 'Who Gets the Ventilator? Disability Discrimination in COVID-19 Medical-Rationing Protocols' (2020) 130 *Yale Law Journal Forum* 1; Australian Human Rights Commission, 'Guidelines on the Rights of People with Disability in Health and Disability Care during COVID-19' (21 August 2020) <<https://humanrights.gov.au/our-work/disability-rights/publications/guidelines-rights-people-disability-health-and-disability>>; Mildred Z Solomon, Matthew K Wynia and Lawrence O Gostin, 'Covid-19 Triage: Optimizing Health Outcomes and Disability Rights' (2020) 383(5) *New England Journal of Medicine* e27:1–3; Ivanka Antova 'Disability Rights During COVID-19: Emergency Law and Guidelines in England' (2020) 28(4) *Medical Law Review* 804. Outside the pandemic, discrimination against individuals with a disability has been labelled a 'health crisis' by the Queensland Public Advocate and is being examined by the Royal Commission on Disability: Josh Bavas, 'Disabled Teen Dies After Flu Complications, Parents Claim Medical Response Inadequate', *ABC News* (online, 27 September 2019) <<https://www.abc.net.au/news/2019-09-27/disability-disabled-teen-dies-flu-hospital-care-royal-commission/11551048>>.
- 18 See, eg, Michelle A Gunn and Fiona McDonald, 'COVID-19, Rationing and the Right to Health: Can Patients Bring Legal Actions if they are Denied Access to Care?' (2020) *Medical Journal of Australia* (advance, 28 July 2020) <<https://www.mja.com.au/journal/2020/covid-19-rationing-and-right-health-can-patients-bring-legal-actions-if-they-are>>; Ruth Townsend and Michael Eburn, 'COVID-19: Legal and Ethical Implications for Your Practice' (2020) 17 *Australasian Journal of Paramedicine* 1; Anne-Maree Kelly, 'COVID-19 and Medical Litigation: More Than Just the Obvious' (2020) 32(4) *Emergency Medicine Australia* 703.
- 19 See, eg, I Glenn Cohen, Andrew M Crespo and Douglas B White, 'Potential Legal Liability for Withdrawing or Withholding Ventilators during COVID-19: Assessing the Risks and Identifying Needed Reforms' (2020) 323(19) *Journal of the American Medical Association* 1901; Kathleen Liddell et al, 'Who Gets the Ventilator? Important Legal Rights in a Pandemic' (2020) 46(7) *Journal of Medical Ethics* 421; David Lock QC, 'Legal Issues Arising out of Medical Priority Decision-Making', *LinkedIn* (Blog Post, 8 January 2021) <<https://www.linkedin.com/pulse/legal-issues-arising-out-medical-priority-decision-making-lock-qc/>>.

canvassed the need for legal immunity when triaging,²⁰ each jurisdiction has distinct legal regimes.²¹

This article seeks to address these gaps and provide a comprehensive account of the possible legal challenges that could arise when doctors in Australia withhold or withdraw life-sustaining treatment in the COVID-19 pandemic. The article begins in Part II by defining rationing at the bedside and considers the importance of transparent rationing decisions from a theoretical perspective. Part III then sets out the clinical context of end-of-life decision-making, including how decisions about life-sustaining treatment are made both in normal and pandemic circumstances. In particular, this section addresses tensions between rationing decisions and determinations of ‘medical futility’. To anchor the legal analysis, Part IV then provides a clinical scenario where life-sustaining treatment is withheld due to a severe resource shortage. In Part V the article evaluates challenges that could arise in response to this scenario based in administrative law, human rights law, negligence, and under the courts’ *parens patriae* jurisdiction. Part VI concludes by arguing that despite the practical difficulties in protecting individual rights, law has an important role to play in scrutinising and guiding the design of decision-making policies and processes. This should be a critical part of Australia’s COVID-19 response and will inform not only this pandemic but also future public health emergencies.

20 See, eg, Cohen, Crespo and White (n 19); Amy L McGuire et al, ‘Ethical Challenges Arising in the COVID-19 Pandemic: An Overview from the Association of Bioethics Program Directors (ABPD) Task Force’ (2020) 20(7) *American Journal of Bioethics* 15; Marco Ricci and Pasquale Gallina, ‘COVID-19: Immunity from Prosecution for Physicians Forced to Allocate Scarce Resources: The Italian Perspective’ (2020) 24(1) *Critical Care* 295.

21 One distinction is that Australia does not have a national human rights charter, as in the United Kingdom or Canada, where resource allocation decisions have been legally challenged under these instruments. See generally Jonathan Herring, *Medical Law and Ethics* (Oxford University Press, 4th ed, 2012) 68–72; Colleen M Flood and Michelle Zimmerman, ‘Judicious Choices: Health Care Resource Decisions and the Supreme Court of Canada’ in Jocelyn Downie and Elaine Gibson (eds), *Health Law at the Supreme Court of Canada* (Irwin Law, 2007) 25, 54; Martha Jackman, ‘Charter Review as a Health Care Accountability Mechanism in Canada’ (2010) 18 *Health Law Journal* 1. Also, Australia’s administrative law has diverged in some respects from that of the United Kingdom, where there have been more attempts to challenge rationing decisions: Herring 60–72. The United Kingdom courts typically defer to rationing decisions, but appear to be more willing to scrutinise the decision-making processes more heavily in cases concerning life-sustaining treatment. See, eg, *R (Ross) v West Sussex Primary Care Trust* [2008] EWHC 2252 (Admin) [39]: ‘Courts must subject their decision to anxious scrutiny because the Claimant’s life is at stake’ (*West Sussex Primary Care*).

II BEDSIDE RATIONING AND THE IMPORTANCE OF LEGITIMATE DECISION-MAKING

A Rationing Defined

At the outset, it is critical to establish what is meant by the term ‘rationing’.²² There is extensive debate about what constitutes rationing,²³ and to navigate this complexity Ubel and Goold’s widely-cited definition captures a broad range of situations: rationing is any implicit or explicit mechanism that allows a person to go without necessary or beneficial health services.²⁴ Specific to the ICU, Truog et al similarly define rationing as ‘the allocation of healthcare resources in the face of limited availability, which necessarily means that beneficial interventions are withheld from some individuals’.²⁵ The key factor underlying both definitions is that a person is being denied treatment that can benefit them, due to scarcity of resources. This article adopts these broad definitions as a basis for the legal analysis in Part V.

B Bedside Rationing by Doctors

While the COVID-19 pandemic has brought considerable attention to rationing, it has always been a ubiquitous part of the health care system. Although rationing in healthcare is a ‘morally charged term’,²⁶ even in the normal course rationing is unavoidable because healthcare resources are not unlimited. Some degree of rationing is therefore necessary and morally acceptable, provided it is accomplished fairly and transparently.²⁷

22 In Keith Syrett, *Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective* (Cambridge University Press, 2007) 45–50, the author suggests a rationing ‘taxonomy’ to illustrate how rationing can occur at various levels of the health care system by denial of treatment; selection of treatment; delay in treatment; deterrence to seek treatment; deflection to other treatments; dilution (reduction of quantity/quality of treatment); and termination of treatment. See also Rebekah J Walker and Leonard E Egede, ‘Rationing of Care: Conceptual Ambiguity and Transparency in Data Collection and Synthesis’ (2016) 31(12) *Journal of General Internal Medicine* 1415.

23 Ubel categorises the ‘confusing array’ of rationing definitions into three broad groups: Peter A Ubel, *Pricing Life: Why It’s Time for Health Care Rationing* (MIT Press, 2000) 13–4. First are those that depend on the explicitness or implicitness of the rationing decision, with some arguing that rationing only refers to overt, intentional decisions, typically made at the administrative level: at 16–19. Second, some definitions are distinguished based on the scarcity of the resource with some commentators arguing that rationing only occurs when the resource is *absolutely* scarce (for example, organs for transplantation), and not when resources are *relatively* scarce (for example, intensive care beds when the unit is not at capacity or access to subspecialists, who are limited in number). Third, some definitions depend on whether the treatment or service is *necessary* (for example, renal dialysis for end-stage kidney disease), while others define rationing to also encompass limits on merely *beneficial* but unnecessary services (for example, using an MRI instead of a CT scan when both would provide the same diagnostic outcome, but the CT scan carries risks associated with radiation exposure): at 22–8.

24 Ubel and Goold (n 13).

25 Robert D Truog et al, ‘Rationing in the Intensive Care Unit’ (2006) 34(4) *Critical Care Medicine* 958, 958–9.

26 Ubel and Goold (n 13) 210.

27 This argument has considerable support in the literature. See, eg, Norman Daniels and James E Sabin, *Setting Limits Fairly: Can We Learn to Share Medical Resources?* (Oxford University Press, 2002);

Rationing health resources occurs in a variety of ways, by individual, institutional and governmental actors at different levels of the system.²⁸ Specific to the ICU, Truog et al provide a framework of rationing choices doctors engage in.²⁹ Intensivists may ration due to:

1. External constraints (eg, denying an emergency ICU admission because the ICU is full and no patients can be discharged safely);
2. Clinical guidelines (eg, not prescribing a potentially beneficial drug because an accepted guideline dictates treatment with a less expensive substitute); or
3. Clinical judgment (eg, choosing which patient to admit to the last free ICU bed in the absence of a guideline).

An important insight from this framework is all forms of bedside rationing involve an exercise of discretion by the clinician. Rationing using clinical judgment involves the greatest degree of discretion. Yet, even when there are external constraints such as no free beds in the ICU (the subject of this article), a doctor must still decide whether to discharge a patient to accommodate someone else. Similarly, when rationing by clinical guidelines a doctor must decide which guideline to use and how to apply it. This exercise of discretion has implications for the legal analysis of triage decisions.

One concern with rationing by doctors is this exercise of discretion can involve subjectivity and overt or implicit bias,³⁰ and a patient or their family may not be

Norman Daniels, 'Accountability for Reasonableness: Establishing a Fair Process for Priority Setting Is Easier Than Agreeing on Principles' (2000) 321(7272) *BMJ* 1300; Leonard M Fleck, 'Just Caring: Health Care Rationing, Terminal Illness, and the Medically Least Well Off' (2011) 39(2) *Journal of Law, Medicine and Ethics* 156. At the heart of resource allocation decisions are deep moral disagreements about how resources should be divided. Because of this entrenched moral conflict, much of the discourse around bedside rationing emphasises the critical importance of *legitimacy* of rationing decisions, which depend on fair, deliberative decision-making processes.

28 Rationing can occur explicitly, through a range of activities beyond intensive care unit ('ICU') triage, including organ transplant decisions, age-based thresholds for *in vitro* fertilisation, and eligibility for kidney dialysis. Explicit rationing decisions are often made by higher authorities, such as governments or health and hospital boards, who ration by deciding what treatments to subsidise and what services to offer: Elizabeth Martin, *Rationing in Healthcare* (Issues Brief, Deeble Institute for Health Policy Research, 12 February 2015). Rationing also occurs implicitly, by clinicians at the bedside. This occurs in both tangible and intangible ways, including decisions about how much time to spend with a given patient, whether to deny a patient a costly medication, and which patients are deprioritised when there are insufficient resources to meet all demands: Truog et al (n 25) 961.

29 Truog et al (n 25) 960.

30 Ibid 961. Studies confirm that bedside rationing involves significant variation between clinicians and in some cases can conceal implicit bias. See, eg, Jeffrey Kirby, 'Balancing Legitimate Critical-Care Interests: Setting Defensible Care Limits Through Policy Development' (2016) 16(1) *American Journal of Bioethics* 38, 41–2. Variation can occur based on factors including functional or employment status: Gordon Guyatt et al, 'Influence of Perceived Functional and Employment Status on Cardiopulmonary Resuscitation Directives' (2003) 18(3) *Journal of Critical Care* 133; disability: Pauline Heslop et al, 'Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD)' (Final Report, Norah Fry Research Centre, Bristol University, 2013) <<http://www.bris.ac.uk/cipold/fullfinalreport.pdf>>; race and ethnicity: Michelle van Ryn and Stephen S Fu, 'Paved with Good Intentions: Do Public Health and Human Service Providers Contribute to

aware of or able to challenge the decision. A related concern is that doctors are uncomfortable with rationing, and therefore, tend to internalise resource limits and characterise resource-based decisions as medical ones.³¹ This means they may not consciously realise they are rationing, and resourcing decisions might be cloaked in language that a treatment is ‘futile’ or ‘not clinically indicated’.³²

To address these concerns, some commentators argue doctors should never ration at the bedside, since this interferes with their legal and ethical duties to their patients.³³ However, empirical evidence confirms rationing is a routine and necessary part of intensive care practice.³⁴

III CLINICAL CONTEXT OF END-OF-LIFE DECISION-MAKING DURING THE COVID-19 PANDEMIC

With the ethical and theoretical underpinnings of intensive care rationing in mind, this section considers clinical aspects of end-of-life decisions, both generally and in the COVID-19 pandemic. These provide important context to the legal analysis that follows. This section also includes a brief overview of the types of existing Australian ICU triage policies for COVID-19, as this is also relevant to the legal analysis.

Racial/Ethnic Disparities in Health?’ (2003) 93(2) *American Journal of Public Health* 248); personal background: H Hinkka et al, ‘Factors Affecting Physicians’ Decisions to Forgo Life-Sustaining Treatments in Terminal Care’ (2002) 28(2) *Journal of Medical Ethics* 109); religion: David W Frost et al, ‘Patient and Healthcare Professional Factors Influencing End-of-Life Decision-Making During Critical Illness: A Systematic Review’ (2011) 39(5) *Critical Care Medicine* 1174; and/or country of origin and culture: Chad G Ball et al, ‘The Impact of Country and Culture on End-of-Life Care for Injured Patients: Results from an International Survey’ (2010) 69(6) *Journal of Trauma: Injury, Infection and Critical Care* 1323).

31 See generally Syrett (n 22) 69; Truog et al (n 25) 959.

32 Eliana Close et al, ‘Doctors’ Perceptions of How Resource Limitations Relate to Futility in End-of-Life Decision-Making: A Qualitative Analysis’ (2019) 45(6) *Journal of Medical Ethics* 373 (‘Doctors’ Perceptions’); Tony Hope, David Sprigings and Roger Crisp, ‘“Not Clinically Indicated”: Patients’ Interests or Resource Allocation?’ (1993) 306(6874) *BMJ* 379.

33 See, eg, Norman G Levinsky, ‘The Doctor’s Master’ (1984) 311(24) *New England Journal of Medicine* 1573; Vegard Bruun Wyller, ‘Give to the Doctor What Is Due to the Doctor: Why “Fair Rationing at the Bedside” Is Impossible’ in Marion Danis et al (eds), *Fair Resource Allocation and Rationing at the Bedside* (Oxford University Press, 2014) 253.

34 Factors that influence rationing decisions include perceptions of scarcity, resource availability, and triage principles. See, eg, Samia A Hurst et al, ‘Prevalence and Determinants of Physician Bedside Rationing: Data from Europe’ (2006) 21(11) *Journal of General Internal Medicine* 1138; Andrew B Cooper et al, ‘Scarcity: The Context of Rationing in an Ontario ICU’ (2013) 41(6) *Critical Care Medicine* 1476; René Robert et al, ‘Influence of ICU-Bed Availability on ICU Admission Decisions’ (2015) 5(1) *Annals of Intensive Care* 55; Tasnim Sinuff et al, ‘Rationing Critical Care Beds: A Systematic Review’ (2004) 32(7) *Critical Care Medicine* 1588; Nicholas S Ward et al, ‘Perceptions of Cost Constraints, Resource Limitations, and Rationing in United States Intensive Care Units: Results of a National Survey’ (2008) 36(2) *Critical Care Medicine* 471; Daniel Strech et al, ‘Are Physicians Willing to Ration Health Care? Conflicting Findings in a Systematic Review of Survey Research’ (2009) 90(2–3) *Health Policy* 113; Daniel Strech, Matthis Synofzik and Georg Marckmann, ‘How Physicians Allocate Scarce Resources at the Bedside: A Systematic Review of Qualitative Studies’ (2008) 33(1) *Journal of Medicine and Philosophy* 80.

A Tensions between Rationing and Futility in the COVID-19 Pandemic

Decisions to withhold or withdraw life-sustaining treatment are a regular part of medical practice and precede approximately 28.6% of adult deaths in Australia.³⁵ Ideally, they are made using ‘shared decision-making’ involving the medical team and the patient.³⁶ Nevertheless, there are barriers to shared decisions³⁷ and these decisions can be practically, emotionally and professionally challenging. End of life treatment decisions are complex, multi-variate and often depend on a patient’s values and wishes.³⁸ While it may be technically possible to sustain a critically ill person’s life, certain interventions may only prolong an inevitable death. There may be multiple decision makers involved,³⁹ with different views about how to proceed. Not infrequently, a patient near the end of life may lack decision-making capacity and therefore need a substitute decision maker to provide consent to treatment or to provide information about the patient’s pre-morbid status and wishes for end-of-life care.⁴⁰ This may further complicate decision-making because a patient’s wishes may be unclear. Advance care planning is one way for individuals to direct future decisions, but uptake of these instruments in Australia is low.⁴¹

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- 35 Helga Kuhse et al, ‘End-of-Life Decisions in Australian Medical Practice’ (1997) 166(4) *Medical Journal of Australia* 191, 195. This figure is consistent with data from Europe that suggest non-treatment decisions precede up to 28% of all deaths, however, the studies used a different methodology so a relative comparison must be treated with caution: Agnes van der Heide et al, ‘End-of-Life Decision-Making in Six European Countries: Descriptive Study’ (2003) 362(9381) *Lancet* 345.
- 36 Douglas B White et al, ‘Towards Shared Decision-Making at the End of Life in Intensive Care Units’ (2007) 167 *Archives of Internal Medicine* 461; Ministry of Health (NSW), Office of the Chief Health Officer, *End-of-Life Care and Decision-Making: Guidelines* (Guideline No GL2005_057, 22 March 2005) <http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=GL2005_057>; Australian and New Zealand Intensive Care Society, ‘ANZICS Statement on Care and Decision-Making at the End of Life for the Critically Ill’ (Edition 1.0, 2014) <<https://www.anzics.com.au/wp-content/uploads/2018/08/ANZICS-Statement-on-Care-and-Decision-Making-at-the-End-of-Life-for-the-Critically-Ill.pdf>> (‘End-of-Life Statement’).
- 37 See, eg, White et al (n 36); Nicolas Couët et al, ‘Assessments of the Extent to which Health-Care Providers Involve Patients in Decision-Making: A Systematic Review of Studies Using the OPTION Instrument’ (2015) 18(4) *Health Expectations* 542.
- 38 For example, a patient who is in a persistent vegetative state might have previously expressed strong views that life was worth prolonging, no matter her condition, and so not regard continued treatment as futile. In contrast another person who believed that life was not worth living unless they could interact with their loved ones might consider further treatment futile.
- 39 Decision makers can include doctors, nurses, allied health professionals, the patient and their family or friends.
- 40 There are a range of potential substitute decision makers depending on the particulars of a case including those appointed by the patient or under legislation. A court or tribunal can also act as the decision maker. See generally Ben White, Lindy Willmott and Shih-Ning Then, ‘Adults Who Lack Capacity: Substitute Decision-Making’ in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 3rd ed, 2018) 207.
- 41 Ben P White et al, ‘Prevalence of Advance Care Directives in the Community: A Telephone Survey of Three Australian States’ (2019) 49(10) *Internal Medicine Journal* 1261; B White et al, ‘Prevalence and Predictors of Advance Directives in Australia’ (2014) 44(10) *Internal Medicine Journal* 975. See also Craig Sinclair et al, ‘Advance Care Planning in Australia during the COVID-19 Outbreak: Now More Important Than Ever’ (2020) 50(8) *Internal Medicine Journal* 918.

One of the most common justifications for forgoing life-sustaining treatment is that it is unable or very unlikely to benefit the patient.⁴² Doctors have an ethical and professional duty to only offer interventions that are potentially beneficial to their patients, and to avoid treatments that are ‘futile’, not ‘beneficial’.⁴³ Although ostensibly straightforward, the concept of futility is fraught. There is extensive literature on how to define the term and procedural approaches that attempt to resolve disagreements.⁴⁴ While the word ‘futile’ appears to suggest an objective medical assessment, there is consensus in the literature that most judgments about futility involve a value-laden assessment of whether a treatment is in the patient’s interests.⁴⁵

Another problem with futility in practice is that it can mask or be conflated with rationing.⁴⁶ When a patient or family wants life-sustaining treatment a doctor does not want to provide, there are two separate ethical rationales that can justify the doctor’s decision: (1) that the intervention is not of overall benefit to the patient (ie, it is futile or ‘not in the patient’s interests’); and (2) that limited resources should not be used for this patient (distributive justice).⁴⁷ Both rationales could apply to the same case, but since they are ethically distinct, when making decisions and communicating with patients and substitute decision makers, doctors should clearly distinguish between them.⁴⁸ Some literature suggests doctors do not sufficiently do this in practice, raising concerns about unconscious rationing or

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- 42 Another major rationale for not treating is a lawful refusal of that treatment by the patient or their substitute decision-maker. See, eg, *Brightwater Care Group v Rossiter* (2009) 40 WAR 84 (*‘Brightwater Care’*). See generally Bernadette Richards, ‘General Principles of Consent to Medical Treatment’ in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 3rd ed, 2018) 135, 149–50.
- 43 See, eg, Australian and New Zealand Intensive Care Society, ‘End-of-Life Statement’ (n 36) 44. See also Medical Board of Australia, ‘Good Medical Practice: A Code of Conduct for Doctors in Australia’ (Code, Australian Health Practitioner Regulation Agency, October 2020) ss 4.13.3–4.13.4 <<https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>>.
- 44 See, eg, Ben P White, Lindy Willmott and Eliana Close, ‘Futile, Non-Beneficial, Potentially Inappropriate or “Disputed” Treatment’ in Nathan Emmerich et al (eds), *Contemporary European Perspectives on the Ethics of End of Life Care* (Springer, 2020) 181.
- 45 The concept is usually used to indicate treatment beyond that which is strictly incapable of having an effect, for example, treatment that has a very low chance of conferring a benefit (quantitative futility) or treatment that fails to result in an adequate quality of life (qualitative futility). See, eg, Paul R Helft, Mark Siegler and John Lantos, ‘The Rise and Fall of the Futility Movement’ (2000) 343(4) *New England Journal of Medicine* 293; Dominic JC Wilkinson and Julian Savulescu, ‘Knowing When to Stop: Futility in the ICU’ (2011) 24(2) *Current Opinion in Anaesthesiology* 160; Ben White et al, ‘Withholding and Withdrawing Potentially Life-Sustaining Treatment: Who Should Decide?’ in Ian Freckelton and Kerry Petersen (eds), *Tensions and Traumas in Health Law* (Federation Press, 2017) 454, 458–62.
- 46 Close et al, ‘Doctors’ Perceptions’ (n 32); David Orentlicher, *Matters of Life and Death: Making Moral Theory Work in Medical Ethics and the Law* (Princeton University Press, 2001) ch 10; James L Bernat, ‘Medical Futility: Definition, Determination and Disputes in Critical Care’ (2005) 2(2) *Neurocritical Care* 198, 202.
- 47 See, eg, Close et al, ‘Doctors’ Perceptions’ (n 32); Hope Sprigings and Crisp (n 32); Wilkinson and Savulescu (n 45); Michael A Rubin and Robert D Truog, ‘What to Do When There Aren’t Enough Beds in the PICU’ (2017) 19(2) *AMA Journal of Ethics* 157, 159–162.
- 48 See, eg, Hope, Sprigings and Crisp (n 32); Wilkinson and Savulescu (n 45); Rubin and Truog (n 47), 158–160.

rationing by stealth.⁴⁹ Spector-Bagdady et al note that a challenge for doctors making end-of-life decisions in the COVID-19 pandemic is determining ‘which interventions should not be offered to a patient with COVID-19 because he or she does not fundamentally stand to benefit, and which might be beneficial but nevertheless withheld due to resource constraints’.⁵⁰

B The Importance of ICU Support for Some Patients with COVID-19

In addition to challenges for end-of-life decision-making generally, there are factors unique to the COVID-19 pandemic that compound existing complexities. If a person has deteriorated and needs intubation to breathe,⁵¹ the decision must be made urgently, and when a ventilator is withdrawn from a person who is ventilator-dependent, typically they will die very quickly.⁵² Therefore, some of the challenges associated with decision-making for COVID-19 patients include the speed at which life-saving decisions must be made, difficulty in predicting disease trajectory, risks of viral transmission to health-care workers when intubating a patient, and complications caused by a patient’s co-infections and comorbidities.⁵³

From a system perspective, a central focus of pandemic planning is quickly scaling healthcare capacity to adjust to surges in demand. In the ICU, accommodating a surge requires increasing bed and ventilator capacity through a variety of activities including postponing elective surgeries that would require

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- 49 Rubin and Truog (n 47) 161; Close et al, ‘Doctors’ Perceptions’ (n 32); Orentlicher (n 46); Bernat (n 46) 201–202. An empirical study by Hurst et al (n 34) found that doctors are more likely to ration at the bedside when there is a small expected benefit, a low chance of success, poor quality of life, and when the patient is over 85. Such factors could also drive a recommendation that treatment is ‘futile’ or ‘not clinically indicated’. See also Jeffrey P Burns and Robert D Truog, ‘Futility: A Concept in Evolution’ (2007) 132(6) *CHEST* 1987, in which the authors note ‘[f]ailure to distinguish between the rationale behind the concepts of futility and rationing has been an important source of confusion in the literature for the past 20 years’: at 1990.
- 50 Kayte Spector-Bagdady et al, ‘Flattening the Rationing Curve: The Need for Explicit Guidelines for Implicit Rationing during the COVID-19 Pandemic’ (2020) 20(7) *American Journal of Bioethics* 77, 78.
- 51 While the majority of COVID-19 patients recover after experiencing mild to moderate symptoms, a minority of patients will develop serious pneumonia complications including acute respiratory distress syndrome (‘ARDS’), necessitating ICU admission and ventilation. A study of the largest case series from China observed that approximately 81% of COVID-19 infections are mild and do not require hospitalisation, 14% require hospital care, and 5% require admission to intensive care: Zunyou Wu and Jennifer M McGoogan, ‘Characteristics of and Important Lessons from the Coronavirus Disease 2019 (COVID-19) Outbreak in China’ (2020) 323(13) *Journal of the American Medical Association* 1239. See also Peter G Gibson, Ling Qin and Ser Hon Pua, ‘COVID-19 Acute Respiratory Distress Syndrome (ARDS): Clinical Features and Differences from Typical Pre-COVID-19 ARDS’ (2020) 213(2) *Medical Journal of Australia* 54. Estimates from Italy suggest approximately 10 to 25% of hospitalised COVID-19 patients will require intubation and ventilation: Italian Society of Anesthesia, Analgesia, Resuscitation and Intensive Care, *Clinical Ethics Recommendations for the Allocation of Intensive Care Treatments, In Exceptional, Resource-Limited Circumstances* (16 March 2020), cited in Robert D Truog, Christine Mitchell and George Q Daley, ‘The Toughest Triage: Allocating Ventilators in a Pandemic’ (2020) 382(21) *New England Journal of Medicine* 1973.
- 52 Truog, Mitchell and Daley (n 51).
- 53 Phua et al (n 12). See also Alberto Zangrillo et al, ‘Fast Reshaping of Intensive Care Unit Facilities in a Large Metropolitan Hospital in Milan, Italy: Facing the COVID-19 Pandemic Emergency’ (2020) 22(2) *Critical Care and Resuscitation* 91.

postoperative ICU support, opening additional beds in existing ICUs, and using available beds in private or children's hospitals.⁵⁴ Likewise, ICUs must also plan to staff these additional beds with highly-skilled health care workers who are able to provide critical care.⁵⁵ Another mechanism for COVID-related surges is '[f]acilitating end of life discussions and decisions in those appropriate ICU patients assessed as not reaching a meaningful recovery'.⁵⁶ This highlights tensions between rationing treatment and the concept of 'futility' discussed in the preceding section, as doctors and patients (or their substitute decision makers) may disagree about what constitutes a 'meaningful recovery'. Finally, a further challenge is ensuring sufficient and equitable access to palliative care for those who are denied life-sustaining treatment.⁵⁷

C Australian COVID-19 Triage Policies

In Australia, COVID-19 triage policies, guidelines and frameworks have been issued by state governments,⁵⁸ hospitals,⁵⁹ professional organisations,⁶⁰ clinicians and academic scholars.⁶¹ The Australian Commonwealth Government has announced no concrete plans for a national policy, but has indicated as part of its emergency response plan for COVID-19 that '[t]he Australian Government and state and territory governments will work together to develop new models of care to manage patients and agree on novel coronavirus triage criteria (if required)'.⁶²

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- 54 See, eg, Ministry of Health (NSW), Agency for Clinical Innovation, 'NSW Adult Intensive Care Services Pandemic Response Planning' (ACI 0442, September 2020) 4 <<https://www.health.nsw.gov.au/Infectious/covid-19/communities-of-practice/documents/covid-19-adult-intensive-care-pandemic-response-planning.pdf>> ('NSW Pandemic Response Plan'); Australia and New Zealand Intensive Care Society, 'COVID-19 Guiding Principles' (n 14). There is potential in Australia to triple intensive care bed capacity, although there is a shortfall of invasive ventilators and appropriate clinical staff: Edward Litton et al, 'Surge Capacity of Australian Intensive Care Units in Case of Increase in Demand Caused by COVID-19 in Australia' (2020) 212(10) *Medical Journal of Australia* 463.
- 55 Ministry of Health (NSW), NSW Pandemic Response Plan (n 54) 5.
- 56 Ibid 4.
- 57 Amit Arya et al, 'Pandemic Palliative Care: Beyond Ventilators and Saving Lives' (2020) 192(15) *Canadian Medical Association Journal* E400.
- 58 See, eg, Department of Health (Qld), 'Queensland Ethical Framework to Guide Clinical Decision-Making in the COVID-19 Pandemic' (20 April 2020) <<https://community.amaq.com.au/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=77ad2a98-5496-4af4-9700-47609b40ab3a&forceDialog=0>> ('Queensland COVID-19 Guidelines'); NSW Pandemic Response Plan (n 54); Department of Health (WA), 'Framework to Guide Decision-Making on the Appropriateness of Intensive Care Management during the COVID-19 Pandemic' (21 December 2020) <<https://ww2.health.wa.gov.au/-/media/Corp/Documents/Health-for/Infectious-disease/COVID19/COVID19-Framework-to-guide-intensive-care-management-during-the-pandemic.pdf>> ('WA COVID-19 Guidelines').
- 59 See, eg, Erwin Loh and Daniel Fleming, 'COVID-19: Ethical Principles for Resource Allocation', *InSight+* (online, 20 July 2020) <<https://insightplus.mja.com.au/2020/28/covid-19-ethical-principles-for-resource-allocation/>>; Lisa Mitchell, Emma Tumilty and Giuliana Fuscaldo, 'In Victoria, Whether You Get an ICU Bed Could Depend on the Hospital', *The Conversation* (online, 19 August 2020) <<https://theconversation.com/in-victoria-whether-you-get-an-icu-bed-could-depend-on-the-hospital-144209>>.
- 60 See, eg, Australia and New Zealand Intensive Care Society, 'COVID-19 Guiding Principles' (n 14).
- 61 Dawson et al (n 14); Jansen et al (n 14). See also Angus Dawson, 'Building an Ethics Framework for COVID-19 Resource Allocation: The How and the Why' (2020) 17(4) *Journal of Bioethical Inquiry* 757.
- 62 Department of Health (Cth) (n 10) 16.

The focus on a state-based response is unsurprising, given that the constitutional responsibility for health and hospital services exists at the state level, and operational and ICU triage decisions occur within hospitals.⁶³ The Australian Government has not yet issued national triage guidance, presumably because Australian ICUs have not been overwhelmed.⁶⁴

Although a comprehensive analysis of Australian COVID-19 triage policies is beyond the scope of this article, a few observations about the Australian triage policy environment will inform the legal analysis in Part V. First, policy is a critically important tool in COVID-19 triage as it can provide doctors with specific guidance about how to allocate resources. In general, policy operates as a regulatory mechanism with both legal and ethical weight. It can provide additional duties beyond the bare minimum standard of reasonable practice (given that policy and guidelines are often the ‘gold standard’)⁶⁵ and may be relevant to, though not necessarily determinative of, the standard of care in negligence claims.⁶⁶ Therefore, scrutiny of the content of triage policies is essential, including guidance about who gets priority, and whether this meets legal standards or unfairly discriminates against certain populations. Additionally, the *failure* to engage in pandemic preparedness and issue policy is a broader issue, which could also have legal ramifications.⁶⁷

The second key point about these policies is that there is significant variability in how triage has been approached between and within Australian states and territories.⁶⁸ Some states have no mention of a COVID-19 triage policy on their

63 There are some mechanisms the Commonwealth Government could use to promote national triage policy, should it wish to do so, although it appears unlikely to take this route. For example, the Commonwealth Government could use its corporations power to mandate any hospitals that are incorporated to have a triage policy in place: *Australian Constitution* s 51(xx). With agreement between the Commonwealth and states, there could also be a reference of powers under section 51(xxxvii) of the Constitution or a cooperative scheme.

64 Indeed, the Department of Health (Cth), ‘Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements’ (Plan, 8 May 2018) <<https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-nat-CD-plan.htm>> (which supports the Australian Health Sector Emergency Response Plan for Novel Coronavirus) indicates allocation of available resources is the responsibility of states and territories: at 8.

65 See, eg, Emily Jackson, ‘The Relationship between Medical Law and Good Medical Ethics’ (2015) 41(1) *Journal of Medical Ethics* 95.

66 *Queensland v Masson* (2020) 94 ALJR 785 (*‘Masson’*). See also Eliana Close et al, ‘Transparent Triage Policies during the COVID-19 Pandemic: A Critical Part of Medico-Legal Risk Management for Clinicians’ (forthcoming, copy on file with the author) (*‘Transparent Triage Policies’*).

67 See, eg, James G Hodge and Erin Fuse Brown, ‘Assessing Liability for Health Care Entities That Insufficiently Prepare for Catastrophic Emergencies’ (2011) 306(3) *Journal of the American Medical Association* 308.

68 The lack of state government action was criticised at the start of the pandemic. For example, threatened resignations from members of the NSW Ministry of Health’s Ethics and Advisory Panel (HEAP) due to the NSW Government’s delay in issuing appropriate triage policies: Dylan Welch, ‘Critical Decisions About Who Will Live or Die During the Coronavirus Peak May Be Left to Frontline Doctors’, *ABC News* (online, 6 April 2020) <<https://www.abc.net.au/news/2020-04-06/nsw-health-not-drawing-up-life-or-death-guidelines-for-doctors/12123406>>.

websites.⁶⁹ In contrast, the New South Wales Ministry of Health has a pandemic planning framework on its website, which refers to a COVID-19 triage protocol to be activated if resources are overwhelmed ('NSW COVID-19 Guidelines').⁷⁰ However, the framework does not provide a link to this document and it does not appear to be publicly available elsewhere. The Western Australian and Queensland Health Departments both issued ethical guidelines for COVID-19 ICU decision-making, but at some point in mid-2020 the Queensland document was removed from its website.⁷¹ Additionally, existing policies appear to vary in their content and scope. For example, during the spike in COVID-19 cases in Victoria in August 2020 bioethicists observed worrying variation in the content of different hospitals' policies.⁷² Overall, while transparent state-wide government policies are important, there appears to be a general lack of policies at this level in Australia, and those that do exist are not available for public scrutiny. Not having this state-wide policy is problematic because it can result in a 'postcode lottery', where individuals could receive vastly different treatment depending on the hospital they attend and who treats them.⁷³

The third point to note is that resource allocation policies have varying degrees of guidance and legitimacy. There is a distinction between broad ethical guidelines

69 As of 27 November 2020, we could not locate a triage policy on the Health Department websites from the ACT, South Australia, the Northern Territory or Victoria. See Close et al, 'Transparent Triage Policies' (n 66).

70 The Ministry of Health (NSW), NSW Pandemic Response Plan (n 54) indicates: 'A NSW guideline for pandemic resource-based decision-making for ICU triage has been designed to ensure that NSW ICU services and LHDs are supported to provide consistent care in a way that suits current epidemiological and clinical conditions. This guideline has been developed by intensive care clinical experts and ethicists in consultation with NSW COVID-19 Critical Intelligence Unit (CIU) and the NSW Health Ethics Advisory Panel (HEAP). It includes establishment of triage governance committees (TGC) and appointment of triage officers (TO), activation of pandemic resource-based decision-making and use of allocation frameworks and tools': at 5. The document then references: Ministry of Health (NSW), 'NSW Health COVID-19 Intensive Care Guidance Drawn from Principles in the NSW Health Influenza Pandemic Plan (PD2016_016)' ('NSW COVID-19 Guidelines'). Unlike other the references in the NSW Pandemic Response Plan, no hyperlink is provided to the NSW COVID-19 Guidelines and they do not appear to be publicly available elsewhere. The original pandemic guidelines upon which the NSW COVID-19 Guidelines appear to be based are available online, however: NSW Health Influenza Pandemic Plan (Policy Directive No 2016_016, 27 May 2016) <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_016.pdf>.

71 Department of Health (WA), WA COVID-19 Guidelines (n 58). The Queensland Department of Health ('Queensland Health') issued its guidance on 20 April 2020, but as of 26 August 2020 the document no longer appears on the Queensland Health website: Queensland COVID-19 Guidelines (n 58); Department of Health (Qld), *Resources and Information for Clinicians* (Web Page, 26 August 2020) <<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/novel-coronavirus-qld-clinicians/resources-for-clinicians>>. Queensland's Chief Health Officer, Dr Jeanette Young, indicated she preferred to avoid the need for rationing and the document was made private because she 'did not ever want to get into the ethics of who we would deny care to': Lydia Lynch, 'Secret Plan Outlined Which Patients Would Miss Out if Hospitals Were Overrun', *Brisbane Times* (online, 18 March 2021) <<https://www.brisbanetimes.com.au/politics/queensland/secret-plan-outlined-which-patients-would-miss-out-if-hospitals-were-overrun-20210317-p57bn3.html>>.

72 Mitchell, Tumilty and Fuscaldo (n 59).

73 Liddell et al (n 19); Dominic JC Wilkinson and Robert D Truog, 'The Luck of the Draw: Physician-Related Variability in End-Of-Life Decision-Making in Intensive Care' (2013) 39(6) *Intensive Care Medicine* 1128, 1128.

(for example, those authored by professional organisations such as the Australia and New Zealand Intensive Care Society)⁷⁴ and specific operational *triage* protocols that provide concrete guidance about which patients to prioritise and what occupancy thresholds trigger rationing.⁷⁵ The latter may be issued at the level of the institution, however, for reasons stated above a state-wide policy is desirable.

The final point is that public consultation is important in determining the content of resource-allocation policies,⁷⁶ but the extent and nature of consultation underpinning existing documents in Australia appears to vary.⁷⁷

IV CLINICAL SCENARIO

The analysis of legal challenges to ICU triage decisions in Part V is based on a clinical scenario that many ethical guidelines have considered: an ICU is overwhelmed and the number of patients who need ventilatory support exceeds a hospital's capacity.

As end-of-life decision-making is multi-variate and complex, the legal position for any individual case will be fact-specific. Nevertheless, Part V uses the scenario below to set out some broad parameters of the law. Additionally, although the patient in the scenario has COVID-19, the reasoning would also apply if the individual had a different potentially life-threatening illness that required ICU support.

A Scenario: Denial of ICU Admission Due to Extreme Bed Shortage

Philip is a 67-year-old man with a recent diagnosis of early-stage Parkinson's disease, a progressive neurological disease. His Parkinson's symptoms are well-controlled with medication and he is functionally well, with little to no impact on his day-to-day life other than some fatigue, stiffness, and occasional tremor when the most recent dose of medication wears off. Philip contracts COVID-19 in the

74 Australia and New Zealand Intensive Care Society, 'COVID-19 Guiding Principles' (n 14).

75 A distinguishing characteristic of triage is that a doctor (or committee) known as a 'triage officer' uses an algorithm or established system to determine a level of treatment and priority for each individual patient: Iserson and Moskop (n 11) 276. Moskop and Iserson note that triage systems 'rely, implicitly or explicitly, on a several different health care values' including 'the values of human life, the efficient use of resources and fairness': John C Moskop and Kenneth V Iserson, 'Triage in Medicine, Part II: Underlying Values and Principles' (2007) 49(3) *Annals of Emergency Medicine* 282, 282. See also Close et al, 'Transparent Triage Policies' (n 66).

76 See, eg, Donna Levin et al, 'Altered Standards of Care During an Influenza Pandemic: Identifying Ethical, Legal, and Practical Principles to Guide Decision-Making' (2009) 3(2) *Disaster Medicine and Public Health Preparedness* S132.

77 Development of the Queensland Health ethical framework included consultation with clinicians, consumers, academics and ethicists: Department of Health, 'Queensland COVID-19 Guidelines' (n 58) 1–2, 14. The Ministry of Health (NSW), 'NSW COVID-19 Guidelines' (n 70) were developed by clinicians and ethicists in consultation with the NSW Health Ethics Advisory Panel, but do not appear to have involved public consultation: Ministry of Health (NSW), 'NSW Pandemic Response Plan' (n 54). It is unclear whether development of the Department of Health (WA), 'WA COVID-19 Guidelines' (n 58) involved consultation.

community and is managing his symptoms at home for a few days when he experiences worsening fever and respiratory distress. His wife brings him to the emergency department of the nearest tertiary hospital, where he is admitted. However, due to a significant increase in COVID-19 cases, the ICU is full and numerous critically ill patients require admission. The intensivist in charge of ICU admissions indicates that, normally, Philip's worsening breathlessness would benefit from ICU admission, so that he could be put on a ventilator if he deteriorates. However, the intensivist indicates that due to Philip's neurologic condition, he is deprioritised for admission to the ICU based on the application of the hospital's triage policy.⁷⁸ Philip's condition is worsening and if he does not access a ventilator soon, he is at risk of death.

V POTENTIAL LEGAL CHALLENGES TO PANDEMIC TRIAGE DECISIONS IN AUSTRALIA

The scenario above raises a variety of potential legal issues, many of which have not been tested in court in response to a pandemic. This part of the article aims to set out the broad parameters of the legal challenges that could arise in response to the scenario, looking at first principles and existing case law on disputes about life-sustaining treatment.

The sections that follow consider the following sources of possible legal redress: negligence; criminal law; administrative law; human rights law; the *parens patriae* (patients' best interests) jurisdiction; and guardianship legislation. The article does not seek to provide an exhaustive account of every possible source of legal liability but evaluates these particular challenges as the most common or likely to arise in disputes about life-sustaining treatment. For each legal challenge, the article evaluates the Part IV clinical scenario, to test the boundaries of Australian legal liability for decisions made during the COVID-19 pandemic when the ICU is overwhelmed. Since every case is fact specific, and the pandemic factual situation is untested by the courts, it is not possible to go into detail on every element of every legal challenge. However, by providing broad contours of the law, the analysis will demonstrate that rationing is generally within the remit of individual institutions and clinicians, and the law largely fails to provide appropriate protections to ensure transparent and accountable rationing decisions. In other words, the law is unlikely to provide an effective platform for legal challenges of these kinds of decisions. Nevertheless, there is scope for legal scrutiny of policies and decision-making processes.

78 The authors acknowledge that clinical decision-making is complex, and the scenario described represents a simplified factual situation intended to illustrate some of the legal complexities that may arise. As discussed in Part III(C), triage protocols can be detailed and vary in their content and criteria. Some indicate when the ICU is overwhelmed, triage decisions should be made by a committee to avoid pressure on a single doctor and to insulate the decision against inappropriate considerations: see, eg, Truog, Mitchell and Daley (n 51). However, this approach is not universal.

A Negligence

1 Negligence: General Principles

The primary legal claim where monetary compensation is sought from the hospital and/or doctor for harm suffered is a civil action alleging negligence.⁷⁹ Doctors owe their patients a duty of care to exercise reasonable care and skill in the provision of professional advice and treatment, which extends to ‘examination, diagnosis and treatment’ and the provision of advice.⁸⁰

In the United States, laws have been enacted in many States which provide healthcare professionals and hospitals with immunity from civil liability for any injury or death sustained because of any acts or omissions undertaken in good faith during the COVID-19 pandemic.⁸¹ The United Kingdom has taken a different approach and enacted legislation to provide indemnity for clinical negligence of health professionals and others engaged in National Health Service activities connected to care, treatment or diagnostic services responding to the COVID-19 outbreak.⁸² At the time of writing no such laws have been enacted in Australia.

79 Note that doctors may also owe concurrent duties of care in tort and contract, and claims may arise under consumer protection legislation: see Tina Cockburn and Des Butler, ‘Medical Negligence’ in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 3rd ed, 2018) 271, 274–5, 379–86; Bill Madden, Janine McIlwraith and Benjamin Madden, *Australian Medical Liability* (Lexis Nexis Butterworths, 3rd ed, 2017) [4.2]–[4.8], [4.16]. We limit our discussion to the tort of negligence, since in practice most claims seeking compensation are brought this way: see *Rosenberg v Percival* (2001) 205 CLR 434, 450 [49] (Gummow J) (*‘Rosenberg’*).

80 *Rogers v Whitaker* (1992) 175 CLR 479, 483 [5] (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ) (*‘Rogers’*). Following a review of the law of negligence in Australia, non-uniform civil liability legislation has been enacted to varying extents across Australian jurisdictions: David Andrew Ipp et al, *Review of the Law of Negligence* (Final Report, September 2002) <https://treasury.gov.au/sites/default/files/2019-03/R2002-001_Law_Neg_Final.pdf>. The law of medical negligence is therefore no longer solely common law based and is not uniform across Australia: Barbara McDonald, ‘Legislative Intervention in the Law of Negligence: The Common Law, Statutory Interpretation and Tort Reform in Australia’ (2005) 27(3) *Sydney Law Review* 443; Barbara McDonald, ‘The Impact of the Civil Liability Legislation on Fundamental Policies and Principles of the Common Law of Negligence’ (2006) 14(3) *Torts Law Journal* 268. Careful consideration of the relevant legislation in the specific jurisdiction is necessary to determine the extent to which particular provisions apply. Detailed consideration of the civil liability legislation in each state and territory is beyond the scope of this paper, although relevant comparative provisions have been included in the references.

81 Discussion of these laws is beyond the scope of this article. See, eg, ‘State Covid-19 Health Care Immunity Laws’, *Center for Justice and Democracy* (Fact Sheet, 25 June 2020) <<https://centerjd.org/content/fact-sheet-state-covid-19-health-care-immunity-laws>>; Anjelica Cappellino, ‘Hospitals are Virtually Untouchable in Light of COVID-19 Immunity Bills, but Some Cases May Stand’, *Expert Institute* (Blog Post, 31 August 2020) <<https://www.expertinstitute.com/resources/insights/hospitals-are-virtually-untouchable-in-light-of-covid-19-immunity-bills-but-some-cases-may-stand/>>. Such ‘altered standards of care’, which involve both immunity laws and resource allocation guidelines to guide decision-making, have been debated and discussed in previous pandemics and disasters: Rebecca Mansbach, ‘Altered Standards of Care: Needed Reform for When the Next Disaster Strikes’ (2011) 14(1) *Journal of Health Care Law and Policy* 209.

82 *Coronavirus Act 2020* (UK) ss 11–13. See Turnock et al, ‘Rapid Development of a Clinical Decision-Making Committee in a UK Paediatric Hospital during the COVID-19 Pandemic’ (2020) 20(2) *Medical Law International* 167.

To succeed in an action for negligence, the plaintiff must prove on the balance of probabilities that there was a breach of a relevant duty⁸³ and that the patient suffered damage (harm)⁸⁴ recognised as compensable by law,⁸⁵ which was caused by the breach.⁸⁶ If the elements of a negligence claim are established and no defences are made out, the defendant may be liable to pay damages.

Two defences are potentially relevant. First, given that this scenario is likely to arise in a public hospital context, in some jurisdictions the hospital defendant (as a public authority) may avail itself of a statutory resource allocation ‘defence’ in response to a claim alleging negligence in establishing a triage policy.⁸⁷ This

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- 83 *Roads and Traffic Authority of New South Wales v Dederer* (2007) 234 CLR 330, 337–8 [18] (Gummow J). The standard of care is assessed by reference to medical knowledge at the time of the alleged breach: see, eg, *Roe v Ministry of Health* [1954] 2 QB 66 (‘Roe’); *Civil Law (Wrongs) Act 2002* (ACT) s 42; *Civil Liability Act 2002* (NSW) s 50(1); *Personal Injuries (Liabilities and Damages) Act 2003* (NT) (no equivalent provision); *Civil Liability Act 2003* (Qld) s 22(1); *Civil Liability Act 1936* (SA) s 41(1); *Civil Liability Act 2002* (Tas) s 22(1); *Wrongs Act 1958* (Vic) s 59(1); *Civil Liability Act 2002* (WA) s 5PB(1). At common law, the determination as to whether a person is in breach of their duty of care involves two key considerations, namely: whether a reasonable person would have foreseen the risk of injury; and an assessment as to whether he or she has reasonably responded to this risk, taking into account matters such as the magnitude of the risk, the degree of probability of the risk occurring, the expense, difficulty and inconvenience of taking alleviating action and any conflicting responsibilities that the defendant may have (the negligence calculus). See, eg, *Wyong Shire Council v Shirt* (1980) 146 CLR 40 (‘Shirt’); *New South Wales v Fahy* (2007) 232 CLR 486, 511 [79] (Gummow and Hayne JJ) (‘Fahy’); *Adeels Palace Pty Ltd v Moubarak* (2009) 239 CLR 420, 432–3 [12]–[13], 439 [39] (French CJ, Gummow, Hayne, Heydon and Crennan JJ) (‘Moubarak’); *Waverley Council v Ferreira* [2005] Aust Torts Reports 81, [45] (Ipp JA, Spigelman CJ agreeing at [1], Tobias JA agreeing at [108]) (‘Ferreira’); *Rosenberg* (2001) 205 CLR 434. This position has been confirmed by civil liability legislation: *Civil Law (Wrongs) Act 2002* (ACT) s 43; *Civil Liability Act 2002* (NSW) s 5B; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) (no equivalent provision); *Civil Liability Act 2002* (Qld) s 9; *Civil Liability Act 1936* (SA) s 32; *Civil Liability Act 2002* (Tas) s 11; *Wrongs Act 1958* (Vic) s 48; *Civil Liability Act 2002* (WA) s 5B.
- 84 Various terms have been employed to describe this essential component of the negligence action, including ‘damage’, ‘loss’, ‘injury’, and ‘harm’: *Harriton v Stephens* (2004) 59 NSWLR 694, 703 [41]–[42] (Spigelman CJ).
- 85 For a discussion of this aspect, see Amanda Stickley, *Australian Torts Law* (LexisNexis Butterworths, 3rd ed, 2013) [12.4]–[12.20].
- 86 *Tabet v Gett* (2010) 240 CLR 537, 577 [109]–[110] (Kiefel J). Causation is a question of fact, which the plaintiff bears the burden of proving, on the balance of probabilities. This requires the plaintiff to establish: (a) that the defendant’s negligence was a necessary condition in the occurrence of the plaintiff’s harm (factual causation); and (b) that it is appropriate for the scope of the negligent person’s liability to extend to the harm so caused (scope of liability).
- 87 *Tzaidas v Child* (2004) 61 NSWLR 18. A resource allocation defence may be available for the benefit of public authorities, which may include public hospitals, as defined by: *Civil Law (Wrongs) Act 2002* (ACT) s 109; *Civil Liability Act 2002* (NSW) s 41; *Civil Liability Act 2003* (Qld) s 34; *Civil Liability Act 2002* (Tas) s 37; *Wrongs Act 1958* (Vic) s 79; *Civil Liability Act 2002* (WA) s 5U. (There are no equivalent provisions in the Northern Territory or South Australia: *Personal Injuries (Liabilities and Damages) Act 2003* (NT); *Civil Liability Act 1936* (SA)). The resource allocation ‘defence’ sets out the principles which are applied in the determination as to whether a public authority has breached a duty of care, and the provisions are not uniform across Australian jurisdictions: *Civil Law (Wrongs) Act 2002* (ACT) s 110; *Civil Liability Act 2002* (NSW) s 42; *Civil Liability Act 2003* (Qld) s 35; *Civil Liability Act 2002* (Tas) s 38; *Wrongs Act 1958* (Vic) s 83; *Civil Liability Act 2002* (WA) s 5W. There are no equivalent provisions in the Northern Territory or South Australia: *Personal Injuries (Liabilities and Damages) Act 2003* (NT); *Civil Liability Act 1936* (SA). Careful consideration is therefore required of the comparative legislation in the relevant jurisdiction to determine the extent to which the public authority

‘defence’ provides that resource allocation decisions by public authorities are generally not open to challenge.⁸⁸ In addition, issues relating to the application of the *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* (‘*Wednesbury*’) unreasonableness test may arise.⁸⁹ For example, in Queensland, where negligence is alleged against a public authority based on an alleged wrongful exercise of or failure to exercise a public function (here a decision relating to the allocation of resources, including, for example, not allocating enough ICU beds or not purchasing enough ventilators), such act or omission does not constitute a wrongful exercise or failure unless the decision was so unreasonable that no reasonable public authority in the defendant’s position could have made it.⁹⁰ Case law predating the civil liability legislation confirms that there are limits to the application of the resource allocation defence and that public authorities must meet certain minimum standards of care.⁹¹ However, these defences have not yet been tested during a pandemic in Australia.

Second, a doctor could aim to establish they acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.⁹² If this statutory ‘professional

defence may apply. For example, as set out above, in Queensland ‘public authority’ is defined by *Civil Liability Act 2003* (Qld) s 34. As hospitals in Queensland are constituted as hospital and health services (‘HHS’) under the *Hospital and Health Boards Act 2011* (Qld) (‘*HHBA*’), it is also necessary to consider *HHBA Act 2011* (Qld) s 18 to determine whether an HHS is a ‘public authority’.

- 88 For example, section 42 of the *Civil Liability Act 2002* (NSW) provides that the following principles apply in deciding whether a public authority has a duty or has breached a duty: ‘(a) the functions required to be exercised by the authority are limited by the financial and other resources that are reasonably available to the authority for the purpose of exercising those functions; (b) the general allocation of those resources by the authority is not open to challenge; (c) the functions required to be exercised by the authority are to be determined by reference to the broad range of its activities (and not merely by reference to the matter to which the proceedings relate); (d) the authority may rely on evidence of its compliance with the general procedures and any applicable standards for the exercise of its functions as evidence of the proper exercise of its functions in the matter to which the proceedings relate.’ In *State of New South Wales v Ball* (2007) 69 NSWLR 463, part of the statement of claim was struck out which included particulars of negligence in relation to the allocation of resources by the Child Protection Enforcement Agency, a public authority.
- 89 [1948] 1 KB 223. The *Wednesbury* test was applied in *Stovin v Norfolk County Council* [1996] AC 923 (‘*Stovin v Wise*’), and in a medical negligence case which considered resource allocation, *R v Central Birmingham Health Authority Ex parte Collier* (England and Wales Court of Appeal – Civil Division, Brown, Neil and Gibson LJ, 6 January 1988). The relevant provisions in the civil liability legislation are not uniform across the various Australian jurisdictions: *Civil Law (Wrongs) Act 2002* (ACT) s 111; *Civil Liability Act 2002* (NSW) s 43, 43A; *Civil Liability Act 2003* (Qld) s 36; *Civil Liability Act 2002* (Tas) s 40; *Wrongs Act 1958* (Vic) s 84; *Civil Liability Act 2002* (WA) s 5X. (There are no equivalent provisions in the Northern Territory or South Australia: *Personal Injuries (Liabilities and Damages) Act 2003* (NT); *Civil Liability Act 1936* (SA)). For discussion see Madden, McIlwraith and Madden (n 79) ch 11.
- 90 *Civil Liability Act 2003* (Qld) s 36. Note that the legislative provisions are not uniform, and in other jurisdictions *Wednesbury* unreasonableness only arises if the action against the public authority is based on a breach of a statutory duty.
- 91 *Brotherston v Royal Perth Hospital* (1995) 15 SR (WA) 42a; *Bull v Devon Health Authority* (1989) 22 BMLR 79. For a discussion, see Madden, McIlwraith and Madden (n 79) ch 11.
- 92 *Civil Liability Act 2002* (NSW), s 50(1). Note that the legislative provisions are not uniform across Australia: *Civil Liability Act 2002* (NSW), s 50; *Civil Liability Act 2003* (Qld), s 22(1); *Civil Liability Act 1936* (SA), s 41(1); *Civil Liability Act 2002* (Tas), s 22(1); *Wrongs Act 1958* (Vic), s 59(1); *Civil*

practice' defence is established, a judicial determination follows as to whether the defence should be refused by reason of the irrationality exception.⁹³

2 Application to the Scenario

(a) Duty of Care

Philip may seek compensation for personal injuries sustained by commencing an action in negligence against the individual intensivist and the hospital (on the basis of vicarious liability⁹⁴ or breach of the hospital's own non-delegable duty of care).⁹⁵ As Philip was admitted to the hospital's emergency department,⁹⁶ the hospital (and the treating doctor) owes him a duty of care to exercise reasonable

Liability Act 2002 (WA), s 5PB(1). There are no corresponding provisions in the ACT or NT: *Civil Law (Wrongs) Act 2002* (ACT); *Personal Injuries (Liabilities and Damages) Act 2003* (NT). See generally Madden, McIlwraith and Madden (n 79) ch 9; Cockburn and Butler (n 79) [8.230]–[8.240]. In *Sparks v Hobson* (2018) 361 ALR 115 ('Sparks'), at [210]–[220], a majority of the NSWCA (Macfarlan and Simpson JJA) applied *McKenna v Hunter & New England Local Health District* (2013) Aust Torts Reports 82 at [160], [165] and held there must be an established 'practice' for the defence to be made out. This limits the scope of the defence as it 'necessarily excludes unusual factual circumstances': at [333] (Simpson JA). By contrast, Basten JA rejected the suggestion that the defence only applies where the defendant can identify 'a regular course of conduct adopted in particular circumstances': at [31]. In a novel case, Basten JA considered that the defence may be invoked by a defendant 'by reference to how an assessment of the circumstances (which may be unique) would be undertaken by a knowledgeable and experienced practitioner': at [31]. See Roger Magnussen 'Sparks v Hobson Must Go to the High Court: Here's Why', *Sydney Health Law* (Blog Post, 9 May 2018) <<https://sydneyhealthlaw.com/2018/05/09/sparks-v-hobson-must-go-to-the-high-court-heres-why/>>. The High Court refused special leave to appeal: Transcript of Proceedings, *Sparks v Hobson* [2018] HCATrans 191.

- 93 This approach was affirmed in *Dobler v Kenneth Halverson* (2007) 70 NSWLR 151 (Giles JA, Ipp JA agreeing at [138] and Basten JA agreeing at [139]). The appeal was from the NSW Supreme Court in *Halverson v Dobler* [2006] NSWSC 1307 (McClellan CJ). See generally Bill Madden and Tina Cockburn, 'Determining the Standard of Care in Professional Negligence Cases: *Dobler v Halverson*' [2008] (85) *Precedent* 54; Bill Madden and Tina Cockburn, 'Three Dimensions of the Standard of Care in Professional Negligence Cases' (2008) 4(8) *Australian Civil Liability* 95; Cockburn and Butler (n 79) 307–310; Madden, McIlwraith and Madden (n 79) ch 9. As to the 'irrationality exception', note that the legislative provisions are not uniform across Australia: *Civil Liability Act 2002* (NSW), s 5O(2); *Civil Liability Act 2003* (Qld), s 22(2); *Civil Liability Act 1936* (SA), s 41(2); *Civil Liability Act 2002* (Tas), s 22(2); *Wrongs Act 1958* (Vic), s 59(2); *Civil Liability Act 2002* (WA), s 5PB(4). There are no corresponding provisions in the ACT or NT: *Civil Law (Wrongs) Act 2002* (ACT); *Personal Injuries (Liabilities and Damages) Act 2003* (NT). For case law consideration, see: *Hope v Hunter and New England Area Health Service* (2009) 10 DCLR (NSW) 63; *South Western Sydney Local Health District v Gould* (2018) 97 NSWLR 513.
- 94 *Roe* [1954] 2 QB 66; *Samios v Repatriation Commission* [1960] WAR 219; *Cassidy v Ministry of Health* [1951] 2 KB 343; *Gold v Essex County Council* [1942] 2 KB 293.
- 95 *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553; *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542; *Sherry v Australasian Conference* [2006] NSWSC 75; *Roe* [1954] 2 QB 66.
- 96 Note that there is no general common law duty to come to the aid of a person in danger: *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 444 (Brennan J); *Jaensch v Coffey* (1984) 155 CLR 549, 578 (Deane J); *Broughton v Competitive Foods Australia Pty Ltd* (2005) Aust Torts Reports 81, [2] (Handley JA). Therefore, doctors do not generally owe duties to treat non-patients, even in an emergency: *Capital & Counties plc v Hampshire County Council* [1997] QB 1004. Nevertheless, such a duty has arisen in special circumstances: see, eg, *Lowns v Woods* (1996) Aust Torts Reports 81, 63, 155 (Kirby P); 63, 176 (Cole JA). The decision of the trial judge *Woods v Lowns* (1995) 36 NSWLR 344, 356 (Badgery-Parker J) was upheld.

care and skill in providing treatment.⁹⁷ If Philip dies, his wife (and potentially relatives/dependants) could bring an action in negligence for psychiatric injury (or nervous shock);⁹⁸ and/or for loss of support (compensation to relatives).⁹⁹

(b) *Breach of Duty*

The standard of care depends on the facts and circumstances of the particular case.¹⁰⁰ In *Mulholland v Medway NHS Foundation Trust*,¹⁰¹ a case involving the standard of care owed by a triage nurse in a busy accident and emergency department, Justice Green concluded that the standard was to be assessed by reference to the context and the necessity to ‘make a quick judgment call as to where next to send the patient’.¹⁰² Where the decision was made by an intensivist, the standard of care would be determined by reference to a professional peer.

As to breach, death is obviously a reasonably foreseeable consequence of withholding necessary ventilation. Secondly, the risk of injury or death would clearly not be insignificant in the sense that there was a ‘clear risk’¹⁰³ or

97 *Rogers* (1992) 175 CLR 479, 483 [5] (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

98 *Hunter Area Health Service v Marchlewski* (2000) 51 NSWLR 268; *Kemp v Lyell McEwin Health Service* (2006) 96 SASR 192; *Lane v Northern NSW Local Health District* [2013] NSWDC 12 (‘*Lane*’). See generally Cockburn and Butler (n 79) 284–92.

99 *Civil Law (Wrongs) Act 2002* (ACT) s 24; *Compensation to Relatives Act 1987* (NSW) s 3(1); *Compensation (Fatal Injuries) Act 1974* (NT) s 7; *Civil Proceedings Act 2011* (Qld) s 64; *Civil Liability Act 1936* (SA) s 23; *Fatal Accidents Act 1934* (Tas) s 4; *Wrongs Act 1958* (Vic) s 16; *Fatal Accidents Act 1959* (WA) s 4. See *Krishna v Loustos* [2000] NSWCA 272 (‘*Krishna*’) (defendant doctor found liable to plaintiff by reason of materially contributing to the death of her husband: damages recovered both for nervous shock and under the *Compensation to Relatives Act 1987* (NSW)). For a discussion, see Amanda Stickley, *Australian Torts Law* (LexisNexis Butterworths, 4th ed, 2016) ch 16.

100 In treatment cases, the starting point for the determination of the relevant standard of care is what could reasonably be expected of a person professing that skill and expertise, judged at the date of the alleged negligence: *Civil Law (Wrongs) Act 2002* (ACT) (no equivalent provision); *Civil Liability Act 2002* (NSW), s 50(1); *Personal Injuries (Liabilities and Damages) Act 2003* (NT) (no equivalent provision); *Civil Liability Act 2003* (Qld), s 22(1); *Civil Liability Act 1936* (SA), s 41(1); *Civil Liability Act 2002* (Tas), s 22(1); *Wrongs Act 1958* (Vic), s 59(1); *Civil Liability Act 2002* (WA) s 5PB(1). See also *Rogers* (1992) 175 CLR 479, 487. The standard of care is determined objectively. Even at common law, the majority of the High Court held in *Rogers* that ‘that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade’: at 487 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ) (citations omitted). See generally the civil liability legislation provisions, case law and secondary sources cited in footnote 93 above. In relation to Philip’s case, the relevant standard of care would be that of an intensivist and intensive care unit in a comparative tertiary metropolitan hospital in the midst of a pandemic: see, eg, *Knight v Home Office* [1990] 3 All ER 237.

101 [2015] EWHC 268 (QB).

102 *Ibid* [90] (Green J).

103 *Drinkwater v Horwath* [2006] NSWCA 222, [19] (Basten JA), [25] (Hodgson JA). At common law, the determination as to whether a person is in breach of their duty of care involves two key considerations, namely: whether a reasonable person would have foreseen the risk of injury; and an assessment as to whether he or she has reasonably responded to this risk, taking into account matters such as the magnitude of the risk, the degree of probability of the risk occurring, the expense, difficulty and inconvenience of taking alleviating action and any conflicting responsibilities that the defendant may have (the negligence calculus). See *Shirt* (1980) 146 CLR 40; *Fahy* (2007) 232 CLR 486, 511 [79] (Gummow and Hayne JJ); *Moubarak* (2009) 239 CLR 420, 432–3 [12]–[13], 439 [39] (French CJ, Gummow, Hayne, Heydon and Crennan JJ); *Ferreira* (2005) Aust Torts Reports 81–818, [45] (Ipp JA,

‘significant in a practical sense’.¹⁰⁴ Whether or not there was a breach will therefore often turn on the third inquiry: were the intensivist’s actions reasonable in the circumstances?

In the scenario, the doctor’s duty of care to multiple patients seeking entry into the ICU is in direct conflict. This was highlighted by Justice Turner in *Morrison v Liverpool Women’s NHS Foundation Trust*:¹⁰⁵

[I]n the clinical context a balance has to be struck between the needs of any given patient and any other competing professional demands placed upon the clinicians involved. Sometimes, the seriousness and urgency of a patient’s presentation and the absence of any conflicting factors will mandate a swift and decisive response. On other occasions, it is equally obvious that the needs of the patient must be deprioritised to allow the clinicians to attend other demands on their time as a matter of priority.¹⁰⁶

In a complete ICU overwhelm, as an unprecedented, extreme event, a court is more likely to find that the relevant duty of care has not been breached on the basis that reasonable care has been taken in the circumstances. But this does not mean there is no risk of liability for the intensivist or the hospital. A severe bed shortage may be insurmountable, but a doctor must still take reasonable steps to provide life-sustaining treatment, or risk civil liability in negligence. Further, while doctors cannot be compelled to provide treatment against their clinical judgment,¹⁰⁷ they still have a duty to exercise reasonable care and skill when treating patients. Thus, if ventilation is clinically indicated, it is doubtful that doctors can unilaterally decide to withhold care on the grounds that a scarce resource would be more effectively used on future (expected) patients.¹⁰⁸ In this context, it is important to note that the duty is not a duty to achieve the outcome of providing treatment, but rather to take reasonable steps to try to provide it.¹⁰⁹ Thus, if the doctor failed to find an ICU bed or ventilator for Philip, but took reasonable steps to do so it is likely that the duty of care will have been met. In the scenario reasonable steps might involve considering whether to discharge patients already in the ICU, discussing the application of the triage policy with colleagues or hospital administration, and perhaps attempting to consult with the patient’s family about

Spigelman CJ agreeing at [1], Tobias JA agreeing at [108]); *Rosenberg* (2001) 239 CLR 420. This position has been confirmed by civil liability legislation: *Civil Law (Wrongs) Act 2002* (ACT) s 43; *Civil Liability Act 2002* (NSW) s 5B; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) (no equivalent provision); *Civil Liability Act 2002* (Qld) s 9; *Civil Liability Act 1936* (SA) s 32; *Civil Liability Act 2002* (Tas) s 11; *Wrongs Act 1958* (Vic) s 48; *Civil Liability Act 2002* (WA) s 5B.

104 *Fahy* (2007) 232 CLR 486, 554 [226] (Callinan and Heydon JJ).

105 [2020] EWHC 91 (QB).

106 *Ibid* [24] (Turner J).

107 *Re J (A Minor)* [1993] Fam 15, [26]–[27] (Lord Donaldson); *R (Burke) v General Medical Council (Official Solicitor intervening)* [2006] QB 273, 300–1 [50] (Lord Phillips).

108 Liddell et al (n 19).

109 *Lange v O’Carrigan* [2013] NSWDC 183, [253] (Levy DCJ): ‘Dr O’Carrigan’s duty in that regard extended to ensuring that when operating on her left hip he would adhere to accepted protocols and checking procedures so as to be able to recognise and avoid foreseeable complications such as leg lengthening where it was reasonably possible to do so. The scope and content of that duty did not extend to a guarantee that the operation would be successful as “... Of all sciences medicine is one of the least exact”: *Thake v Maurice* [1986] QB 644, 688. The practise of the surgeon’s art should not be seen as being an exception to that statement’.

Philip's values and wishes for end-of-life care. The hospital could also be liable if it failed to have a reasonable plan in place, both for increasing ICU bed and staff capacity and for triaging patients.

Evidence of clinical practice guidelines and triage policies is admissible and relevant (though not necessarily determinative) to assessing whether a doctor has taken reasonable care,¹¹⁰ and discharged the 'peer professional defence'.¹¹¹ However, 'documents such as policy guidelines and ... manuals, codes of practice or professional standards, which are often expressed in general and imprecise terms, are not to be "construed and applied with the nicety of a statute"'.¹¹² The court considers both the nature of guidelines or policies and whether the doctor's interpretation of them was reasonable,¹¹³ their content, their source,¹¹⁴ and the degree to which they were relied on (or ignored) in reaching a decision. Additionally, a court would be likely to consider how a guideline was developed, and policies that have been rapidly-developed in the COVID-19 context without full stakeholder consultation and input might be more closely scrutinised.¹¹⁵ Government-issued or institution-wide detailed triage policies might therefore carry more weight than broad ethical or professional guidelines, which leave more room for interpretation.¹¹⁶ The extent to which the policy or guideline was adopted in practice may also be relevant. The key point to note is that purporting to use a triage guideline on its own is not conclusive of meeting the standard of care. A simple blanket application of a policy without exercising reasonable clinical judgment may lead to a breach of duty.

(c) *Damage*

If a breach of duty is established, as set out above, to succeed in a negligence claim, it is also necessary for Philip to establish that he suffered *damage* (harm), recognised by law, which was caused by the breach of duty. In a COVID-19 triage situation, as in other end-of-life cases, causation may be difficult to establish

110 *R (BA) v Secretary of State for Health and Social Care* [2018] EWCA Civ 2696; Loane Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences* (LexisNexis, 3rd ed, 2008) 228.

111 The legislation is not uniform across Australia: *Civil Liability Act 2002* (NSW) ss 50, 5P; *Civil Liability Act 2003* (Qld) s 22; *Civil Liability Act 1936* (SA) s 41; *Civil Liability Act 2002* (Tas) s 22; *Wrongs Act 1958* (Vic) ss 59, 60; *Civil Liability Act 2002* (WA) s 5PB. See generally *Masson* (2020) 94 ALJR 785.

112 *Masson* (2020) 94 ALJR 785, 805 [95] (Nettle and Gordon JJ), citing *Minister for Immigration, Local Government and Ethnic Affairs v Gray* (1994) 50 FCR 189, 208 (French and Drummond JJ). See also, *Australian Securities and Investments Commission v Administrative Appeals Tribunal* (2011) 195 FCR 485, 500 [129] (Stone, Jacobson and Collier JJ); *Australian Prudential Regulation Authority v TMeffect Pty Ltd* (2018) 125 ACSR 334, 349–50 [59]–[60] (Perry J).

113 *Masson* (2020) 94 ALJR 785; *Ambulance Service of NSW v Worley* [2006] NSWCA 102.

114 Jackson (n 65).

115 Some commentators argue that rapidly-developed COVID-19 guidelines might be subject to particular legal scrutiny, given the lack of long-term evidence-based development seen with other authoritative guidelines: David Metcalfe, Carole Pitkeathley and Jonathan Herring, "'Advice, Not Orders?": The Evolving Legal Status of Clinical Guidelines' (2020) *Journal of Medical Ethics* 0:1.

116 *Masson* (2020) 94 ALJR 785, 789 [11], 800 [79] (Kiefel CJ, Bell and Keane JJ), 803 [89], 805 [95] (Nettle and Gordon JJ).

depending on the patient's condition.¹¹⁷ Since Philip is in a very critical condition and would likely suffer serious injury or die in any event, it may not be possible to establish causation.¹¹⁸ Additionally, while 'harm' is broadly defined in civil liability legislation,¹¹⁹ the loss of chance of a better medical outcome is not damage recognised by law.¹²⁰ Where the plaintiff cannot establish, on the balance of probabilities, that his damage was caused by the defendant's negligence, he will not recover even if it can be established that the defendant's negligence caused the loss of a chance of a better outcome.

(d) Defences

Another core obstacle for a negligence claim in the scenario is the potential for a defendant to establish a defence. A doctor who follows an appropriate triage policy could argue they have made out the 'professional practice' defence.¹²¹

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- 117 As explained in footnote 86 above, causation is a question of fact, which the plaintiff bears the burden of proving, on the balance of probabilities. This requires the plaintiff to establish: (a) that the defendant's negligence was a necessary condition in the occurrence of the plaintiff's harm (factual causation); and (b) that it is appropriate for the scope of the negligent person's liability to extend to the harm so caused (scope of liability). This is now enshrined in civil liability legislation: *Civil Law (Wrongs) Act 2002* (ACT) s 45; *Civil Liability Act 2002* (NSW) s 5D; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) (no equivalent provision); *Civil Liability Act 2003* (Qld) s 11; *Civil Liability Act 1936* (SA) s 34; *Civil Liability Act 2002* (Tas) s 13; *Wrongs Act 1958* (Vic) s 51; *Civil Liability Act 2002* (WA) s 5C. Each limb of causation requires separate consideration and both limbs must be established by the plaintiff on the balance of probabilities: *Civil Law (Wrongs) Act 2002* (ACT) s 46; *Civil Liability Act 2002* (NSW) s 5E; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) (no equivalent provision); *Civil Liability Act 2003* (Qld) s 12; *Civil Liability Act 1936* (SA) s 35; *Civil Liability Act 2002* (Tas) s 14; *Wrongs Act 1958* (Vic) s 52; *Civil Liability Act 2002* (WA) s 5D; discussed *Strong v Woolworths* (2012) 246 CLR 182; *Wallace v Kam* (2013) 250 CLR 375. Factual causation may be difficult to establish: see, eg, *Barnett v Chelsea & Kensington Hospital Management Committee* [1969] 1 QB 428. Barnett consumed tea containing arsenic. He went to hospital and was vomiting and appeared ill. The doctor declined to examine him and told him to go home and contact his own doctor. The court held that although the doctor may have breached his duty to treat Barnett, there was no effective treatment for arsenic poisoning and Barnett would have died anyway. Barnett's widow could not prove there was any loss or damage caused by the breach. See also *Wilsher v Essex Area Health Authority* [1988] AC 1074; *Lane* [2013] NSWDC 12 [227]–[230], [335] (Williams DCJ).
- 118 This was the basis of the finding adverse to the plaintiffs in *Lane* [2013] NSWDC 12. 'However the plaintiffs have been unable to establish that even if all the things they say should not have been done were done and if all the things they say should have been done were not done, it was more likely than not that Mrs Lane's outcome would have been meaningfully different in the short term, that is that Mrs Lane wouldn't have died at or about the time she did in fact die': at [335] (Williams DCJ). Williams DCJ held that the claim in negligence arising out of the plaintiff's mother's treatment while in hospital was not established: at [362]. See also *Krishna* [2000] NSWCA 272, [98]–[99] (Spigelman CJ).
- 119 Harm is broadly defined as 'harm of any kind, including personal injury (including both physical and psychiatric injury) or death; damage to property and economic loss': *Civil Law (Wrongs) Act 2002* (ACT) s 40; *Civil Liability Act 2002* (NSW) s 5; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) (no equivalent provision); *Civil Liability Act 2003* (Qld) s 2; *Civil Liability Act 1936* (SA) s 3; *Civil Liability Act 2002* (Tas) s 9; *Wrongs Act 1958* (Vic) s 43; *Civil Liability Act 2002* (WA) s 3.
- 120 *Tabet v Gett* (2010) 240 CLR 537, 559 [46] (Gummow ACJ); 564 [67]–[69] (Hayne and Bell JJ); 581 [124], 586 [142] (Kiefel J).
- 121 *Civil Law (Wrongs) Act 2002* (ACT) (no equivalent provision); *Civil Liability Act 2002* (NSW) ss 5O, 5P; *Personal Injuries (Liabilities and Damages) Act 2003* (NT) (no equivalent provision); *Civil Liability Act 2003* (Qld) s 22; *Civil Liability Act 1936* (SA) s 41; *Civil Liability Act 2002* (Tas) s 22; *Wrongs Act 1958* (Vic) ss 59, 60; *Civil Liability Act 2002* (WA) s 5PB. See *Masson* (2020) 94 ALJR 785.

However, as noted above, on a narrow construction of this defence, a ‘practice’ must be established,¹²² which may not be possible in the novel context of COVID-19 rationing decisions.

The hospital could also raise a statutory resource allocation ‘defence’ in this scenario, such that if Philip argues, for example, that the hospital should have spent more funds on ventilators or allocated more resources to ICU, such resource allocation decisions are simply not open to challenge.¹²³

B Criminal Law

1 Criminal Law: General Principles

Some international authors have raised the potential for criminal liability in response to ICU triage decisions in the COVID-19 pandemic,¹²⁴ and have argued doctors should have immunity from prosecution.¹²⁵ Although criminal prosecutions in a medical context are typically reserved for the most egregious conduct, the potential for charges in a pandemic setting are not merely academic. After the Hurricane Katrina disaster, a doctor and two nurses faced potential murder charges for administering medications to nine critically ill older individuals who were in hospital awaiting evacuation when the storm hit.¹²⁶

When a doctor withholds or withdraws life-sustaining treatment from a patient and the patient dies as a result, criminal liability is possible if there was no lawful basis for the decision.¹²⁷ Although the criminal law in Australia varies by state and territory, in broad terms, the central legal issue is whether the patient died

122 In *Sparks* (2018) 361 ALR 115, 165–167 [210]–[220], a majority of the NSWCA (Macfarlan and Simpson JJA) applied *McKenna v Hunter & New England Local Health District* (2013) Aust Torts Reports 82 at [160], [165], and held there must be an established ‘practice’ for the defence to be made out. This limits the scope of the defence as it ‘necessarily excludes unusual factual circumstances’: at 187 [333] (Simpson JA). By contrast, Basten JA rejected the suggestion that the defence only applies where the defendant can identify ‘a regular course of conduct adopted in particular circumstances’: at 123 [31]. In a novel case, Basten JA considered that the defence may be invoked by a defendant ‘by reference to how an assessment of the circumstances (which may be unique) would be undertaken by a knowledgeable and experienced practitioner’: at 123 [31]. See Magnussen (n 92). The High Court refused special leave to appeal: Transcript of Proceedings, *Sparks v Hobson* [2018] HCATrans 191.

123 *Tzaidas v Child* [2004] NSWCA 252. A resource allocation defence may be available for the benefit of public authorities, which may include public hospitals, as defined by: *Civil Law (Wrongs) Act 2002* (ACT) s 109; *Civil Liability Act 2002* (NSW) s 41; *Civil Liability Act 2003* (Qld) s 34; *Civil Liability Act 2002* (Tas) s 37; *Wrongs Act 1958* (Vic) s 79; *Civil Liability Act 2002* (WA) s 5U. There are no equivalent provisions in the Northern Territory or South Australia: *Personal Injuries (Liabilities and Damages) Act 2003* (NT); *Civil Liability Act 1936* (SA). The resource allocation ‘defence’ sets out the principles which are applied in the determination as to whether a public authority has breached a duty of care: *Civil Law (Wrongs) Act 2002* (ACT) s 110; *Civil Liability Act 2002* (NSW) s 42; *Civil Liability Act 2003* (Qld) s 35; *Civil Liability Act 2002* (Tas) s 38; *Wrongs Act 1958* (Vic) s 83; *Civil Liability Act 2002* (WA) s 5W. There are no equivalent provisions in the Northern Territory or South Australia: *Personal Injuries (Liabilities and Damages) Act 2003* (NT); *Civil Liability Act 1936* (SA).

124 See, eg, Cohen, Crespo and White (n 19); Liddell et al (n 19).

125 See, eg, Cohen, Crespo and White (n 19); Ricci and Pasquale (n 20).

126 Susan Okie, ‘Dr Pou and the Hurricane: Implications for Patient Care during Disasters’ (2008) 358(1) *New England Journal of Medicine* 1. These charges were put before a grand jury, which refused to indict.

127 If the patient does not die, but suffers injury then other charges are possible, such as assault. These other potential criminal charges are beyond the scope of this article.

unlawfully.¹²⁸ A person is deemed to have killed another if they have caused their death (directly or indirectly),¹²⁹ and that killing is unlawful if it occurs without lawful authorisation, justification or excuse.¹³⁰ An unlawful homicide will generally constitute either murder (for example, in circumstances when the person intended to cause death or grievous bodily harm) or manslaughter.¹³¹

Our analysis here is based on the usual characterisation by the criminal law of decisions to withhold or withdraw life-sustaining treatment being omissions, rather than acts.¹³² Liability in such instances will arise only if the prosecution proves beyond a reasonable doubt that: (a) the doctor owed a duty to provide treatment; (b) the duty was breached; and (c) the breach caused the death of another.

(a) Duty

The main duty that arises in cases regarding life-sustaining treatment is the duty to provide the necessities of life.¹³³ A person who voluntarily assumes responsibility for someone who cannot care for themselves (for example, due to physical or mental incapacity) has a legal duty to provide that person with the ‘necessaries of life’.¹³⁴ This duty exists at common law in the Australian Capital Territory, New South Wales, South Australia and Victoria, and is set out in the Criminal Codes of the Northern Territory, Queensland, Tasmania, and Western

128 See generally Cameron Stewart, ‘Euthanasia, Suicide and Assisted Dying’ in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 3rd ed, 2018) 525, 528–530, 532–3; Simon Bronitt and Bernadette McSherry, *Principles of Criminal Law* (Thomson Reuters, 4th ed, 2017) ch 9.

129 See, eg, *Criminal Code Act 1899* (Qld) s 293. See also s 296: ‘A person who does any act or makes any omission which hastens the death of another person who, when the act is done or the omission is made, is labouring under some disorder or disease arising from another cause, is deemed to have killed that other person’.

130 See, eg, *ibid* s 291. A well-recognised excuse is if the patient refuses life-sustaining treatment (either directly or via an Advance Health Directive). See, eg, *Brightwater Care* (2009) 40 WAR 84; *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88.

131 While the primary distinction for unlawful killings is murder and manslaughter, another type of unlawful killing is culpable driving. Manslaughter is usually conceptualised as an unlawful killing that does not amount to murder. The fault element for murder varies by jurisdiction in Australia. See generally Bronitt and McSherry (n 128) 521–5.

132 Ben White, Lindy Willmott and John Allen, ‘Withholding and Withdrawing Life-Sustaining Treatment: Criminal Responsibility for Established Medical Practice?’ (2010) 17(5) *Journal of Law and Medicine* 849, 856.

133 This has been identified as the primary source of potential criminal liability in these cases. See, eg, *Brightwater Care* (2009) 40 WAR 84; *Re RWG* [2000] QGAAT 49, [55]–[63] (Presiding member Lyons, members Joachim and Howard); *Re HG* [2006] QGAAT 26, [101]–[107] (President Lyons, Dr Stafford and Assoc Prof Willmott); *Re SAJ* [2007] QGAAT 62, [54] (Presiding member Clarkson, Professor Willmott and Dr Stafford).

134 For a discussion of these criminal law duties in relation to futile treatment, see Lindy Willmott, Ben White and Jocelyn Downie, ‘Withholding and Withdrawal of “Futile” Life-Sustaining Treatment: Unilateral Medical Decision-Making in Australia and New Zealand’ (2013) 20(4) *Journal of Law and Medicine* 907.

Australia.¹³⁵ Breach of this duty is not an independent offence but will provide the basis for charges in murder or manslaughter.¹³⁶

The duty to provide the necessities of life rests on two primary considerations. First, the treatment must be necessary (in other words, required) to sustain life. It is settled law that medical treatment that is ‘futile’ or ‘non-beneficial’ is not considered a necessary of life.¹³⁷ However, when life-sustaining treatment is rationed, this treatment is by definition of benefit, so this element will be made out. Second, the duty only arises when a doctor has ‘care and charge of a person’. In a hospital setting, this duty will clearly arise when the patient lacks decision-making capacity, for example, because they were unconscious or sedated for the purpose of providing mechanical ventilation. But it could also include cases where a person has decision-making capacity,¹³⁸ particularly where a patient may not be readily able to discharge themselves to find a new health care facility due to, for example, being critically ill (including ventilated).¹³⁹

(b) Breach

The duty to provide the necessities of life may be breached negligently or intentionally.¹⁴⁰ An explicit decision to withhold an ICU admission and ventilation when the system is overwhelmed, would be intentional. The standard of care required under the criminal law is less demanding than in civil negligence, and mere inadvertence will not breach it. The defendant must have demonstrated reckless disregard of the danger to the patient’s health and welfare, and must have been either ‘indifferent to an obvious risk of injury to health, or actually to have foreseen the risk but to have determined nevertheless to run it’.¹⁴¹

(c) Causation

Causation is determined objectively, and the prosecution must generally prove that the breach of duty was a ‘substantial cause’ of the patient’s death. In the Code jurisdictions, a person who breaches the duty will be ‘held to have caused any

135 *Criminal Code Act 1983* (NT) s 183; *Criminal Code Act 1899* (Qld) s 285; *Criminal Code Act 1924* (Tas) s 144; *Criminal Code Act Compilation Act 1913* (WA) s 262. Note also that the Northern Territory is the only jurisdiction to set out a general duty to act to avoid death or danger to another: *Criminal Code Act 1983* (NT) s 155. See Bronitt and McSherry (n 128) 564. See also *Brightwater Care* (2009) 40 WAR 84; *Auckland* [1993] 1 NZLR 235 (for the New Zealand context).

136 White, Willmott and Allen (n 132) 856.

137 Case law establishes that the duty to provide the necessities of life does not compel doctors to provide treatment when it is not clinically indicated, however, doctors’ decisions not to treat that have resulted in death have nevertheless resulted in coronial investigations. See, eg, *Inquest into the Death of June Woo* [2009] QCC (COR 2713/02, 1 June 2009); *Inquest into the Death of Paul Melo* [2008] NTMC 080 (D0223/2007, 18 December 2008).

138 Compare, however, suggestions to the contrary in *Brightwater Care* (2009) 40 WAR 84. For discussion of this case in relation to futile treatment, see Willmott, White and Downie (n 134).

139 White, Willmott and Allen (n 132) 859.

140 For example, in Queensland in *R v Young* [1969] Qd R 417, the majority of the Court indicated the duty is ‘for practical purposes in the same terms as that imposed by the common law’ for manslaughter based on criminal negligence: 441 (Lucas J, Hoare J agreeing at 444). See White, Willmott and Allen (n 132) 856.

141 *R v Stone* [1977] QB 354, 363 (Geoffrey Lane LJ, Nield and Croom-Johnson JJ).

consequences to the life or health of any person to whom he owes the duty by reason of such omission'.¹⁴² As was observed for a negligence claim, it might be difficult to establish causation if the patient is seriously ill prior to being in charge and control of the doctor and would not have recovered in any event.

(d) *Defences*

There are two potential defences, although neither has been tested in this context. First, some Codes recognise that the duty to provide the necessities of life is subject to a lawful excuse.¹⁴³ The meaning of this phrase was considered in two New Zealand cases, *Auckland Area Health Board v Attorney-General (NZ)* ('*Auckland*')¹⁴⁴ and *Shortland v Northland Health Ltd* ('*Shortland*').¹⁴⁵ The former case was a dispute about artificial ventilation, while the latter concerned admission to a dialysis program for end-stage renal failure. In both cases, the Court considered that not providing the treatment was in accordance with 'good medical practice' and this constituted a lawful excuse. The reasoning in both cases centred on the patient's inability to benefit from the treatment.¹⁴⁶ The Australian position is less certain as this issue has not been judicially considered in this context.¹⁴⁷ Moreover, in a pandemic rationing case the factual context would be different; unlike in *Auckland* and *Shortland*, the patient would clearly benefit from the treatment but is being denied treatment due to a lack of available resources. This would likely not constitute 'good medical practice', at least as it pertains to the individual patient. It is possible though that 'lawful excuse' could be framed more broadly than good medical practice in the context of a pandemic with the Court excusing criminal liability for a doctor forced to choose which patient receives a ventilator. This remains unclear, however, given the novel situation of a pandemic and limited guidance from the cases.

A second possible defence that a doctor faced with criminal charges could raise is that of necessity.¹⁴⁸ The Code jurisdictions explicitly excuse¹⁴⁹ or justify¹⁵⁰ acts done in an extraordinary or sudden emergency, codifying the common law defence of necessity.¹⁵¹ The way jurisdictions frame this defence has implications for when

142 *Criminal Code Act 1983* (NT) s 153. The provisions in the other Code jurisdictions are similar in substance: see *Criminal Code Act 1899* (Qld) s 285; *Criminal Code Act Compilation Act 1913* (WA) s 262.

143 *Criminal Code* (Qld) s 285.

144 [1993] 1 NZLR 235 ('*Auckland*').

145 [1998] 1 NZLR 433 (Court of Appeal) ('*Shortland*').

146 In *Shortland* [1998] 1 NZLR 433 (Court of Appeal), this was because the patient had moderate dementia and could not comprehend or sufficiently cooperate with dialysis.

147 See Willmott, White and Downie (n 134).

148 The defence of necessity takes two forms, either justifying the conduct (individuals should not be criminally liable if they have 'done the right thing' and acted proportionately in the face of harm) or excusing the conduct (a defendant is excused when there is an extraordinary act and they had no choice but to act as they did): Jeremy Finn, 'Emergency Situations and the Defence of Necessity' (2016) 34(2) *Law in Context* 100, 103–4.

149 *Criminal Code Act 1899* (Qld) s 25; *Criminal Code Act 1983* (NT) s 33. See also *Perka v The Queen* [1984] 2 SCR 232.

150 *Crimes Act 1958* (Vic) s 322R; *Criminal Code Act Compilation Act 1913* (WA) s 25.

151 See, eg, *R v Loughnan* [1981] VR 443.

it will apply.¹⁵² For example, the Queensland Criminal Code couches the defence as an excuse:

[A] person is not criminally responsible for an act or omission done or made under such circumstances of sudden or extraordinary emergency that an ordinary person possessing ordinary power of self-control could not reasonably be expected to act otherwise.¹⁵³

In contrast, the Codes in Western Australia and Victoria frame the defence as a justification, requiring the defendant to have acted reasonably in response to an emergency.¹⁵⁴ The common law in New South Wales, South Australia and Tasmania appear to recognise both forms of the defence.¹⁵⁵ The main distinction is that an excuse requires some imminent peril, where the person had ‘no real choice’ but to offend, while a justification looks at the conduct as a whole as the lesser of two evils.¹⁵⁶ Finn notes:

While excusatory necessity may well be appropriate for disaster victims or survivors who had no real choice but to offend, disaster responders will more than likely want their conduct to be considered as deliberate, correct and the choice of a lesser evil; and hence, to raise a justification defence.¹⁵⁷

2 Application to the Scenario

If Philip died from being denied ICU admission and a ventilator, it is possible criminal charges could result (although, practically, this would also be subject to prosecutorial discretion).¹⁵⁸ The intensivist is in ‘charge’ of Philip and owes him a duty of care to provide the necessities of life because of Philip’s critically ill state. As was observed in the negligence analysis, a central inquiry will be whether this duty was breached. Not providing Philip with life-sustaining treatment is a deliberate choice, however, the intensivist is working with a severe bed shortage, which would be considered by the court in determining whether her actions are reasonable. To establish the standard of care required for criminal negligence, as noted above, the prosecution must prove beyond a reasonable doubt, that the doctor had ‘reckless disregard’ for the patient’s welfare. In determining this, the court would be likely to consider the decision-making process, including the relevant triage protocols and guidelines, how they were applied, and the extent to which Philip’s individual clinical situation was considered.

The intensivist might also seek to use the circumstances of the pandemic to amount to a ‘lawful excuse’, discussed above. Alternatively, the intensivist could seek to establish the defence of necessity. However, the success of this defence

152 Finn (n 148).

153 *Criminal Code 1899* (Qld) s 25.

154 *Ibid.* See *Crimes Act 1958* (Vic) s 322R; *Criminal Code Act Compilation Act 1913* (WA) s 25.

155 Finn (n 148) 106. See, eg, *R v Loughnan* [1981] VR 443; *R v Rogers* (1996) 86 A Crim R 542; *Taiapa v The Queen* (2009) 240 CLR 95, 108–9 [36]–[37] (French CJ, Heydon, Crennan, Kiefel and Bell JJ).

156 Finn (n 148) 102.

157 *Ibid.*

158 Consideration of the implications of withdrawing life-sustaining treatment in the pandemic context is beyond the scope of this article, however, the analysis might be different (with increased potential for criminal liability) if Philip was already in the ICU and a choice was made to withdraw him from a ventilator. See, eg, Cohen, Crespo and White (n 19).

might depend on the jurisdiction, and whether the defence is framed as an excuse or a justification.¹⁵⁹ Given that the triage decision is a rational, deliberate act, this would not easily fit into the requirements of ‘excuse’ jurisdictions, so the intensivist may have more success in jurisdictions with justificatory defences.

C Administrative Law (Judicial Review and Complaints Mechanisms)

This section considers two key mechanisms of administrative law potentially relevant to rationing decisions. Beyond the internal review that might be provided by (for example) a supervising consultant or hospital clinical ethics committee, the key external mechanisms are judicial review and ombudsman type complaint schemes. Importantly, the application of judicial review principles in such a context is under-explored in Australia, and as will be seen there are various hurdles to such a challenge. However, the judicial review principles have a broader relevance to this study. Irrespective of the accessibility of judicial review mechanisms (or even ombudsman complaint mechanisms) in this unique and often urgent context, the underlying standards of lawful public decision-making are very relevant to the design of processes and policies. Moreover, these standards can arise for consideration, indirectly, where the ‘lawfulness’ of action arises as a question in other legal actions (such as criminal or torts proceedings).¹⁶⁰

1 Judicial Review: General Principles

In the United Kingdom, administrative law has been used extensively over the last four decades to challenge decisions about health resource allocation (both higher level decisions and those involving decisions by clinicians). The nature of the judicial oversight changed markedly during this time, from one exhibiting judicial deference¹⁶¹ to one embracing a greater scrutiny of the decisions below.¹⁶² Although commentary in the early 2000s suggested that Australia would likely see increased claims for judicial review of rationing decisions,¹⁶³ this has not yet eventuated.

In the United Kingdom, the trend towards using judicial review to scrutinise health rationing has continued through the COVID-19 pandemic. Thus far, the most high-profile scrutiny has been on the COVID-19 rapid critical care guideline for adults issued by the National Institute for Health and Care Excellence

159 Finn (n 148).

160 For recent examples at the highest level, see *New South Wales v Robinson* (2019) 266 CLR 619; *Binsaris v Northern Territory* (2020) 94 ALJR 664.

161 In the United Kingdom, courts typically abstained, ultimately, from adjudicating health rationing decisions (including those with an allocative decision made by the doctor) by treating them as non-judicial. For example, in *R v Cambridge Health Authority; Ex parte B* [1995] 1 WLR 898, Sir Thomas Bingham MR stated: ‘Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which a court can make’: at 906.

162 Christopher Newdick, ‘Priority Setting, Patients’ Rights and Judicial Review’, in Christopher Newdick, *Who Should We Treat? Rights and Rationing in the NHS* (Oxford University Press, 2nd ed, 2005) 93.

163 Cameron Stewart, ‘Tragic Choices and the Role of Administrative Law’ (2000) 321(7253) *BMJ* 105.

(‘NICE’).¹⁶⁴ In March 2020, complainants indicated by letter they were commencing an action for judicial review of the guideline, on the basis that it was discriminatory.¹⁶⁵ It was alleged to be discriminatory because of its reliance on the Clinical Frailty Scale (‘CFS’), which automatically deprioritised individuals with a disability. In response, NICE revised the guideline to lessen reliance on the CFS when assessing some individuals.¹⁶⁶

Such successful administrative law strategy has been more elusive in Australia. As noted above, there are various potential hurdles for a successful judicial review challenge to bedside rationing decisions in Australia. Although there have been a few cases that have used this avenue to challenge aspects of health service provision,¹⁶⁷ these actions have largely been unsuccessful in Australia.¹⁶⁸ Cases from the United Kingdom present some interesting scenarios that may be instructive, however, in recent decades there has been some divergence of administrative law principle in the two jurisdictions, and so caution is required in any comparison.

Importantly, at the outset, Australian courts have (for the most part) steadfastly maintained the traditional strict distinction between the ‘legality’ and the ‘merits’ of an impugned decision. The judicial review court will not revisit the ‘merits’ of a decision; one of the established grounds of ‘illegality’ must be made out (turning essentially upon questions about the existence of power and the correctness of process). The judicial reticence famously expressed in the older United Kingdom *R v Central Birmingham Health Authority; Ex parte Collier* decision (‘[the] courts of this country cannot arrange the lists in the hospital’)¹⁶⁹ continues to be strongly present in Australia.¹⁷⁰ A practical correlative of this constraint is that the usual

164 National Institute for Health and Care Excellence, *COVID-19 Rapid Guideline: Critical Care in Adults* (NICE Guideline NG159, 3 September 2020) <<https://www.nice.org.uk/guidance/ng159>>. This guideline applies to the whole of the National Health Service and, although it is not mandatory for clinicians, health practitioners are expected to take it into account. Although this guideline was drafted to support decision-making when resources are overwhelmed, it does not constitute a national rationing protocol. The National Health Service considered drafting rationing guidelines, but never released them: David D Kirkpatrick and Benjamin Mueller, ‘UK Backs Off Medical Rationing Plan as Coronavirus Rages’, *The New York Times* (online, 3 April 2020) <<https://www.nytimes.com/2020/04/03/world/europe/britain-coronavirus-triage.html>>. See also Dominic Wilkinson and Jonathan Pugh, ‘Is it Irrational Not to Have a Plan? Should There Have Been National Guidance on Rationing in the NHS?’, *Journal of Medical Ethics* (Blog Post, 2 March 2021) <<https://blogs.bmj.com/medical-ethics/2021/03/02/is-it-irrational-not-to-have-a-plan-should-there-have-been-national-guidance-on-rationing-in-the-nhs/>>.

165 In accordance with the judicial review pre-action protocol, counsel set out their concerns with the policy in a detailed letter.

166 ‘NICE Updates Rapid COVID-19 Guideline on Critical Care’, *National Institute for Health and Care Excellence* (News Release, 25 March 2020) <<https://www.nice.org.uk/news/article/nice-updates-rapid-covid-19-guideline-on-critical-care>>.

167 See, eg, *Blyth District Hospital v South Australian Health Commission* (1988) 17 ALD 135.

168 See generally Cameron Stewart, ‘Judicial Review of Treatment Decisions: A Further Role for the Courts?’ (1999) 7(2) *Journal of Law and Medicine* 212, 215.

169 *R v Central Birmingham Health Authority; Ex parte Collier* (England and Wales Court of Appeal, Stephen Brown, Neill, Ralph Gibson LJ, 6 January 1988).

170 Contrast now (for example), in the United Kingdom context, *R v North and East Devon Health Authority; Ex parte Coughlan* [2001] QB 213; *R (Daly) v Secretary of State for the Home Department* [2001] 2 AC

result of even a successful judicial review is an order for the decision-maker to proceed again. Only very rarely, essentially where there is no residual discretion left upon correction of the legal error, will the court direct a decision-maker to a substantive result (as opposed to procedural compliance).¹⁷¹ It should also be noted that judicial review, of itself, does not sound in damages.¹⁷² Moreover, while interlocutory remedies are available in judicial review (which might help to maintain the status quo in urgent clinical contexts), the formal review processes are not designed to proceed quickly or flexibly – and, of course, they are generally subject to (potentially lengthy) appeal.

Beyond these basic structural discouragements, there are threshold requirements to consider in Australia. First, the idea of ‘non-justiciability’ – resting particularly on the notion that some public decisions have a political or international entanglement which makes judicial review inappropriate – has a lingering presence in Australia.¹⁷³ As the earlier United Kingdom cases indicate,¹⁷⁴ the allocation of scarce resources (particularly in emergency situations) might be seen as falling in this category of policy-laden decisions involving complex polycentric considerations.¹⁷⁵

Beyond questions of ‘justiciability’, in broad terms judicial review (under either the general law or statutory systems in Australia)¹⁷⁶ concerns only ‘public’ decisions. Once again, Australia has ostensibly maintained a stricter approach on this issue,¹⁷⁷ such that complications might conceivably arise in the sometimes complex private/public structures of health – absent some notable expansion of thinking.¹⁷⁸ Under the statutory system of judicial review (in the jurisdictions in which it operates alongside general law judicial review), an additional overlay requires essentially that there be ‘a decision of an administrative character made

532. Various features of the Australian context appear to have contributed to the lingering strictness: the looming presence of an entrenched separation of judicial power at the federal level, the ‘codifying’ effect of 1970s judicial review reforms, and the relative under-engagement of Australian administrative law with broader human rights issues. Cf, eg, *R v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910.

171 See, eg, *Commissioner of State Revenue (Vic) v Royal Insurance Australia Ltd* (1994) 182 CLR 51; *Plaintiff S297/2013 v Minister for Immigration and Border Protection* (2015) 255 CLR 231; *Minister for Immigration and Ethnic Affairs v Conyngham* (1986) 11 FCR 528.

172 *Park Oh Ho v Minister for Immigration and Ethnic Affairs* (1989) 167 CLR 637.

173 See particularly *Minister for Arts, Heritage and Environment v Peko Wallsend* (1987) 15 FCR 274; *Stewart v Ronalds* (2009) 76 NSWLR 99; *Aye v Minister for Immigration & Citizenship* [2009] FCA 978.

174 See, eg, *R v Secretary of State for Social Services; Ex parte Hincks* (1980) 1 BMLR 93.

175 See further Chris Finn, ‘The Justiciability of Administrative Decisions: A Redundant Concept?’ (2002) 30(2) *Federal Law Review* 239.

176 In broad terms, there are two ‘systems’ of judicial review operating in Australia: the general law system, which is the contemporary manifestation of inherited English principles, and the ‘ADJR’ system, which originated with the *Administrative Decisions (Judicial Review) Act 1977* (Cth) (‘ADJR’) but has since been effectively replicated in Queensland, the ACT and Tasmania – in most cases running in tandem with the general law system. See *Administrative Decisions (Judicial Review) Act 1989* (ACT); *Judicial Review Act 1991* (Qld) (‘JRA’); *Judicial Review Act 2000* (Tas).

177 See especially *NEAT Domestic Trading Pty Ltd v AWB Ltd* (2003) 216 CLR 277; compare and contrast *R v Panel on Take-overs and Mergers, Ex parte Datafin plc* [1987] QB 815.

178 See, eg, *R (A) v Partnerships in Care Ltd* [2002] EWHC 529 (Admin) (managers of a private psychiatric hospital susceptible to judicial review).

... under an enactment'.¹⁷⁹ The 'decision' requirement carries a criterion of some finality to the action (unless it is legally specified step in a process).¹⁸⁰ The 'administrative character' requirement, despite generally being interpreted quite liberally, can potentially cause difficulties in the case of public 'professional' decisions¹⁸¹ – including medical decisions by doctors.¹⁸² It also prevents direct statutory judicial review challenges to the promulgation of general rules or principles (even by subordinate legislation)¹⁸³ – although decisions *under* subordinate legislation can be so challenged¹⁸⁴ (and indeed general law judicial review offers more scope to challenge the general rules or principles themselves). The requirement of 'made under an enactment' (as extended to subordinate legislation)¹⁸⁵ has been interpreted to mean that the decision must be expressly or impliedly required or authorised by the enactment – and that the decision must confer, alter or otherwise affect legal rights and obligations (and in that sense the decision must derive from the enactment).¹⁸⁶ This may raise difficulties in the context of a doctor's rationing decision – and indeed is no longer easy to establish in many scenarios.¹⁸⁷ Non-statutory public decisions are more easily challenged under general law judicial review, most readily where there are impacts on rights and public duties involved.¹⁸⁸

Technical threshold issues aside, proceeding with a judicial review challenge in a rationing context will involve stretching the available well-set grounds of review from their usual field of application. This was observed in the United Kingdom in both *R v Central Birmingham Health Authority; Ex parte Walker*,¹⁸⁹ and *R v Central Birmingham Health Authority; Ex parte Collier*.¹⁹⁰ Yet, many of these grounds have necessarily proven their adaptability in various new governmental contexts. Some of the grounds might struggle for meaningful application in the context of health rationing, however, the broader relevance of

179 See especially *ADJR 1977* (Cth) ss 3(1), 5(1). Cf, in the context of general law review at federal level, the additional requirement that there be 'an officer or officers of the Commonwealth' under challenge:

Judiciary Act 1903 (Cth) s 39B; *Australian Constitution* s 75(v).

180 *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321.

181 Cf, for example, the arguments in the often-cited *Evans v Friemann* (1981) 35 ALR 428.

182 See, eg, *A v Central Queensland Network Authorised Mental Health Service* [2019] QSC 015, especially at [44] (Crow J); compare the appeal in *MDF v Central Queensland Network Authorised Mental Health Service* [2020] QCA 108.

183 See, eg, *Roche Products Pty Ltd v National Drugs and Poisons Schedule Committee* (2007) 163 FCR 451.

184 See, eg, *ADJR 1977* (Cth) s 3(1).

185 See, eg, *ibid*, and note the further extension to a 'non-statutory scheme or program' involving public funds in *JRA 1991* (Qld) s 4(b).

186 *Griffith University v Tang* (2005) 221 CLR 99, 130 (Gummow, Callinan and Heydon JJ).

187 The non-reviewability of a university's exclusion of a PhD student (the critical modern case on point) indicates that the test may not be satisfied where it is possible to categorise the relationship involved as a purely consensual one (such that 'legal rights and obligations' are not at stake), or where the force of the decision derives not from statute but from another source (eg, the law governing any private arrangement that may have been interposed): *Griffith University v Tang* (2005) 221 CLR 99, 124 (Gummow, Callinan and Heydon JJ); *Australian National University v Burns* (1982) 64 FLR 166.

188 *R v Electricity Commissioners* [1924] 1 KB 171; *Hot Holdings Pty Ltd v Creasy* (1996) 185 CLR 149.

189 (1987) 3 BMLR 32.

190 (England and Wales Court of Appeal, Brown, Neill, Ralph and Gibson LJ, 6 January 1988).

these underlying standards (to process and policy design, and where ‘lawfulness’ arises in other actions) justifies a brief revisiting of the principal bases for challenge:

- Acting beyond power – public bodies and officials must have legal authority for their actions and hence they must remain within the scope of their power, and generally exercise their powers themselves (subject to proper delegation).¹⁹¹
- Failing to observe procedural steps – public bodies and officials must follow any procedural steps laid down for the exercise of their powers (the consequences of non-compliance will depend on a court’s assessment of the intention behind the process).¹⁹²
- Breach of natural justice (or ‘procedural fairness’) – public bodies and officials will frequently be required to provide a ‘fair hearing’ to parties whose interests are affected by their decisions and act without actual or reasonably apprehended bias.¹⁹³
- Relevant/irrelevant considerations – public bodies and officials must take account of mandatory relevant considerations, and not take account of prohibited considerations (such directions may be express or implied).¹⁹⁴
- Improper purpose – public powers should not be exercised for a purpose other than that for which they are conferred.¹⁹⁵
- Acting at the behest of another – a body or official entrusted with a power should not simply act on the instructions of another in its exercise.¹⁹⁶
- Inflexible application of policy – while (lawful) policies and guidelines promote consistency and certainty in decision-making, a body or official should not blindly apply them without regard to the merits of the particular matter.¹⁹⁷
- Unreasonableness – exercises of discretion are challengeable where, viewed in context, it ‘lacks an evident and intelligible justification’.¹⁹⁸
- No evidence – decision makers should not act on a chain of reasoning that included a critical fact for which there is no evidence.¹⁹⁹

191 *Independent Commission Against Corruption v Cunneen* (2015) 256 CLR 1.

192 *Project Blue Sky Inc v Australian Broadcasting Authority* (1998) 194 CLR 355.

193 *Kioa v West* (1985) 159 CLR 550; *Plaintiff S10/2011 v Minister for Immigration and Citizenship* (2012) 246 CLR 636; *Ebner v Official Trustee in Bankruptcy* (2000) 205 CLR 337; *CNY17 v Minister for Immigration and Border Protection* (2019) 94 ALJR 140.

194 *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* (1986) 162 CLR 24.

195 *Mandurah Enterprises Pty Ltd v Western Australian Planning Commission* (2010) 240 CLR 409.

196 *Bread Manufacturers of NSW v Evans* (1981) 180 CLR 404.

197 *Green v Daniels* (1977) 51 ALJR 463.

198 *Minister for Immigration and Citizenship v Li* (2013) 249 CLR 332.

199 See, eg, *Australian Postal Corporation v Sellick* (2008) 245 ALR 561; *Kostas v HIA Insurance Services Pty Ltd* (2010) 241 CLR 390. Note an additional variation on this in the context of statutory judicial review: *ADJR 1977* (Cth) s 5(3).

2 Complaints Mechanisms: General Principles

A distinct area of administrative law, which may provide a more agile response to doctors' decisions to ration care, are complaints mechanisms. Administrative law has expanded and diversified enormously with a significant proliferation of 'complaint' bodies across the public (and quasi-public) sectors. The phenomenon has been led by the parliamentary ombudsman offices, but includes (importantly) various health complaints bodies²⁰⁰ that can have jurisdiction expressly extending into hospitals and across traditional private/public boundaries, and might wield more determinative powers or stronger referral powers than traditional ombudsman offices.²⁰¹ In broad terms, the key benefits of an ombudsman-type process are speed, cheapness, procedural informality and flexibility, ease of use and breadth of inquiry. Several of the health complaints bodies are legislatively mandated to provide prompt and efficient responses to complaints.²⁰² Moreover, the right to complain is commonly conferred broadly – extending to persons including a guardian or representative, or another health practitioner.²⁰³ Additionally, the health complaints processes can operate in parallel to other legal proceedings.²⁰⁴

The legislation does vary in detail across Australian jurisdictions, but in each statute there are provisions about who can complain, the nature of complaints that may be considered, the range of possible responses and procedural requirements. Often there is explicit provision that the failure to provide a health service is a ground for complaints.²⁰⁵ In the Northern Territory, South Australia, Tasmania, and Victoria, the complaint must be that the health provider 'acted unreasonably' by not providing a health service for the user.²⁰⁶

200 See Health Ombudsman (Qld); Health Care Complaints Commission (NSW); Health Services Commissioner (Vic); Health Complaints Commissioner (Tas); Health and Community Services Complaints Commissioner (SA); Health Services Commissioner (ACT) (within the Human Rights Commission); Health and Community Services Complaints Commission (NT); Health and Disability Services Complaints Office (WA).

201 See, eg, *Health Ombudsman Act 2013* (Qld) s 14.

202 See, eg, *ibid* s 15.

203 See, eg, *ibid* s 32.

204 See, eg, *ibid* s 43.

205 *Australian Human Rights Commission Act 1995* (ACT) s 39(1)(c); *Health and Community Services Complaints Act 1998* (NT) s 23(1)(a); *Health and Community Services Complaints Act 2004* (SA) s 25(1)(a); *Health Complaints Act 1995* (Tas) s 23(1)(a); *Health Services (Conciliation and Review) Act 1987* (Vic) s 16(1)(a); *Health and Disability Services (Complaints) Act 1995* (WA) s 25(1)(a). In the Northern Territory, South Australia, Tasmania, and Victoria, the complaint must be that the health provider 'acted unreasonably' by not providing a health service for the user. The Australian Capital Territory legislation is slightly broader and does not impose a requirement that the failure to provide a health service must be unreasonable; the nature of the complaint can simply be that the service was not provided: *Human Rights Commission Act 1995* (ACT) s 39(1)(c). The legislation in New South Wales and Queensland does not specifically mention the failure to provide a service as a ground for complaint. These complaints could fit in New South Wales under the category of a 'health service that affects, or is likely to affect ... clinical management or care ...' or in Queensland as part of 'treatment or care': *Health Care Complaints Act 1993* (NSW) s 7; *Health Ombudsman Act 2013* (Qld) s 31.

206 *Health and Community Services Complaints Act 1998* (NT) s 23(1)(c); *Health and Community Services Complaints Act 2004* (SA) s 25(1)(a); *Health Complaints Act 1995* (Tas) s 23(1)(a); *Health Services (Conciliation and Review) Act 1987* (Vic) s 25(1)(a).

There are some notional limitations that are relevant to the present context, however. It has been suggested that the Health Ombudsman systems are broadly premised on public safety, rather than the protection of rights at the individual level.²⁰⁷ This is perhaps evident in some legislative focus on powers relating to registration, practice prohibition and referral²⁰⁸ – which also underlines the fact that subject to specific exceptions the traditional ombudsman jurisdiction generally rests on recommendatory rather than determinative powers. Also, while there is typically some agility built into the actual process for making complaints in these types of systems,²⁰⁹ prescribed complaint acceptance processes might not naturally lend themselves to highly urgent matters.²¹⁰

The experiences of the general parliamentary ombudsman offices are also potentially instructive in this regard. The traditional ombudsman function has often been understood as stopping short of a full ‘merits review’ of a decision (ie, not recommending correction simply ‘on the basis of disagreement’ – in the absence of some identified error, unreasonableness or unfairness).²¹¹ Additionally, early Victorian and South Australian decisions in fact indicated that ‘policy’ matters might not be within parliamentary ombudsman jurisdiction.²¹² Yet, in most of the Australian jurisdictions the ombudsman officers have in reality readily engaged to some extent with ‘policy’ matters in their complaint handling function – albeit expecting some agency resistance on such matters, perhaps generally focussing more on the consequences rather than the propriety of a policy, and in some instances recognising that there might be a separate body that could more appropriately deal with the policy issues.²¹³ This history is instructive in the context of the issues examined in this article. There may be difficulties, or reticence, in respect of the extent to which a complaints regime can engage with and evaluate triage and rationing type policies. Interestingly, questions of resource allocation are expressly protected by some of the health complaint statutes.²¹⁴

3 *Application to the Scenario*

A judicial review claim would first turn upon threshold inquiries relating to the status of the hospital (public here), and in the case of statutory judicial review (in jurisdictions where it is available) the application of the requirement that there

207 Claire E Brolan, ‘Queensland’s New *Human Rights Act* and the Right to Access Health Services’ (2020) 213(4) *Medical Journal of Australia* 158.

208 See, eg, *Health Ombudsman Act 2013* (Qld) pts 7, 8, 9.

209 Ibid s 33.

210 Ibid ss 34–5. However, note that in Queensland immediate action can be taken regarding a health practitioner’s registration in some circumstances, including if the practitioner’s conduct poses a serious risk to persons: s 58.

211 See, eg, *Hu v Giles* [2010] FCA 174, [26] (Logan J).

212 *Booth v Dillon [No 2]* [1976] VR 434 (see also *Nisselle v Brouwer* (2007) 16 VR 296); *Salisbury City Council v Biganovsky* (1990) 54 SASR 117.

213 See, eg, Commonwealth Ombudsman, *Annual Report 2007–2008* (Report, 1 October 2008) 21–23 <https://www.ombudsman.gov.au/_data/assets/pdf_file/0015/34332/34046ombudar0708int_fa.pdf>; Commonwealth Ombudsman, *Annual Report 2008–2009* (Report, 1 October 2009) 75 <https://www.ombudsman.gov.au/_data/assets/pdf_file/0016/34027/ombud_anrep_09_full.pdf>.

214 For example, the *Health Care Complaints Act 1993* (NSW) s 91, stipulates that there should be deference to governmental choices about resource allocation.

be a ‘decision of an administrative character ... made under an enactment’. Notably, this would require the court to navigate the traditional equivocation on whether professional decisions (ie, clinical decisions) are ‘administrative’ and difficulties as regards whether a decision sufficiently derives from an ‘enactment’.²¹⁵ The triage policy itself would not be challengeable under statutory judicial review (likely not to be ‘administrative’). There is more scope for direct challenges to non-statutory decisions, and general rules or guidelines, under general law judicial review (in all jurisdictions) – subject (in the case of the latter) to questions of ‘justiciability’ (discussed earlier) and the precise legal framework.

Any judicial review will not revisit the merits of the decision, but rather merely test for legal errors, and in the ordinary course simply result in the decision being made again by an equivalent decision-maker.²¹⁶ The decision to deny Philip treatment could potentially be tested to ensure it is compliant with required standards of natural justice,²¹⁷ does not engage with irrelevant considerations (or fail to consider relevant ones),²¹⁸ was made for the purpose for which it was conferred, and was not manifestly unreasonable, or reliant on a critical fact in reasoning for which there was no evidence. Significantly, the court could also consider whether the decision was made pursuant to a lawful (eg, non-discriminatory and legally sound) triage policy and not an inflexible application of that policy.²¹⁹

The urgency of Philip’s situation can potentially be accommodated by interlocutory orders – provided there is a serious question to be tried and on balance circumstances should be preserved until then.²²⁰ Yet, the extreme and potentially inescapable constraints on resources occasioned by the pandemic and the full ICU might limit Philip’s challenge in various ways. For example, failures

215 Note again, however, the extension of ‘enactment’ to subordinate legislation, and note its further extension to a ‘non-statutory scheme or program’ involving public funds in *JRA 1991* (Qld) s 4(b).

216 The exception being essentially where there is no residual discretion remaining in the hands of the decision-maker once the legal errors are corrected.

217 Via the provision of a fair hearing, eg, in the gathering of relevant information (albeit the standard is highly flexible in the face of urgency, practicability or confidentiality) and the absence of actual or apprehended bias.

218 The boundaries will be determined by any applicable law (and the triage policy, if consistent with the law) – although this ground does not involve an inquiry into the ‘weight’ placed upon particular considerations. See, eg, *Anderson v Director General of the Department of Environment and Climate Change* (2008) 251 ALR 633; *Minister for Immigration and Citizenship v SZJSS* (2010) 243 CLR 164.

219 In the New Zealand *Shortland* litigation (*Shortland v Northland Health Ltd [No 1]*) (High Court of New Zealand, Salmon J, 20 September 1997) (*‘Shortland [No 1]’*); *Shortland v Northland Health Ltd [No 2]* (High Court of New Zealand, Salmon J, 6 November 1997) (*‘Shortland [No 2]’*) there had been a decision not to admit a patient into a dialysis program because it was concluded that his dementia meant he did not meet eligibility guidelines (which were designed to allocate resources). In *Shortland [No 1]*, there was the usual emphasis on the doctors’ entitlement to act in accordance with their clinical judgment (in the absence of an actionable ground of review), however, it was noted that applying a guideline without considering the patient’s circumstances would be an actionable error: at 13. Cf *NW Lancashire Health Authority v A, D and G* [2000] 1 WLR 977, 991 (*‘Lancashire’*); *West Sussex Primary Care* [2008] EWHC 2252 (admin). Yet, a decision shaped by the guideline with appropriate consideration of the patient’s individual circumstances would be permissible – and this was ultimately determined to be the position here in the latter decision: at 9. An appeal was dismissed in broad terms: *Shortland* [1998] 1 NZLR 433 (Court of Appeal).

220 *Australian Coarse Grain Pool Pty Ltd v Barley Marketing Board [No 1]* (1982) 46 ALR 398.

to consider relevant considerations must be ‘material’,²²¹ improper purposes must be ‘substantial’²²² and the courts will be disinterested in non-critical facts in an application of the ‘no evidence’ ground.²²³ Moreover, a breach of natural justice will not be remedied where it could not possibly have affected the outcome,²²⁴ and indeed general remedial discretion may preclude futile orders in any context.

Given the barriers to judicial review in this context, the health complaints mechanism might provide more accessible recourse – jurisdiction is likely to be clear, and this is likely to be an avenue of greater procedural ease, speed and flexibility. It appears to be available even if Philip died, owing to the breadth of the conferred ‘right to complain’. However, complaint mechanisms also have limitations in response to pandemic rationing. Complaint acceptance processes may still pose some difficulty for the urgency of Philip’s case. Additionally, the determinative powers of a health complaints mechanism are likely to be somewhat constrained, and the degree to which the decision can be re-visited might be limited somewhat by the added complexity of any clinical judgements involved, entanglement with broader questions of policy, and perhaps some express legislative protection of resource allocation choices – as well as the traditional resistance to such complaint investigations entailing a full ‘merits review’.

D Human Rights Law

Some literature on COVID-19 has flagged human rights as a potential source of legal redress against rationing decisions.²²⁵ For example, in Canada, response to COVID-19 pandemic triage protocols has included reference to the *Charter of Rights and Freedoms 1982*.²²⁶ This section examines potential challenges under Australian state human rights charters and anti-discrimination statutes. Although there have been attempts to challenge bedside rationing decisions outside of the pandemic using human rights instruments, these actions have met with little success.²²⁷

1 Human Rights Charters: General Principles

In Australia, the scope for a legal challenge to a rationing decision based on human rights charters appears to be very limited. Just three Australian jurisdictions

221 Cf *Lansen v Minister for Environment and Heritage* (2008) 174 FCR 14.

222 *Thompson v Randwick Municipal Council* (1950) 81 CLR 87.

223 See, eg, *Minister for Immigration and Multicultural Affairs v Rajamanikkam* (2002) 210 CLR 222; *Australian Postal Corp v Sellick* (2008) 245 ALR 561.

224 See, eg, *Re Refugee Review Tribunal; Ex parte Aala* (2000) 204 CLR 82; *SZBYR v Minister for Immigration and Citizenship* (2007) 235 ALR 609.

225 See, eg, Liddell et al (n 19).

226 See, eg, Brian Owens, ‘Should Triage Guidelines be Revisited Ahead of a Second Wave of COVID-19?’ (2020) 192(25) *Canadian Medical Association Journal* E690; Sujit Choudhry, ‘COVID-19 & the Canadian Constitution’, *CanLII Connects* (Blog Post, 10 June 2020) <<https://www.canliiconnects.org/en/commentaries/71478>>; Robert Lattanzio, ‘ARCH Letter on Clinical Triage Protocol’, *ARCH Disability Law Centre*, (Blog Post, 13 May 2020) <<https://archdisabilitylaw.ca/resource/arch-letter-on-clinical-triage-protocol/>>.

227 See, eg, *R (Burke) v The General Medical Council* [2006] QB 273; *Shortland* [1998] 1 NZLR 433 (Court of Appeal).

have enacted human rights charters: the Australian Capital Territory;²²⁸ Victoria;²²⁹ and Queensland.²³⁰ These statutes are intended to protect and promote human rights by making it unlawful for government, courts, and public authorities (including health authorities)²³¹ to act in a way that is incompatible with human rights, or to fail to properly consider these rights when making a decision.²³² In this sense, they attempt to instil a culture of respect for human rights within hospitals and state health departments.

As a threshold issue, it is likely that doctors' decisions in public hospitals are broadly subject to human rights legislation, in their capacity as employees or agents on behalf of the public authority providing health services.²³³ However, the applicability of these charters to healthcare decisions has been cast into doubt.²³⁴

Nevertheless, there are three primary protected rights that could be relevant to rationing decisions involving life-sustaining treatment: the right to life;²³⁵ the right against inhuman and degrading treatment;²³⁶ and the right to health services (which is only present in the *Human Rights Act 2019* (Qld)).²³⁷ There are few health law cases in Australia that have considered these rights,²³⁸ and none in an end-of-life context. General guidance from cases in New Zealand and the United Kingdom, both of which are subject to human rights instruments (with provisions similar to

228 *Human Rights Act 2004* (ACT).

229 *Charter of Human Rights and Responsibilities Act 2006* (Vic).

230 *Human Rights Act 2019* (Qld).

231 Section 40A(3)(b)(iii) of the *Human Rights Act 2004* (ACT) specifically provides that 'public health services' are within the ambit of the legislation, as does section 10(3)(b)(ii) of the *Human Rights Act 2019* (Qld). The Victorian *Charter of Human Rights and Responsibilities Act 2006* (Vic) does not specify this.

232 *Human Rights Act 2004* (ACT) s 40B; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 38(1).

233 *Human Rights Act 2004* (ACT) ss 40–40A; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 4; *Human Rights Act 2019* (Qld) ss 9–10.

234 In a 2006 case, a Victorian judge suggested there may be scope for human rights-based arguments in Australian healthcare. In *Royal Women's Hospital v Medical Practitioners Board of Victoria* (2006) 15 VR 22, 38 [72] Maxwell P said, in obiter, that 'there is a proper place for human rights-based arguments in Australian law' given the recent expansion of the areas in which Australian courts were prepared to consider the use of international human rights conventions. This case, which was in relation to access to medical records, was decided on other grounds. However, a later commentator has argued in contrast that recent jurisprudence from the High Court indicates these charters will be narrowly interpreted: Tim Vines and Thomas Faunce, 'A Bad Trip for Health-Related Human Rights: Implications of *Momcilovic v the Queen* (2011) 85 ALJR 957' (2012) 19(4) *Journal of Law and Medicine* 685. See also Ruth Townsend and Thomas Faunce, 'Condliff v North Staffordshire Primary Care Trust: Can Human Rights Redress Inequities in United Kingdom and Australian Cost-Containment-Driven Health Care Reforms?' (2011) 19 *Journal of Law and Medicine* 225.

235 *Human Rights Act 2004* (ACT) s 9; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 9; *Human Rights Act 2019* (Qld) s 58.

236 *Human Rights Act 2004* (ACT) s 10; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 10.

237 The right to respect for privacy and family has also been argued. See, eg, *R (Condliff) v North Staffordshire Primary Care Trust* [2011] EWCA Civ 910; *Lancashire* [2000] 1 WLR 977.

238 See, eg, *Kracke v Mental Health Review Board* (2009) 29 VAR 1.

those in the Australian Capital Territory, Queensland and Victoria),²³⁹ suggests that claims against bedside rationing decisions may be unlikely to succeed.

(a) *Right to Life*

A challenge to a decision based on the right to life may not succeed unless it was unfair or irrational.²⁴⁰ For example, in the New Zealand *Shortland* case, after an unsuccessful judicial review argument,²⁴¹ the applicant argued that discontinuing dialysis was a deprivation of the right to life contrary to section 8 of the *New Zealand Bill of Rights Act 1990* (NZ).²⁴² The Court of Appeal ruled that the actions of the health authority (effectively, the decisions of the treating doctors) did not ‘deprive’ the patient of his life within the meaning of section 8.²⁴³ The Court held that the authority’s duty was to be assessed in context: the hospital had satisfied its duty under criminal law to provide the patient with the ‘necessaries of life’. It had followed a careful process in assessing and ultimately rejecting him for dialysis.

(b) *Inhuman and Degrading Treatment*

United Kingdom cases, which have challenged bedside rationing based on inhuman and degrading treatment, also suggest that such arguments may be unlikely to succeed.²⁴⁴ There are two reasons for this. First, this type of challenge is reserved for very serious circumstances:²⁴⁵ the patient’s treatment must reach a minimum level of severity amounting to inhuman or degrading treatment. This will not usually be the case in bedside rationing decisions pertaining to ICU admission.²⁴⁶ An exception is withholding a basic level of care, for example, failing to wash or feed a patient who consequently suffered significant bedsores or malnutrition.²⁴⁷

The second difficulty is that courts often refuse to adjudicate in cases of genuine resource constraints.²⁴⁸ Recently, in *University College London Hospitals*

239 *New Zealand Bill of Rights Act 1990* (NZ); *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953).

240 See generally Fiona McDonald, ‘The Legal Framework of the Australian Health System’ in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson Reuters, 3rd ed, 2018) 75, 98–101. See also Faunce (n 234). However, note that the decision-making process about life-sustaining treatment will be given particular scrutiny: see, eg, *West Sussex Primary Care* [2008] EWHC 2252 (Admin), [35] (Judge Grenfell).

241 *Shortland [No 1]* (High Court of New Zealand, Salmon J, 20 September 1997); *Shortland [No 2]* (High Court of New Zealand, Salmon J, 6 November 1997).

242 *Shortland* [1998] 1 NZLR 433 (Court of Appeal). Section 8 of the *New Zealand Bill of Rights Act 1990* (NZ) states, ‘[n]o one shall be deprived of life except on such grounds as are established by law and are consistent with the principles of fundamental justice’.

243 *Shortland* [1998] 1 NZLR 433 (Court of Appeal).

244 Claims on the basis of inhuman and degrading treatment were rejected in *Lancashire* [2000] 1 WLR 977 (health authority’s decision to restrict referrals to gender reassignment surgery) and *R (Watts) v Bedford Primary Care Trust* [2003] EWHC 2228 (Admin) (one year wait for hip replacement surgery).

245 *Lancashire* [2000] 1 WLR 977, 1000–1 (Buxton LJ).

246 *Kracke v Mental Health Review Board (General)* (2009) 29 VAR 1 118–21 [555]–[568] (President Bell).

247 Jonathan Herring, *Medical Law and Ethics* (Oxford University Press, 4th ed, 2012) 69.

248 *Lancashire* [2000] 1 WLR 977, 1000 (Buxton LJ).

NHS Foundation Trust v MB,²⁴⁹ the United Kingdom High Court of Justice considered an argument based on inhuman and degrading treatment in response to a patient who did not want to vacate a hospital bed. MB was admitted to hospital because of acute neuropsychiatric problems and had a bed on a specialised ward. Appropriate housing and 24-hour support were subsequently arranged for a one-month period. The hospital sought to discharge her to the supported housing to accommodate COVID-19 patients. MB was not satisfied with the one-month period of support that was organised and refused to vacate the hospital bed. Her counsel argued, in part, that discharging her amounted to inhuman and degrading treatment contrary to article 3 of the *European Convention on Human Rights*, since it would lead to a risk of suicide, self-harm and extreme distress. In ruling on this argument, Chamberlain J stated:

[A] hospital may have to decide which of two patients ... has a better claim to a bed ... even ceasing to provide in-patient care to one of them to leave will certainly cause extreme distress or will give rise to significant risks to that patient's health or even life. A hospital which in those circumstances determines rationally, and in accordance with a lawful policy, that A's clinical need is greater than B's, or that A would derive greater clinical benefit from the bed than B, is not precluded by Article 3 ECHR from declining to offer in-patient care to B. This is because in-patient care is a scarce resource ...²⁵⁰

Therefore, although there is little case law on point, it would seem that in most circumstances, a challenge mounted to a doctor's bedside rationing decision on the basis of denial of the right to life or inhuman and degrading treatment would also fail.

(c) *Right to Health*

The *Human Rights Act 2019* (Qld), which passed in 2019 and took effect on 1 January 2020, is the only Australian charter to contain an explicit right to healthcare.²⁵¹ This was a 'historic' inclusion in Australian human rights legislation, and was touted as a way to make the state government 'accountable, by law, to protect and promote the enjoyment of the highest attainable standard of physical and mental health'.²⁵² This may provide some scope to challenge a rationing decision, however, the way the right is framed could limit its effect when considering ICU triage. Section 37 of the *Queensland Human Rights Act 2019* states:

- (1) Every person has the right to access health services without discrimination.

249 [2020] EWHC 882 (QB).

250 Ibid [55] (Chamberlain J).

251 Though Australia has ratified several international conventions which include the right to health, these are not binding in Australia. See, eg, *International Covenant on Economic, Social and Cultural Rights*, opened for signature 19 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12(1); *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 25; *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 24.

252 Brolan (n 207).

- (2) A person must not be refused emergency medical treatment that is immediately necessary to save the person's life or to prevent serious impairment to the person.²⁵³

The Act includes a very narrow construction of the right to health, providing only the right to access health services free from discrimination, rather than guaranteeing access to specific health services (eg, ICU admission) or to broader determinants of health.²⁵⁴ Although the right not to be refused emergency medical treatment is specifically set out, this is subject to such reasonable limits as can be 'demonstrably justified in a free and democratic society' (indeed, as are the other protected rights).²⁵⁵

As in administrative law, further practical challenges arise here regarding the nature of the remedies available. A court action is only possible if the right to health can be attached to another legal proceeding, such as a negligence action, judicial review, or a discrimination action under the *Anti-Discrimination Act 1991* (Qld).²⁵⁶ Damages are not available if a public entity has violated a protected right.²⁵⁷ If a person²⁵⁸ does not have another action to attach the human rights violation to, their only other recourse is to make a complaint to the Queensland Human Rights Commission ('QHRC') under the *Human Rights Act 2019* (Qld). The QHRC can refer it to other entities, if appropriate, including the ombudsman, provided the complainant consents.²⁵⁹ If the QRHC accepts the complaint, it can take any reasonable action it considers appropriate to resolve the matter, including making enquiries, receiving written submissions, or conducting conciliation.²⁶⁰ The purpose of conciliation is to resolve the matter quickly and informally, but in the context of rationing, the QRHC is not empowered to order treatment. Nevertheless, the QHRC can promote public scrutiny and accountability by publishing reports of unresolved complaints and 'repeat offender' entities.²⁶¹

253 *Human Rights Act 2019* (Qld) s 37.

254 See generally Brolan (n 207) 159: 'Determinants of health' are the 'underlying factors that promote conditions in which people can lead a healthy life'.

255 *Human Rights Act 2019* (Qld) s 13. See also *Human Rights Act 2004* (ACT) s 28; *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 7(2).

256 *Human Rights Act 2019* (Qld) s 59.

257 *Ibid* s 59(3).

258 The individual, their agent or a person who is authorised by the Queensland Human Rights Commission are all empowered to make a human rights complaint: *ibid* s 64.

259 *Ibid* s 73.

260 *Ibid* ss 77, 80.

261 See, eg, the Queensland Human Rights Commission's recent 15-page report with recommendations from an unresolved complaint against the Queensland Police & Queensland Health regarding COVID-19 hotel quarantine: Queensland Human Rights Commission, *Hotel Quarantine: Unresolved Complaint Report under Section 88 Human Rights Act 2019* (Report, 15 October 2020) <https://www.qhrc.qld.gov.au/_data/assets/pdf_file/0007/28699/2020.10.15-hotel-quarantine-conditions-unresolved-complaint-report.pdf>.

2 *Anti-Discrimination Statutes: General Principles*

A COVID-19 triage decision could also be challenged under Commonwealth²⁶² or state and territory anti-discrimination legislation.²⁶³ The most likely attribute on the basis of which a patient might claim that a rationing decision is discriminatory is age or disability, though race might also be a factor.²⁶⁴

For simplicity, this section focuses on the Commonwealth anti-discrimination laws. To establish unlawful discrimination, a complainant must prove three main elements on the balance of probabilities.²⁶⁵ First, the alleged unlawful conduct must be based on one of the protected grounds (eg, age or disability). Second, the conduct must constitute direct or indirect discrimination.²⁶⁶ Third, the discrimination must arise in an area of public life specified in the legislation, in this case, the provision of goods, services and facilities, which includes public hospital services.²⁶⁷ Finally, for a successful claim, no exemption or defence must apply.

In a COVID-19 triage case, the most contentious condition would likely be that the conduct amounted to discrimination.²⁶⁸ Not all acts of differential treatment in a health care setting constitute unlawful discrimination. The decision might not be because of a protected attribute, or may not amount to discrimination,

262 *Racial Discrimination Act 1975* (Cth); *Sex Discrimination Act 1984* (Cth); *Australian Human Rights Commission Act 1986* (Cth); *Disability Discrimination Act 1992* (Cth); *Age Discrimination Act 2004* (Cth).

263 *Discrimination Act 1991* (ACT); *Anti-Discrimination Act 1977* (NSW); *Anti-Discrimination Act 1992* (NT); *Anti-Discrimination Act 1991* (Qld); *Equal Opportunity Act 1984* (SA); *Anti-Discrimination Act 1998* (Tas); *Equal Opportunity Act 2010* (Vic); *Racial and Religious Tolerance Act 2001* (Vic); *Equal Opportunity Act 1984* (WA).

264 See, eg, *F v C, B and State of Queensland* [2007] QADT 13 ('*F v C, B*'). The complainant brought an age and disability discrimination claim in relation to being refused a kidney transplant. The issue in this case was whether a settlement arrived at previously was binding. The Commissioner ruled it was not and ordered the parties to undergo further conciliation. See also *Walker v South Australian Health Commission* [2000] HREOCA 15, where a Maori man in great pain alleged he had been refused hospital treatment on the grounds he was 'a drunken Abo'.

265 See generally Chris Ronalds and Elizabeth Raper, *Discrimination Law and Practice* (Federation Press, 4th ed, 2012) 6–7; Neil Rees, Katherine Lindsay and Simon Rice, *Australian Anti-Discrimination Law: Text, Cases and Materials* (Federation Press, 2008) ch 4.

266 Australian legislation prohibits both direct and indirect discrimination. Direct discrimination is when a person is treated less favourably than another person in similar circumstances because of a specified attribute. Indirect discrimination is when a person is required to comply with an unreasonable condition but cannot do so because of a specified attribute, to the person's detriment. See Rees, Lindsay and Rice (n 265) 4–5.

267 See, eg, *Disability Discrimination Act 1992* (Cth) s 24.

268 To prove direct discrimination, the complainant must establish that they experienced less favourable treatment because of the particular attribute in circumstances that are the same as or not materially different from the treatment for an appropriate comparator without that attribute: *Purvis v New South Wales* (2003) 217 CLR 92. See generally Ronalds and Raper (n 265) 32–41. Failure to make reasonable adjustments which result in a disabled person being treated less favourably is also unlawful: *Disability Discrimination Act 1992* (Cth) s 5(2). For indirect discrimination, the complainant must establish: (1) the imposition of a requirement or condition (such as in a guideline or policy); (2) with which the complainant cannot comply; (3) the policy has a differential impact on those with that attribute; and (4) there is no reasonable justification for the policy. The onus is on the respondent to prove that the requirement imposed is reasonable in all the circumstances.

or may be justifiable for other reasons such as a unique clinical presentation.²⁶⁹ It may be a challenge to prove that the less favourable treatment was causally related to the ground of discrimination, and not, for example, due to strictly clinical factors.²⁷⁰ Indeed, age or disability may be a relevant consideration in deciding how to treat a patient, since it can be an indicator of a patient's ability to benefit from the treatment, or suffer harm or side-effects. This is recognised in section 42(3)(a) of the *Age Discrimination Act 2004* (Cth), which provides a general exception for age discrimination in health and medical goods and services, provided the decision to do so is reasonably based on medical, clinical and scientific evidence and professional knowledge about the ability of persons of that person's age to benefit from the goods or services.

If the claimant establishes unlawful discrimination, then the burden shifts to the respondent doctor to prove an exemption under the relevant Act. The exemptions vary depending on the ground of the alleged discrimination. One major defence to a disability discrimination claim is 'unjustifiable hardship'.²⁷¹ Relevant factors in considering unjustifiable hardship are the financial circumstances and the estimated cost,²⁷² and the social benefit or detriment of offering the service.²⁷³ This could be a considerable hurdle in a rationing case.

As observed in some of the other challenges, the nature of remedies in this area also suggests anti-discrimination law may have limited application. A complaint first proceeds to confidential conciliation, and if not settled, it can be considered by a tribunal or a court. The case law in this area in relation to end of life decisions in Australia is scant.²⁷⁴ In cases denying other health services, for example, fertility services (marital status or sexuality discrimination) or a men's health service,²⁷⁵ success has been mixed.²⁷⁶ Additionally, some successful discrimination claims

269 See, eg, *Lancashire* [2000] 1 WLR 977, 996 (Auld J). The Court of Appeal rejected the applicants' discrimination claim to fund their gender reassignment surgery, noting that, '[t]hat is not a matter of sexual or any other discrimination against which the law provides protection; it is a matter of different priorities for different illnesses, a matter of medical judgment'.

270 Though note that the legislation stipulates that when there is more than one reason for the decision, the direct discrimination needs to be only one reason for the act, it need not be the dominant reason. See, eg, *Disability Discrimination Act 1992* (Cth) s 10; *Age Discrimination Act 2004* (Cth) s 16.

271 *Disability Discrimination Act 1992* (Cth) ss 21B and 29A. See generally Rees, Lindsay and Rice (n 265) 287–9.

272 *Disability Discrimination Act 1992* (Cth) ss 11(1)(c)–(d). For example, in *Moxon v Westbus Pty Ltd* [2001] NSWADT 159, the Tribunal held that a bus company had a valid excuse for not installing ramps on their buses because the cost would be too great. This decision was upheld on appeal: *Moxon v Westbus Pty Ltd [No 2]* [2002] NSWADTAP 24.

273 *Disability Discrimination Act 1992* (Cth) s 11(1)(a).

274 See, eg, *F v C, B* [2007] QADT 13.

275 In *Proudfoot v ACT Board of Health* [1992] HREOCA 6, Sir Ronald Wilson stated: 'Ultimately, it is not for the [Human Rights and Equal Opportunity] Commission to actually determine whether the challenged initiatives are in fact necessary or even wholly suitable for achieving the purpose of promoting equal opportunities as between women and men in the field of health care. All that [the exemption] requires is that those who undertake the measures must do so with that purpose in view and that it be reasonable for them to conclude that the measures would further the purpose'.

276 *Pearce v South Australia Health Commission* (1996) 66 SASR 486 ('Pearce'); *MW v Royal Women's Hospital* [1997] HREOCA 6; *JM v QFG* [2000] 1 Qd R 373.

for health services (although not in an end-of-life context) only resulted in compensation; the doctors were not ordered to provide the treatment.²⁷⁷

3 Application to Scenario

It is unlikely that human rights charters would provide Philip with recourse in this case, for reasons discussed above. The most fruitful ground for challenge under the charters could be the right to health services in Queensland. However, the health authority could argue that making a triage decision in a pandemic crisis in accordance with policy constitutes a reasonable limit that is ‘demonstrably justified in a free and democratic society’.²⁷⁸

There may be scope to raise a discrimination challenge, however, since Philip was deprioritised because of his Parkinson’s disease. Disability is defined broadly in the *Disability Discrimination Act 1992* (Cth) and includes ‘total or partial loss of the person’s bodily or mental functions’.²⁷⁹ The complainant must establish that Philip experienced less favourable treatment because of his Parkinson’s in circumstances that are the same or not materially different from the treatment for an appropriate comparator without that attribute. In other words, if a similarly-situated patient without Parkinson’s disease was admitted, this will constitute direct discrimination. Since Philip’s Parkinson’s is in its early stages and would not affect his ability to benefit from a ventilator, there is a strong argument that his Parkinson’s is causally connected to the denial of treatment.²⁸⁰

The denial of treatment may also constitute indirect discrimination, depending on how the decision is framed. Broadly, indirect discrimination exists when there is: (1) the imposition of a requirement or condition (such that imposed by the triage guideline); (2) with which the complainant cannot comply; (3) the policy has a differential impact on those with the protected attribute; and (4) there is no reasonable justification for the policy.²⁸¹ The onus is on the health authority to prove that the exclusion imposed by the triage policy is reasonable in all the circumstances.²⁸² However, if the policy is justified clinically, this may be difficult.

Even if Philip established the decision or the triage policy was discriminatory, the health authority could nevertheless argue it is a reasonable and proportional limit, given the severity of the pandemic. For example, the health authority could argue that it would be financially impossible to provide enough ICU beds,

277 See, eg, *Pearce* (1996) 6 SASR 486 (reproductive technology legislation that limited infertility treatments to heterosexual married couples constituted unlawful discrimination); *JM v QFG* [2000] 1 Qd R 373.

278 *Human Rights Act 2019* (Qld) s 13. Note that in response to a constitutional challenge by the businessman Clive Palmer, the High Court ruled that Western Australia’s border closures were reasonable restrictions/limitations in the circumstances of COVID-19: Transcripts of Proceedings, *Palmer v State of Western Australia* [2020] HCA Trans 180.

279 *Disability Discrimination Act 1992* (Cth) s 4.

280 For a detailed discussion of how triage decisions can be discriminatory, see Bagenstos (n 17). See also Australian Human Rights Commission (n 17) 7, and the discussion in Part V(C)(1) of how the United Kingdom’s National Institute for Health and Care Excellence amended its triage guidelines to lessen reliance on the Clinical Frailty Scale.

281 Rees, Lindsay and Rice (n 265) 130.

282 *Disability Discrimination Act 1992* (Cth) s 6(4). The court will weigh up many factors, including the personal effect on the complainant and the reasons, including cost, for the conduct: *Morgan v GK* [2001] QADT 10.

qualified staff and ventilators to provide life-sustaining treatment to everyone in a pandemic. Finally, as in some of the other challenges, the available remedies are also problematic. As noted, neither unlawful discrimination nor human rights litigation can be used to compel treatment and Philip needs treatment urgently.

E Guardianship Legislation and the Court's *Parens Patriae* Jurisdiction

The final area of law to consider applies when a patient lacks decision-making capacity (for example, because they are a child, are unconscious or have a mental or physical illness that has impaired their decision-making capacity). This would apply to the scenario if Philip lacked decision-making capacity, for example, because of the severity of his COVID-19 illness.

This section considers two related areas of law: the court's *parens patriae* jurisdiction and state and territory guardianship legislation. Most end-of-life case law in this area addresses when a family or caregiver disagrees with a medical recommendation to withhold or withdraw 'futile' life-sustaining treatment, and the court is called upon to consider whether the treatment is in the patient's best interests. In contrast, our scenario involves a rationing decision, where providing treatment *will* provide a benefit to the patient. Therefore, the court is likely to find that treatment, admission to the ICU and access to a ventilator, would be in the patient's best interests.

1 General Principles of the *Parens Patriae* Jurisdiction

The *parens patriae* jurisdiction empowers the court to protect the best interests of individuals who cannot care for themselves.²⁸³ Under this jurisdiction, a doctor caring for a patient who lacks decision-making capacity must 'carry out such treatment as is necessary and appropriate to safeguard the life, health and welfare of that patient'.²⁸⁴ This is an inherent jurisdiction of the supreme courts of the states and territories. Case law on the *parens patriae* jurisdiction emphasises that it is broad, but also should be exercised sparingly and with caution.²⁸⁵ Therefore, there must usually be clear justification for setting aside a medical decision before the court will intervene.²⁸⁶

There have been only a few cases in Australia where family members have sought an order from the court preventing doctors from withdrawing or withholding life-sustaining treatment on the basis of best interests (and no case had an explicit resource component).²⁸⁷ A patient's best interests are determined by the court and are assessed objectively. Relevant factors include: the patient's

283 For a discussion of this jurisdiction in Australia see, for example, *Secretary, Department of Health and Community Services v B (NT)* (1992) 175 CLR 218 ('*Marion's Case*'). See also *Northridge v Central Sydney Area Health Service* (2000) 50 NSWLR 549, 554 [24] (O'Keefe J) ('*Northridge*').

284 *Slaveski v Austin Health* (2010) 32 VR 129, 133 [15] (Dixon J) ('*Slaveski*').

285 *Messiha v South East Health* [2004] NSWSC 1061, [24] (Howie J) ('*Messiha*'); *Marion's Case* (1992) 175 CLR 218.

286 *Marion's Case* (1992) 175 CLR 218 279–80.

287 *Slaveski* (n 284); *Melo v Superintendent of Royal Darwin Hospital* (2007) 21 NTLR 197; *Re Herrington* [2007] VSC 151; *Messiha* [2004] NSWSC 1061; *Northridge* (2000) 50 NSWLR 549. See also from New Zealand, *Auckland Healthcare Services Ltd v L* [1998] NZFLR 998.

previously expressed wishes; the patient's diagnosis and prognosis; the impact on the patient if the treatment is or is not provided.²⁸⁸ When a doctor reasons a treatment is futile or non-beneficial, the application by a family member on behalf of the patient is very likely to fail.²⁸⁹ Australian courts tend to defer to medical judgment when there is disagreement on whether treatment is in the patient's best interests.²⁹⁰

However, the focus of these cases is about determining whether specified treatment is in the patient's best interests, not whether treatment which is recognised as being in a patient's best interests can be withheld on the grounds of rationing. There is little guidance on this point, but some obiter statements suggest that resource constraints are not relevant in determining what is in a patient's best interests.²⁹¹ In *Northridge v Central Sydney Area Health Service* ('*Northridge*'),²⁹² for example, O'Keefe J emphasised that '[t]he exercise of the *parens patriae* jurisdiction should not be for the benefit of others ... including a health care system that is intent on saving on costs'.²⁹³ Using this reasoning, a court's *parens patriae* jurisdiction could be engaged in a rationing case that jeopardises the health or welfare of an individual who lacks decision-making capacity.²⁹⁴

On the other hand, some dicta appear to suggest that the courts may be required to engage with rationing decisions if they were directly before the court, as could arise in a pandemic. In *TS & DS v Sydney Children's Hospitals Network* ('*Mohammed's Case*')²⁹⁵ (a dispute in which parents of a critically-ill infant opposed doctors' recommendations to withdraw life-sustaining treatment), Justice Garling appeared to suggest resource constraints could be determinative in some cases:

It was not suggested by the hospital that there was any financial reason, or any reason relating to a shortage of resources, beds or facilities which would preclude Mohammed being provided with mechanical ventilation if that was in his best interests. There may be occasions when such issues arise. If they do, there are undoubtedly complex questions of public health policy to be

288 *Northern Sydney and Central Coast Area Health Service v CT* [2005] NSWSC 551. See also Lindy Willmott, Ben White and Malcolm K Smith, "'Best Interests" and Withholding and Withdrawing Life-Sustaining Treatment from an Adult Who Lacks Capacity in the *Parens Patriae* Jurisdiction' (2014) 21(4) *Journal of Law and Medicine* 920; Lindy Willmott et al, 'Withholding and Withdrawing Life-Sustaining Treatment in a Patient's Best Interests: Australian Judicial Deliberations' (2014) 201(9) *Medical Journal of Australia* 545.

289 See, eg, *Slaveski* (2010) 32 VR 129 (Dixon J); *Messiha* [2004] NSWSC 1061.

290 See, eg, Willmott, White and Smith (n 288) 931; Willmott et al (n 288).

291 *Northridge* (2000) 50 NSWLR 549, 554 [22] (O'Keefe J); *Messiha* [2004] NSWSC 1061 [9] (Dixon J); *TS & DS v Sydney Children's Hospitals Network* ('*Mohammed's Case*') [2012] NSWSC 1609, [64] (Garling J).

292 (2000) 50 NSWLR 549.

293 *Ibid* 554 [22] (O'Keefe J).

294 See, eg, *ibid*. The patient was admitted to hospital with brain damage from a drug overdose. Six days after he was admitted the treating doctors sought to discontinue life-sustaining treatment. His sister brought an urgent application to the Supreme Court in its *parens patriae* jurisdiction. The Court ordered the patient to be provided with appropriate life-sustaining treatment after the medical team failed to communicate with his family, made a premature diagnosis, and failed to properly adhere to the hospital's policies.

295 *Mohammed's Case* [2012] NSWSC 1609.

considered, and also whether, a Court is best fitted to engage in that area of discourse. Fortunately, in this case, this issue did not arise.²⁹⁶

2 Guardianship Legislation

A detailed consideration of state and territory guardianship legislation is beyond the scope of this article. However, some key points are noted about the broad scheme of this legislation and how it might apply. This legislation empowers substitute decision-makers to act on behalf of adults who lack decision-making capacity.²⁹⁷ The criteria to be applied vary across jurisdictions but generally centre on a person's best interests and/or their will and preferences (that is, what they would have wanted if they had capacity or are wanting now).²⁹⁸ Generally, there is no power for substitute decision-makers to demand treatment that doctors deem is 'futile'.²⁹⁹ However, a rationing decision by definition involves treatment that is in the patient's best interests. In these circumstances, an interested person (such as a family member) can apply to a tribunal or court for relief.³⁰⁰ It is unclear how a tribunal would regard the relevance of resource constraints in this type of application.

3 Application to Scenario

As discussed above, there is no Australian case law that considers whether the court's *parens patriae* jurisdiction would apply to an explicit rationing decision due to a pandemic or disaster situation. If these facts arose outside the pandemic, and Philip lacked capacity and was denied life-sustaining treatment this would clearly be against his best interests and the court would intervene.³⁰¹ However, in the COVID-19 scenario, the court could potentially take the unprecedented nature of the pandemic into account when considering whether to invoke the *parens patriae* jurisdiction in Philip's favour. As noted above, courts have previously shown deference to medical decisions albeit in the context of determining a patient's best interests. It is possible when confronted with a decision to deny a ventilator to one patient to provide it to another, a court may continue this deference and be reluctant to interfere with clinical decision-making allocating resources in this way.

296 Ibid [64] (Garling J).

297 White, Willmott and Then (n 40).

298 See generally *ibid*.

299 Willmott, White and Downie (n 134). In Victoria, this common law position is confirmed by statute: *Medical Treatment Planning and Decisions Act 2016* (Vic) s 8. See also *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 17(2). Conversely, the Queensland guardianship legislation requires a substitute decision-maker's consent to withhold or withdraw life-sustaining treatment (even if that treatment is 'futile' or 'non-beneficial'): *Guardianship and Administration Act 2000* (Qld) s 79, sch 2 s 5. This may be problematic if a doctor seeks to withdraw life-sustaining treatment from a person who lacks capacity, for example, if they were seeking to admit a different patient into the ICU, or seeks to prevent a person from being admitted as in our scenario with Philip. See also the definition of 'life-sustaining measures': sch 2 s 5A.

300 Available remedies vary by jurisdiction: White, Willmott and Then (n 40). For example, a substitute decision-maker could apply for a declaration that the treatment is in the person's best interests.

301 See, eg, *Northridge* (2000) 50 NSWLR 549, in which the decision to withdraw treatment was clearly too hasty and the Court intervened under its *parens patriae* jurisdiction.

Similarly, Philip's wife could apply under the state and territory guardianship legislation, for example, for a declaration that treatment is in Philip's best interests.³⁰² As noted above, it is unclear how a tribunal or court would approach the resource component in this type of application.

VI CONCLUSION

Although the COVID-19 pandemic presents new challenges for society and health systems, in some ways the law's role in end-of-life decision-making remains the same. End-of-life law has three primary functions,³⁰³ reflecting the scope of medical law more broadly. First, the law is a mechanism to protect individual patient rights, including the right to bodily integrity (through laws concerning consent to treatment), and the right not to be unfairly or arbitrarily denied treatment. Second, the law protects health professionals who act in good faith in accordance with legal and other processes, including those established by professional and government policies. Third, the law also serves the important function of establishing mechanisms to resolve disputes when needed. This multi-pronged focus remains constant in a pandemic, but the challenge is how to best achieve these same objectives in an uncharted environment of scarce resources, when public interest considerations outweigh individual rights.

Examining the first function, when an ICU is overwhelmed in a pandemic the rights of patients who need access to life-sustaining treatment are a critical focus. The kind of life-and-death triage described in this article is unprecedented in Australia, yet could be necessary due to COVID-19, or indeed in any future pandemic or disaster that overwhelms health care resources. Given the incredibly high stakes, the importance of ensuring that decisions are made fairly is elevated. Implicit biases or poorly constructed triage policies can have very serious (and potentially unintended) consequences for individuals. The analysis in this article has demonstrated that while the law in Australia might not provide an agile response to compel treatment in an individual case, it can facilitate the scrutiny of decision-making processes, resource allocation policies and medical guidelines. Additionally, in Australian jurisdictions with human rights legislation the law can also play a forward-looking role (albeit in a more limited way) by requiring government health authorities consider human rights when drafting emergency legislation or developing policies.

Turning to the second function of end-of-life law, for health professionals at the frontlines, their interest in making decisions using clear processes, and being protected by the law when they do so, has been intensified in the COVID-19 pandemic. Doctors, particularly in the ICU, experience distress when they are

302 Cf *Re HG* [2006] QGAAT 26, where the Queensland Guardianship and Administrative Tribunal (as it then was) consented to the withholding of health care in a different context.

303 Ben White et al, 'Knowledge of the Law About Withholding or Withdrawing Life-Sustaining Treatment by Intensivists and Other Specialists' (2016) 18(2) *Critical Care and Resuscitation* 109; Thaddeus Mason Pope, 'Legal Fundamentals of Surrogate Decision-Making' (2012) 141(4) *CHEST* 1074.

forced to ration without appropriate processes and support.³⁰⁴ Concerns about the lack of appropriate protections for doctors have been voiced emphatically in the pandemic, with calls for immunity (or indemnity) laws and resource allocation protocols and policies. This article has demonstrated that courts will show considerable deference to resource allocation decisions, even when they endanger a person's life, provided doctors make them using clear and rational processes. The critical factor is that governments and hospitals must establish and support such processes, ideally with transparent public scrutiny and consultation.

Turning to the third function, using the law to facilitate dispute resolution is particularly difficult in the pandemic context. Additionally, the law's traditional focus on individual interests in cases about life-sustaining treatment sits awkwardly with the societal considerations that arise in a public health emergency. However, the law still plays an important role in encouraging legitimacy in rationing decisions by promoting transparency in allocative choices,³⁰⁵ as litigation may compel these instruments and processes to become more transparent. While this may not benefit an individual who has been denied treatment, it can nevertheless lead to better decision-making in the future. Moreover, the pandemic may encourage courts to grapple with resourcing issues squarely and lead to more clarity in the novel application of traditional legal challenges, which will be critical for future health crises.

Despite upholding some of the central functions of law at end of life, this article has also demonstrated that law's traditional approach has several well-known limitations, which are exacerbated in a pandemic setting. First, dispute resolution mechanisms lack speed, flexibility, and agility; many of the legal challenges considered in this article would not apply if a patient has died. Additionally, the intervention of law in medical decision-making has sometimes been regarded as inapt. Law's focus is on establishing general rules to guide behaviour but its application in the context of a specific patient can fail to recognise the nuance of a given clinical situation. Another related limitation is that medical law has generally functioned as a protector of individual rights through mechanisms such as consent and avoiding discriminatory decisions. This is perhaps why it has failed somewhat to adequately account for decisions that must consider the public interest. These limitations underscore the importance of government departments and hospitals making COVID-19 triage policies and guidelines transparent and available for public scrutiny and engagement, prior to ICUs reaching crisis levels. Encouraging more transparency about the criteria that will be used for triage, while confronting and politically-loaded, enables robust public deliberation about society's values. Regrettably, the brief review of triage policies in this article suggests that at the time of writing this transparency is lacking in Australia.

Triage decisions in a health crisis should not be discriminatory, arbitrary, or secret. This is why, the law's limitations aside, it remains an important part of the wider framework that can help ensure Australia responds appropriately to the

304 Close et al, 'Doctors' Perceptions' (n 32).

305 Syrett (n 22) 61–3.

challenges brought by the COVID-19 pandemic and by future public health emergencies. Therefore, engagement with law, although not determinative, should be a central part of reflections about how to respond and how to structure pandemic triage plans. In particular, the law's capacity to promote fair and non-discriminatory decision-making should be harnessed. To date, there has been little focus in the ethical literature on the contribution law could make to these decisions and more is needed. This could also include greater consideration of legal issues beyond the scope of this article, including whether guidance in existing triage guidelines complies with the law. While law cannot 'solve' the problems of COVID-19 pandemic triage, its mechanisms can nevertheless help lead to better decision-making.