THE PRINCIPLE OF NECESSITY IN CONTEMPORARY AUSTRALIAN HEALTH LAW: A VALID VEHICLE FOR HEALTH CARE DECISION-MAKING, OR A DEFUNCT DOCTRINE?

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Since Re F (Mental Patient: Sterilisation) [1990] 2 AC 1, the 'doctrine of necessity' has been considered a legal basis for doctors to provide treatment to patients who lack capacity to make decisions for themselves, at least in the United Kingdom. While the language of 'necessity' is still used in Australian hospitals, the doctrine has received only scarce judicial and academic attention domestically, leaving doubt about its standing recognition under Australian law. In this doctrinal analysis, I consider the medical treatment legislation relevant to each state and territory as well as the key cases, and seek to answer these three questions: (1) Does the doctrine of necessity still exist within Australian civil law? (2) If it does, is it a sound basis for health care professionals to make treatment decisions for patients who cannot consent? And, (3) does it even matter?

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I INTRODUCTION

It has long been entrenched in the law that no medical or surgical treatment may be provided to a competent patient without their informed consent, lest the intervention amount to assault.[1] However, there will inevitably be times when a patient is unable to make decisions for themselves. In these situations where a patient has reduced decision-making ability,[2] the courts have held that it is appropriate for a health professional to act in the patient's best interests, without consent, as a matter of 'necessity'. This doctrine of necessity evolved in the United Kingdom ('UK') courts, with the House of Lords crystallising its position in *Re F (Mental Patient: Sterilisation)* ('*Re F*') that 'it will not only be lawful for doctors, on the ground of necessity, to operate on or give other medical treatment to adult patients disabled from giving their consent; it will also be their common law duty to do so'.[3]

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[1] *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, 310 ('*Marion's Case*'); *Rogers v Whitaker* (1992) 175 CLR 479; *F v R* (1983) 33 SASR 189. See generally *Schloendorff v Society of New York Hospital* 211 NY 125 (NY, 1914); *Malette v Shulman* (1990) 67 DLR (4th) 321 (Ontario Court of Appeal).

[2] Historically the law has referred to a patient's 'capacity'. However, the emerging trend in health care and disability services favours the term 'decision-making ability' with this strengths-based language being more inclusive and patient-centric. It is anticipated that this is the language which will be used in the new WA *Guardianship Act* following the review that is currently underway. See Law Reform Commission of Western Australia, *Project 114 Guardianship and Administration Act 1990 (WA)* (Discussion Paper Vol 1, December 2024).

[3] *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 55–6 (Lord Brandon) ('*Re F*').

However, 'necessity' is not an invention of health law. Rather, it originated first as a defence to past criminal conduct. Later, the same rationale was applied to tort cases in civil courts, with the defendant party arguing that their past wrongful conduct should be excused based on this 'doctrine' or 'principle' of necessity. In Australian and UK law, these principles were well aligned. *Re F* was the first time that necessity had been considered applicable to future conduct, marking a significant deviation from the prior case law. The civil law doctrine of necessity has since been considered only a few times by Australian courts, leaving it 'unclear how far the extended principle of necessity articulated by Lord Goff of Chieveley can be relied upon in Australia'.[4]

In the leading High Court of Australia decision, *Secretary, Department of Health and Community Services v JWB and SMB* ('*Marion's Case*'), McHugh J remarked that that 'the approach of their Lordships [in *Re F*] is not consistent with the common law of Australia'.[5] These remarks have been cited by the Guardianship and Administration Board of Western Australia ('WA'), which commented further that it would not be appropriate to use the doctrine of necessity as justification for imposing 'a restraint as part of a regime of behaviour management, and which falls short of medical management, without the consent of a guardian'.[6]

Additionally, every Australian state and territory has its own legislation dealing with urgent treatment decisions (these include the Mental Health Acts,[7] and the Guardianship and other Acts which provide for urgent treatment without consent, which I will collectively refer to as the 'Medical Treatment Acts'[8]) as well as a legislated criminal defence of emergency in most jurisdictions.[9] In circumstances where legislation has been passed which covers the same ground as the common law, the principle of parliamentary sovereignty ordinarily

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[4] Nick O'Neill and Carmelle Pesiah, 'Substitute Consent to Medical and Dental Treatment' in Nick O'Neill and Carmelle Pesiah (eds), *Capacity and the Law* (Sydney University Press, 2011) [12.2.1].
[5] *Marion's Case* (n 1) 310.
[6] *Re BCB; Application for Guardianship Order* (2002) SR (WA) 338, [33] ('*Re BCB*'), cited in *Re BTO* (Full Board of the Guardianship and Administration Board of WA, Barker J, Members McCutcheon and Child, 14 October 2004) ('*Re BTO*').
[7] *Mental Health Act 2014* (WA); *Mental Health Act 2015* (ACT); *Mental Health Act 2016* (Qld); *Mental Health and Wellbeing Act 2022* (Vic); *Mental Health and Related Services Act 1998* (NT); *Mental Health Act 2009* (SA); *Mental Health Act 2013* (Tas).
[8] *Guardianship Act 1987* (NSW); *Health Care Decision Making Act 2023* (NT); *Guardianship and Administration Act 2000* (Qld); *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Guardianship and Administration Act 1995* (Tas); *Medical Treatment Planning and Decisions Act 2016* (Vic).
[9] *Criminal Code Act 1995* (Cth) s 10.3; *Criminal Code 2002* (ACT) s 41; *Criminal Code 1899* (Qld) s 25; *Criminal Code Act 1983* (NT) s 33; *Criminal Law Consolidation Act 1935* (SA) s 15E; *Criminal Code Act Compilation Act 1913* (WA) s 25.

requires that the statute prevails. Yet, doctors in Australian hospitals still to this day talk about the 'doctrine of necessity' when contemplating whether they can provide treatment to a patient with reduced decision-making ability, rather than using the urgent treatment language from the legislation. Surveys have highlighted that junior doctors' knowledge of legal issues, particularly regarding advanced care directives and substitute decision-making for people without decision-making capacity, is limited, and there is a need for further education.[10] However, it would only be worthwhile educating doctors on this nuance of law if the difference actually mattered.

Therefore, this paper sets out to answer the following three questions:

(1) Does the doctrine of necessity still exist within the Australian civil law?

(2) If it does, is it a sound basis for health care professionals to make treatment decisions for patients who cannot consent?

(3) Does it matter?

In answering these questions, it is appropriate to first look back through the evolution of the doctrine of necessity, highlighting the areas where the case law leaves uncertainty, and then consider whether there is any work which the common law doctrine may yet be able to do which is not covered by the statutes.

II ORIGINS OF THE DOCTRINE OF NECESSITY

A *Necessity as a Defence to Crime*

'Necessity' is a common law defence originating in the British criminal law, later being imported to the civil law where it has primarily been applied to cases in tort. *Stephen's Digest of the Criminal Law* ('*Stephen's Digest*')[11] is often considered the starting point for necessity:

> An act which would otherwise be a crime may in some cases be excused if the person accused can show that it was done only in order to avoid consequences which could not otherwise be avoided, and which, if they had followed, would have inflicted upon him or upon others whom he was bound to protect inevitable and irreparable evil, that no more was done than was reasonably necessary for that

[10] See, eg, Jamie Bryant et al, 'Junior Medical Officers' Knowledge of Advance Care Directives and Substitute Decision Making for People Without Decision Making Capacity: A Cross Sectional Survey' (2022) 23 *BMC Medical Ethics* 74.

[11] Sir James Fitzjames Stephen, *A Digest of the Criminal Law (Crimes and Punishments)* (MacMillan, 4th ed, 1887 ('*Stephen's Digest*').

> purpose, and that the evil inflicted by it was not disproportionate to the evil avoided. The extent of this principle is unascertained.[12]

The two cases which established the defence of necessity in Australian law are *R v Davidson*[13] and *R v Loughnan*.[14]

In *R v Davidson*, Dr Davidson was charged with 'unlawfully' performing four abortion procedures and contemplating a fifth. Justice Menhennitt directed the jury to consider the defence of necessity, based on the definition from *Stephen's Digest*, and the jury ultimately acquitted Dr Davidson on all five charges, finding that the crime of abortion was necessary to avoid the imminent perils of mental harm or death befalling each of those five mothers.

The case of *R v Loughnan* was not a medical case, but further refined the defence of necessity. The facts were that Mr Loughnan escaped from Pentridge Prison in Victoria, was subsequently arrested by police, and then charged with offences relating to his escape, which he appealed on the basis that his escape was a matter of necessity. The majority judgment by Young CJ and King J explored the defence of necessity from its origins to date, including both Sir James Stephen's definition and its application in *R v Davidson*.[15] The majority summarised Stephen's definition as a three-part test:[16]

> (1) The criminal act must have been done in order to avoid certain consequences which would have inflicted irreparable evil upon the accused or upon others whom he was bound to protect;
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> (2) The accused must honestly believe on reasonable grounds that he was placed in a situation of imminent peril;
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> (3) The acts done to avoid the imminent peril must not be out of proportion to the peril to be avoided.

This became the basis of the defence of necessity in the Australian criminal law and remains so to date. However, the decisions by the UK courts in *Re F* and *Re T (Adult: Refusal of Medical Treatment)* ('*Re T*')[17] took a different approach, leading to the evolution of the doctrine into a tool for forward decision-making, culminating in the decision of *Re A (Children) (Conjoined Twins: Surgical*

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[12] *R v Davidson* [1969] VR 667, 669–70 (Menhennitt J) ('*R v Davidson*'), citing *Stephen's Digest* (n 11) ch 3 art 32.
[13] Ibid.
[14] *R v Loughnan* [1981] VR 443 ('*R v Loughnan*').
[15] *R v Davidson* (n 12).
[16] *R v Loughnan* (n 14) 448 (Young CJ, King J).
[17] *Re T (Adult: Refusal of Treatment)* [1992] EWCA Civ 18 ('*Re T*'); *Re F* (n 3).

Separation) ('*Re A*').[18] While arising in an extraordinary set of circumstances, *Re A* saw the Court of Appeal affirm the position in *Re F* regarding the doctrine of necessity as authority.

B *Evolution from Criminal Law Defence to Civil Law Doctrine*

1 *Re F*

Ms F was a 36-year-old woman who lived with considerable cognitive impairment such that she needed to reside full-time in a care facility, where she had found companionship with another, male, resident. In the interests of supporting Ms F to live the fullest life possible, her mother and her care team did not want to prevent her from forming close personal relationships. However, they anticipated the possibility that their relationship might progress to a sexual one. They were concerned that Ms F might not have the capacity to understand the changes that might occur to her should she fall pregnant, and certainly would not have the ability to care for a baby. Further, she would not be able to reliably use contraception and, in any event, all contraception has a risk of failure. Therefore, Ms F's mother sought to explore the possibility of medical sterilisation.[19] Her treating medical practitioners agreed that sterilisation was in Ms F's best interests, however as Ms F was also unable to weigh up the risks and benefits of the surgery, she lacked the capacity to make decisions about her care. As the health service was not certain of the legal basis on which the procedure may be performed, it applied to the court for orders authorising the invasive treatment.

In considering the origins of the principle of necessity, Lord Goff described a range of circumstances where the defence may apply, noting that although in the past the principle had only been relied upon in circumstances of emergency, 'emergency is however not the criterion or even a pre-requisite; it is simply a frequent origin of the necessity which impels intervention'.[20] Therefore, the 'elderly person who suffers a stroke which renders him incapable of speech or movement'[21] requires health care intervention as a matter of necessity just as much as the person pulled from the path of an oncoming vehicle.[22] The basis for this principle is that the law expects that doctors and other health care workers will use 'their best endeavours' to provide treatment to any person who is unable to make decisions for themselves, for 'otherwise they would be deprived of

[18] *Re A (Children) (conjoined twins: surgical separation)* [2001] 2 WLR 480 (EWCA) ('*Re A*').
[19] *Re F* (n 3).
[20] Ibid 24.
[21] Ibid 76 (Lord Goff).
[22] Ibid 74 (Lord Goff).

medical care which they need and to which they are entitled'.[23] Subsequently, however, in many cases, 'it will not only be lawful for doctors, on the ground of necessity, to operate on or give other medical treatment to adults disabled from giving their consent; it will also be their common law duty to do so'.[24]

In articulating the doctrine of necessity insofar as it provided a justification for the health service to take a future action to sterilise Ms F, Lord Goff held:

> [T]o fall within the principle, not only (1) must there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.[25]

In considering the facts of the case, the Court in *Re F* held that the doctors and other health care staff could provide Ms F with routine (and emergency) care on the basis of necessity,[26] however the doctrine of necessity did not extend to sterilisation procedures. Therefore, it was necessary for the court to make orders authorising such a procedure (and multiple judges discussed the court's jurisdiction to make such orders).

Traditionally, the principle underpinning the defence of necessity was that, in the heat of the moment where there is little time to think and an imperative to act urgently to avoid some peril, the wrongful collateral harm caused by such action may be excusable.[27] However, the way the Court used the doctrine in *Re F* as a vehicle for rendering lawful a future event marked a significant evolution of the doctrine, and potentially opened the door for it to be used in a variety of health care situations. Further, this determination by the House of Lords established that it was the weighing up of the competing harms, not the urgency, that enlivened the doctrine of necessity as a vehicle for decision-making under common law. On this basis, their Lordships were willing to conclude that this justification of necessity should hold as authority for routine as well as emergency treatment.[28]

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[23] Ibid 4 (Lord Brandon).
[24] Ibid.
[25] Ibid 25 (Lord Goff).
[26] Ibid 25-6 (Lord Goff).
[27] See, eg, *Stephen's Digest* (n 12).
[28] Ibid 26.

2 *Re T*

Miss T was a 20-year-old pregnant woman and Jehovah's witness who was brought into hospital following a car accident.[29] At the time Miss T arrived at hospital, her medical condition was such that she was conscious and alert, and did not require urgent medical treatment. At this time, she told nurses and doctors that she did not want any blood transfusions due to her religious beliefs. Subsequently, it was discovered that her baby was very unwell and an emergency caesarean section was performed, however the baby was stillborn. Following this procedure, Miss T's condition deteriorated significantly and she was admitted to the intensive care unit ('ICU'); she did not have capacity to make decisions about her care at this time. While Miss T was in the ICU, her father and her partner (the father of her baby) together applied to the court for orders authorising a blood transfusion, which were granted. Miss T received the transfusion and her condition improved; after she had recovered, she appealed the court's order on the basis that it was against her known wishes.

The Court of Appeal on considering the appeal cited the decision in *Re F*,[30] in particular the holding that there must be 'a necessity to act when it is not practicable to communicate with the assisted person'.[31] In developing this point, Staughton LJ described three possible scenarios in which a person's previous consent or refusal may not be valid, and therefore give rise to the need to reconsider the decision: first, because their consent or refusal was given as a result of 'undue influence';[32] second, because the consent was not made with reference to the 'particular circumstances in which it turns out to be relevant';[33] or third, because the person's 'understanding and reasoning powers may be seriously reduced by drugs or other circumstances, although she is not actually unconscious'.[34]

The Court considered that the facts in *Re T* fell within the second group of scenarios. At the time that Miss T communicated her refusal of any blood transfusions, it was clear that she had an interest in preserving her life, and it was reasonable to consider there might be a number of alternative treatment options which the medical team could use. Miss T had not at that time been asked to consider that her refusal of blood products could result in her death. However, at

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[29] *Re T* (n 17).
[30] Ibid [54] (Staughton LJ) citing *Re F* (n 3) 75 (Lord Goff).
[31] Ibid.
[32] Ibid [56] (Staughton LJ).
[33] Ibid [58] (Staughton LJ).
[34] Ibid [59] (Staughton LJ).

the time that the declaration was sought by Miss T's family, the circumstances were very different and it was clear on the medical evidence that Miss T may not survive without a transfusion. As it was never put to Miss T that her refusal of treatment would hasten her death, it was reasonable for the court to make the orders (and doctors to rely on them) authorising life-sustaining treatment as a matter of necessity.

It appears that this case was more focused on the issue of informed consent (and informed refusal of treatment) than the doctrine of necessity as a vehicle for medical decision-making. Having established that the circumstances had changed sufficiently since the patient's previous refusal of consent for a blood transfusion was made that a new decision was now required, it was reasonable to apply the doctrine of necessity as stated in *Re F* and provide treatment in the patient's best interests.[35]

The Court noted that it will not always be an option for the hospital or family to find a judge and for a court to make a determination before the window for taking action has passed, 'so the medical profession, in the future as in the past, must bear the responsibility unless it is possible to obtain a decision from the courts'.[36] This statement implies that wherever there is an imperative to make decisions about a patient who cannot consent, the onus falls to the doctor (or other health care practitioner in a position to take action for the benefit of the patient) to make a decision, ostensibly by applying the doctrine of necessity as stated in *Re F*.

3 *Re A*

The case of *Re A*[37] involved the incredibly rare event of conjoined twin babies. Doctors had advised that the two girls, who were joined at the hip, were unlikely to survive if they remained conjoined. This is because the smaller twin's heart was barely functional, and her life was being sustained only by the shared circulation with the larger twin. However, the larger twin's heart was not strong enough to sustain them both indefinitely; her heart was under constant strain and at some point it would fail, leaving them both to perish. Surgeons proposed that it might be possible to separate the twins, saving the larger twin and enabling her the chance at life; however it would almost certainly lead to the death of the smaller twin, whose heart would not be strong enough to sustain her.

[35] Ibid [62] (Staughton LJ).
[36] Ibid [61] (Staughton LJ).
[37] *Re A* (n 18).

Previously the Court had held that the doctrine of necessity did not extend to circumstances where the accused's actions led to the death of another person. Yet, inaction in the present case would lead to the death of two. Lord Justice Brooks relied upon the doctrine of necessity, citing again the principle as stated by Sir James Stephen, and concluding (as did Walker and Ward LJJ, in separate judgments and for different reasons), that the exceptional circumstances and the interests of both children required that the proposed surgical separation procedure be authorised by the court.

The application of the doctrine by this Court, including the weighing-up of competing interests, has been criticised as 'crude' and 'ad-hoc'[38] by commentators and, in any event, the factual scenario is so remarkably rare that the judgment offers very little, if any, utility to future courts in future applications of the doctrine. Therefore, the judgments in *Re T* and *Re F* are largely recognised as being the foundation of the lawful authority for health practitioners to provide treatment to patients with diminished decision-making ability under UK common law, especially in emergencies.

III Subsequent Treatment of Necessity as Authority for Decision-Making by Australian Courts

There are many similarities between Australian and UK law; we share similar values, similar social structures and public authorities, similar legal institutions and the same rule of law. Therefore, it is not uncommon for decisions made in UK courts to influence decisions made in Australian courts. UK case law can be imported into Australian law when an Australian court has made a decision citing the wording or rationale of a previous UK decision as its basis. If cited by a state Supreme Court, the decision is binding in that State; positive treatment by the High Court of Australia will make the principles applicable across Australia.

When it comes to the doctrine of necessity as discussed in *Re F* and *Re T*, Australian courts have been reluctant to accept the UK courts' framing outright. *Marion's Case*,[39] a 1992 decision by the High Court of Australia, presented the opportunity for the High Court to engage with the principles from *Re F*, however it appears to me that the Court strategically evaded that discussion. The WA Guardianship Board subsequently commented that *Marion's Case* was therefore

[38] Meredith Blake, 'Doctors Liability for Homicide under the WA Criminal Code' (2011) 35 *UWA Law Review* 287, 291 with reliance on Ian Kennedy, 'Patients, Doctors and Human Rights' in Blackburn and Taylor (eds), *Human Rights for the 1990s: Legal, Political and Ethical Issues* (Mansell Publishing, 1993) 90–1.

[39] *Marion's Case* (n 1).

evidence that the doctrine of necessity did not exist in Australia as a vehicle for making health care decisions.[40]

However, *Re F* was later discussed favourably by the New South Wales ('NSW') Supreme Court in *Hunter and New England Area Health Service v A by his Tutor T* ('*Hunter and New England Area Health Service v A*'),[41] suggesting that these principles may be relevant at least in NSW. The High Court has also mentioned *Re F* in *Binsaris v Northern Territory* ('*Binsaris*') [42] and *The King v Anna Rowan — a Pseudonym* ('*Anna Rowan*'),[43] but in language which suggests the High Court either does not recognise the doctrine of necessity as framed by the UK courts, or only recognises it in a very limited way. This leaves some uncertainty about the common law basis for necessity within Australian law — an ambiguity that would be best resolved by turning to the legislation. However, for the sake of completeness, I will discuss these cases in more detail below.

A *Marion's Case*

Marion was a 14-year-old girl living in the Northern Territory with significant neurological, mental, cognitive and physical disabilities. Marion's doctors recommended that her ovaries and uterus be removed to stabilise hormonal fluctuations, and eliminate consequential stress and behavioural responses associated with menstruation and any potential future pregnancy. Marion's parents agreed with the medical recommendation and had consented to the procedure. However, the hospital was uncertain whether medical sterilisation could proceed on the basis of the parents' consent alone. Therefore, the parents and hospital applied to the court for orders authorising the procedure.[44]

The majority judgment of the High Court in *Marion's Case* was concerned only with the question of whether sterilisation procedures required the consent of the court. Justice McHugh summarised the decision in *Re F* thus:

> In *re F*, the House of Lords held that sterilisation of an incompetent child was justified if it was necessary or in the public interest and that it would be in the public interest if the procedure was in the best interests of the child. Their Lordships held that it will be in the best interests of the patient if a doctor has formed the opinion that sterilisation should be carried out provided that that opinion

[40] See, eg, *Re BCB* (n 6) 345; *Re BTO* (n 6).
[41] *Hunter and New England Area Health Service v A by his Tutor T* [2009] NSWSC 761 ('*Hunter and New England Area Health Service v A*').
[42] *Binsaris v Northern Territory* (2020) 270 CLR 549 ('*Binsaris*').
[43] *The King v Anna Rowan – a Pseudonym* (2024) 278 CLR 470 ('*Anna Rowan*').
[44] *Marion's Case* (n 2) 218.

> corresponds with a respectable body of medical opinion among those experienced in the field. Their Lordships (Lord Griffith dissenting on this point) held that the involvement of a court was highly desirable as a matter of good practice although it was not necessary as a matter of law.[45]

My interpretation of the cautionary treatment of *Re F* by the High Court in *Marion's Case* is that it was specific to the issue of the 'lawfulness' of sterilisation, and not a decision about the principle of necessity. The Court drew a distinction between 'therapeutic' and 'non-therapeutic' decisions,[46] holding that non-therapeutic decisions such as sterilisation could only be authorised by orders of the court in exercising its *parens patriae* jurisdiction.[47] This is an inherent jurisdiction of the court to make orders protecting the welfare of a child which, as clarified by the High Court in this decision, extended to the circumstances in question. After considering the relevant legislation in the Northern Territory (and other Australian jurisdictions) the High Court concluded that parental consent alone was insufficient to authorise the parents or guardians to sterilise a child. Such a procedure required the authorisation of the Family Court of Australia, to make the procedure lawful.[48]

Importantly, the judgments in *Marion's Case* did not involve any meaningful discussion of the principle of necessity at all. The only time the principle properly arose was in Justice McHugh's separate judgment, when discussing the serious harm that might befall Marion if sterilisation was not performed, and therefore the 'necessity for appropriate "treatment"'.[49] Therefore, nothing in *Marion's Case* reads down or excludes the doctrine of necessity as either a defence, or a tool for decision-making, in the Australian health care context. It appears likely that the lack of discussion of necessity by the Court was strategic, so as to avoid needing to engage with the expanded scope proposed by the House of Lords in *Re F*.

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[45] *Marion's Case* (n 2) 323 (McHugh J).
[46] Ibid 243 (Mason CJ, Dawson, Toohey and Gaudron JJ), summarising Nicholson CJ in *Re Marion* (1990) 14 Fam LR 427, 439–40. See also 250.
[47] *Re Marion* (1990) 14 Fam LR 427 (Full Court), 439–41 (Nicholson CJ, dissenting). The High Court in *Marion's Case* overturned the majority decision of the Full Court, and Nicholson CJ's dissenting judgment was given neutral if not favourable treatment by the High Court.
[48] *Marion's Case* (n 1) 230 (Mason CJ, Dawson, Toohey and Gaudron JJ).
[49] Ibid 321 (McHugh J).

B *Re BCB and Related Guardianship Board of WA Decisions*

The case of *MW*[50] concerned an application for guardianship orders in respect of a 64-year-old woman who had considerable intellectual disability and mental health issues for which she required ongoing care and treatment. The State Administrative Tribunal considered the decision of the Full Board of the Guardianship and Administration Board in *Re BCB*,[51] affirmed in *Re BTO* (unreported):[52]

> In short, the Board there noted that the English House of Lords *in Re F (Mental Patient: Sterilization)* [1990] 2 AC 1, recognised that in certain situations a medical practitioner may act in accordance with a "principle of necessity" and treat a patient without obtaining the consent of that patient. However, some doubt about the recognition of such a principle under Australian law was expressed in some of the judgments in the High Court decision in the case colloquially known as *Marion's case* (1992) 175 CLR 218. As a result, in *Re BCB* the Board thought it unwise to conclude that the general law applicable in Western Australia presently permitted a medical practitioner or any other health professional to provide treatment without a patient's consent. With this approach to the law we respectfully agree.[53]

In the discussion of *Marion's Case* above, I suggested that the *ratio* in that case was not so much concerned with the doctrine of necessity as a vehicle for decision-making so much as it was a question of whether judicial approval was needed before a sterilisation procedure could be performed on a minor. Indeed, the doctrine of necessity was given very little discussion by the High Court in its decision. While it may have been open to the Guardianship and Administration Board of WA to consider that the absence of robust discussion about the principle amounted to cautionary treatment, there have been subsequent Australian cases considering the doctrine that suggest the principle remains very much alive.

C *Hunter and New England Area Health Service v A*

Mr A was an older man who had been brought into a hospital emergency department in NSW in a critically unwell state. He was found to be suffering from septic shock and respiratory failure, as a result of which he was unconscious and unable to make decisions about his treatment. He was admitted to the ICU and given emergency treatment, however his condition continued to worsen and he

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[50] *MW* [2005] WASAT 205 ('*MW*').
[51] *Re BCB* (n 6).
[52] *Re BTO* (n 6).
[53] *MW* (n 50) [43].

developed renal failure. At this stage, Mr A was being kept alive by mechanical ventilation and dialysis. It transpired that, 11 months earlier, Mr A had written a document in which he stated that he would refuse dialysis, and on discovering this fact, the hospital applied to the court for orders that the life sustaining dialysis treatment be withdrawn, in complying with Mr A's last known wishes.[54]

The Court held that the treatment already being provided to Mr A, who on arrival to hospital was borderline unconscious and unable to consent to the treatment, must have been provided on the basis of necessity, applying the principle as stated in *Re F* and cited with approval in *Re T*. Therefore treatment was lawfully, and appropriately, commenced. And, given that the document revealed it was against the patient's wishes to receive dialysis, it was appropriate to withdraw that treatment, as 'the principle of necessity does not apply where, among other things, the proposed action "is contrary to the known wishes of the assisted person, to the extent that he is capable of rationally forming such a wish"'.[55]

The willingness of the NSW Supreme Court to apply *Re F* and find that the early treatment of Mr A was lawful under the doctrine of necessity rather than any statutory authority or other principle is suggestive that the defence remains available to Australian health professionals acting in good faith in the performance of their duties.

Different commentators have considered the above cases and each come to different conclusions as to which is the leading authority in Australia. Rankin argues that *Loughnan* is the leading Australian authority for the doctrine of necessity,[56] as does McSherry.[57] Blake discusses the 'more developed jurisprudence in the UK'.[58] Then, the Australian authorities, too, differ: the WA Guardianship Board (above) was concerned only with *Marion's Case*, while the NSW Supreme Court in *Hunter and New England Area Health Service v A* referred only to *Re F* and *Re T* without mention of the earlier Australian cases. In *Binsaris*[59] and *Anna Rowan*,[60] two recent cases which will be discussed later in this paper,

[54] *Hunter and New England Area Health Service v A* (n 40) [1]–[2] (McDougall J).
[55] Ibid [34] (McDougall J) citing *Re F* (n 4) 76 (Lord Goff).
[56] Mark Rankin, 'Abortion Law in NSW: The Problem with Necessity' (2018) 44(1) *Monash University Law Review* 32, 47–51.
[57] Bernadette McSherry, 'The Doctrine of Necessity and Medical Treatment' (2002) 10 *Journal of Law and Medicine* 10.
[58] Blake (n 38) 293.
[59] See, eg, *Binsaris* (n 42) 566.
[60] See, eg, *Anna Rowan* (n 43) 497.

the Court refers only to *Re F* and Virgo in 'Defences in Tort'.[61] While Virgo discusses necessity at some length, in my view the elements of the doctrine are framed in such a way as to lend themselves most readily to citation as they are stated in *Loughnan* and *Re F*. Regardless of the semantics as to which case is most readily quotable, the above is a summary of the development of the common law doctrine to date.

D *Binsaris v Northern Territory*

Mr Binsaris was a detainee at the Don Dale Youth Detention Centre in the Northern Territory who suffered collateral injury when tear gas was deployed by corrections officers, without lawful authorisation, to quell a riot. The prison officers argued that the deployment of tear gas was a matter of necessity. The High Court considered the historical evolution of the liability of public officers, from an initial standpoint of being personally liable for their own decisions, to the state bearing their liability vicariously, to the evolution of 'a defence of public necessity'[62] so that officers were able 'to make the hard choice of sacrificing the interests of some in order to preserve the greater interests of others'.[63] In the course of this discussion, the Court referred to Virgo and *Re F*, however simply rejected the prison officers' argument without discussing the doctrine in great detail. While *Binsaris* remains in the spotlight for other reasons, its usefulness in the current discussion is limited to the implied acknowledgement by the High Court that the defence of necessity likely still exists under Australian common law.

E *The King v Anna Rowan — a Pseudonym*

In *Anna Rowan*, a woman living with intellectual disability had faced several charges relating to sexual offences in company with another person over the course of a number of years. The accused appealed their conviction on the basis that the trial judge had not put it to the jury to consider the 'defence of duress'.[64] The High Court briefly explored the relationship between the defences of 'duress' and 'duress of circumstances' as subtypes within the defence of 'necessity', but ultimately concluded it was 'not necessary to explore this doctrinal development' as it was not raised by either party in their submissions.[65]

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[61] Graham Virgo, 'Justifying Necessity as a Defence in Tort Law' in Dyson, Goudkamp and Wilmot-Smith (eds), *Defences in Tort* (Bloomsbury Publishing, 2015) 135, 146–7.
[62] *Binsaris* (n 42) 567 (Gageler J).
[63] Ibid.
[64] *Anna Rowan* (n 43) 470.
[65] Ibid 489 (Gageler CJ, Gordon, Jagot and Beech-Jones JJ).

Edelman J, agreeing in a separate judgment, discussed the distinction between claiming necessity as though it were an excuse for wrongful conduct, and relying on the principle of necessity as a justification for causing harm so as to avoid a greater evil.[66] The cases of *R v Rogers*[67] and *R v Loughnan*[68] were cited as examples of how the distinction between excuse and justification are often 'muddled'.[69] This somewhat esoteric distinction was only drawn in the course of the lead-in to the discussion of 'duress of circumstances', which Edelman J engaged in more readily than the majority:

> The common law of Australia has not yet embraced any unification of the excuses of duress and necessity, nor has it yet recognised duress of circumstances as a species of necessity alongside duress by human threat. Duress as a defence has remained confined to pressure arising from human threats. Necessity has been left as a shadowy, uncertain defence often treated as though it were only a justification but sometimes also recognised as an excuse. Ultimately, however, from the perspective of justice generally, Woolf LJ was correct to say that "[w]hether 'duress of circumstances' is called 'duress' or 'necessity' does not matter. What is important is that, whatever it is called, it is subject to the same limitations as to 'do this or else' species of duress."[70] Hence, with a keen eye to justice, when the Victorian Parliament abolished the common law defences of duress and necessity, it created statutory excuses of duress and necessity, with nearly identical elements.[71]

These cases offer little to our current discussion of necessity for the purposes of providing treatment beyond acknowledging that necessity exists within the common law. However, the High Court's comments that statutory defences should be preferred over common law ones raises a question of whether the Court would make similar comments in respect of the civil law doctrine. For our purposes, I believe the take-away message from this case is that, when it comes to necessity, the language of the legislation should be preferred over the common law wherever possible.

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[66] Ibid [79]–[80] (Edelman J).
[67] *R v Rogers* (1996) 86 A Crim R 542 ('*R v Rogers*').
[68] *R v Loughnan* (n 14).
[69] *Anna Rowan* (n 43) 498–9 (Edelman J).
[70] *R v Conway* [1989] QB 290, 297 (citation in original).
[71] *Anna Rowan* (n 43) 501.

IV Australian Legislation on Necessity and Medical Decision-Making for Patients with Reduced Decision-Making Ability

A *Statutory Authority for Substituted Medical Decision-Making*

Each Australian state and territory has its own legislation governing treatment of patients who do not have the ability to make decisions for themselves. For matters relating to patients who are unable to make decisions primarily due to a mental health issue, the Mental Health Acts[72] (eg *Mental Health Act 2014* (WA) s 25) set out criteria for a psychiatrist to make orders that the person undergo treatment either in a hospital, or in the community, without requiring the patient's consent, as long as all those criteria are met. In all other cases where a person needs urgent treatment and does not have the ability to make decisions about their treatment, the Medical Treatment Acts[73] are the relevant legislation.

In WA, the *Guardianship and Administration Act 1990* (WA) provides at s 110ZI that, where a person needs urgent treatment and does not have the ability to make decisions about their treatment, and it is not practicable to contact a substitute decision-maker, then the health professional may provide that urgent treatment without consent. If a person needs treatment other than urgent treatment, then the Act directs the health professional to contact a substitute decision-maker, being the first person on the hierarchy provided in s 110ZD who is an adult and willing to make a decision in respect of the patient's treatment.

There are similar provisions for urgent treatment without consent in the relevant legislation for each jurisdiction, with the exception of the Australian Capital Territory ('ACT'). In the ACT, the relevant Act simply states 'this part [consent to treatment without formal representation] does not affect any common law right of a health professional to provide urgent medical treatment without consent'.[74] Interestingly, the ACT Health *Consent for Healthcare Treatment Guideline* directly refers to the 'principle of necessity' and articulates the criteria for relying upon the principle in similar terms as are used in the legislation in other states and territories.[75]

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[72] See above n 7.
[73] See above n 8.
[74] *Guardianship and Management of Property Act 1991* (ACT) s 32N.
[75] ACT Health, Canberra Health Services, 'Section 4: Healthcare Treatment Without Consent', *Consent for Healthcare Treatment Guideline* (Guideline, 21 May 2024) 12 <https://www.canberrahealthservices.act.gov.au/__data/assets/word_doc/0011/1981388/Consent-for-Healthcare-Treatment-.docx>.

B *Statutory Criminal Defences*

While this paper is primarily concerned with the civil law doctrine of necessity, given the adage 'treatment without consent is assault' it is possible that some health practitioners would also be concerned with criminal liability. Therefore, a brief discussion of the statutory criminal defences is also warranted.

In McSherry's commentary on the case of *Re A*[76] she considered that, had the case taken place in Australia, it could have been dealt with appropriately within the scope of the defence of 'sudden or extraordinary emergency' found within the model Criminal Code.[77] The Australian Model Criminal Code Officers' Committee proposed the statutory defence, an example of which is found in the *Criminal Code Act 1995* (Cth) s 10.3.[78] This defence now appears in the Commonwealth,[79] ACT,[80] QLD,[81] NT,[82] SA[83] and WA[84] Criminal Codes, as well as the *Crimes Act 1958* (Vic).[85] There is no comparable section in the Crimes Acts in NSW or Tasmania. Interestingly, when the Victorian legislature introduced this statutory defence into its legislation in 2014, it also expressly 'abolished' the common law defence of necessity.[86] It is probable that, if a situation arose which was so dire or required such prompt action as to be considered an 'emergency', then any health practitioner providing treatment with due care and skill in the best interests of their patient is likely to be able to rely on these statutory defences, just as McSherry suggests.

Section 259 of the WA Criminal Code separately provides that a person is

> not criminally responsible for administering [or (2), not administering or ceasing to administer], in good faith and with reasonable care and skill, surgical or medical treatment (including palliative care)
>
> (a) to another person for that other person's benefit; or

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[76] *Re A* (n 18).
[77] McSherry (n 57) 14.
[78] Criminal Law Officers Committee of the Standing Committee of Attorneys-General, *General Principles of Criminal Responsibility*, Ch 2 (Dec 1992), 67; *Criminal Code Act 1995* (Cth) s 10.3.
[79] *Criminal Code Act 1995* (Cth) s 10.3.
[80] *Criminal Code 2002* (ACT) s 41.
[81] *Criminal Code 1899* (QLD) s 25.
[82] *Criminal Code Act 1983* (NT) s 33.
[83] *Criminal Law Consolidation Act 1935* (SA) s 15E.
[84] *Criminal Code Act Compilation Act 1913* (WA) s 25.
[85] *Crimes Act 1958* (Vic) s 322R.
[86] *Crimes Act 1958* (Vic) s 322S. These changes were introduced in the Crimes Amendment (Abolition of Defensive Homicide) Bill 2014 (Vic) as part of a suite of amendments which also clarified the defences of self-defence, duress and intoxication in relation to all offences, as part of the government's action in addressing the growing issue of family violence.

> (b) to an unborn child for the preservation of the mother's life, if the administration of the treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

Blake notes that, until the decision in Rossiter,[87] 'section 259 was construed and interpreted as a defence of medical necessity, a defence which has been traditionally understood as being about circumstances, not the exercise of personal autonomy'.[88] Further, this section does not mention 'consent' as relevant to this section, or the offences that a doctor may wish to rely upon this section as a defence from.[89] It is arguable that consent and capacity may be relevant to the consideration of whether 'the administration of the treatment is reasonable'. The door appears to be left open to the defence of necessity here, as opposed to the 'sudden emergency' defence elsewhere in the Code.[90] However, such ambiguities are not sufficiently robust for any practitioner to want to rely on these provisions when making urgent treatment decisions, when there is a more appropriate avenue under the Medical Treatment Acts.

V Interaction Between Common Law and Legislation

A fundamental principle of Australian law (as indeed in all common law jurisdictions) is that of parliamentary supremacy: that when legislation is inconsistent with the common law, the legislation overrides to the extent of the inconsistency. The doctrine of necessity originated as a defence in both criminal and tort law, and through *Re F* became particularly important for guiding decision-making in health care, at least in the UK. However, the very existence of the Medical Treatment Acts and the statutory criminal defences impliedly overrules the doctrine of necessity insofar as it applies to proceedings in each participating jurisdiction.

A doctor may well find himself asking 'but why would I oblige myself to rely upon the more onerous requirements of the statutes when I could simply rely on the common law' — a question answered by Gleeson CJ in *R v Rogers*:

> The corollary of the notion that the defence of necessity exists to meet cases where the circumstances overwhelmingly impel disobedience to the law is that the law cannot leave people free to choose for

[87] *Brightwater Care Group (Inc) v Rossiter* [2009] WASC 229 ('*Rossiter*').
[88] However, since *Rossiter* (n 87), the section has been seen more as a defence to protect the patient's autonomy. It achieves this by protecting the health professionals who dutifully abide their patient's wishes even when doing so may lead to the patient's death. See Blake (n 38) 308.
[89] Namely wounding, grievous bodily harm, and murder. See Blake (n 38) 300.
[90] *Criminal Code Act Compilation Act 1913* (WA) s 25.

> themselves which laws they will obey, or to construct and apply their own set of values inconsistent with those implicit in the law. Nor can the law encourage juries to exercise a power to dispense with compliance with the law where they consider disobedience to be reasonable, on the ground that the conduct of an accused person serves some value higher than that implicit in the law which is disobeyed.[91]

The doctor cannot choose to prefer his own approach to the situation by applying the doctrine of necessity if doing so would be inconsistent with the values of the legislation. So, in circumstances where the legislature has set out a clear procedure for making treatment decisions in respect of the patient with diminished decision-making ability, it would be contrary to the spirit of the law to choose to do anything else. As every Australian jurisdiction has mental health and medical treatment legislation (acknowledging there is interjurisdictional variation in the wording), the Parliament of each state and territory expects health professionals to abide by its statutory rules.

However, that conclusion must be caveated on the understanding that, as the doctrine of necessity (insofar as it exists in Australia) operates defensively, the circumstances enlivening its consideration must necessarily arise from a breach of the law.

Although I have been unable to conceive of any examples where a health professional may need to act urgently, but in circumstances which fall outside of the scope of the legislation, it must theoretically be possible for such a circumstance to arise, and therefore it is probable that the defence of necessity still exists to be relied upon in such unexpected situations.

VI Remainder of Necessity at Common Law

Even though the High Court made its decision in *Anna Rowan* on another basis, the Court's discussion of necessity in that case leaves little doubt as to the continued existence of a common law defence of necessity in the criminal law, notwithstanding the establishment of the alternative statutory defences. The case of *Binsaris* clearly leaves the door open to necessity potentially being relied upon in future civil matters, even if it was not held to be applicable to the unique facts of that case. Given that, based on these cases, it is likely that necessity still exists in the common law, the challenge becomes finding situations which could fall

[91] *R v Rogers* (n 67) 546 (Gleeson CJ; Clarke JA and Ireland J agreeing).

outside the scope of the statutory provisions so as to leave a gap which would give rise to consideration of the common law doctrine.

In my view, the following circumstances may warrant consideration of necessity:

(i) the patient is unable to provide consent for medical treatment (the *Re F* problem);

(ii) the patient's condition has deteriorated, and their most recent consent (or refusal) is inconsistent with the practitioner or family's belief about the need for treatment (the *Re T* problem);

(iii) the patient is unable to make decisions due to an acute-on-chronic mix of mental health and physical health issues, leaving uncertainty as to which statutory scheme should apply;

(iv) the patient is acting in a way that jeopardises the health and safety of the treating practitioner, other patients, staff and visitors, and immediate treatment is required to make the situation safe.

A *The Re F Problem*

In this first situation, treatment has been recommended for the patient, however the patient does not have capacity to make decisions about their own care, as was originally the case in *Re F*. The statutory schemes in the Medical Treatment Acts effectively provide a system for health care practitioners to determine whether the treatment is so urgent that it is not practicable to seek a substitute decision-maker, and therefore may provide treatment in the patient's best interests without consent, or whether the treatment can wait until attempts can be made to seek input from a substitute decision-maker in accordance with the legislation.[92] Where the medical treatment is in respect of patients who lack decision-making ability due primarily to a mental illness, this is provided for in the Mental Health Acts. Either way, it is most appropriate that health care practitioners apply the statutory schemes rather than the common law doctrine in these circumstances.

B *The Re T Problem*

In this second situation, the patient has expressed a wish (for example, to decline blood transfusions), but the clinical situation has changed, and the people who would be their substitute decision-makers now have different views on the situation. In these circumstances, the court seeks to protect the patient's

[92] See, eg, *Guardianship and Administration Act 1990* (WA) ss 110ZD, 110ZI.

autonomy; a patient has the right to refuse treatment even if in doing so they may knowingly hasten their own death.[93] However, in *Re T* the circumstances were such that the clinical situation had changed so drastically that the patient's previous refusal of consent could no longer apply to the new situation, and they had never had the opportunity to reconsider their refusal with the new information that doing so could lead to their death. If such a situation were to be repeated in the future, it would be appropriate for the senior clinician (usually a consultant medical practitioner) to determine whether the situation had changed so significantly that the new situation was outside of the scope of the patient's contemplation at the time they previously communicated their decision. If the situation is not substantially different, and the present circumstances were contemplated by the patient at the time they communicated their decision, the clinician should respect the patient's decision. If possible (for example, during an elective surgery), the decision should wait until the patient is able to make the decision for themselves. However, if the situation is so substantially different that the patient could not have contemplated the new circumstances at the time of their original decision, and so urgent that it cannot wait, it may be reasonable for the clinician to make an urgent treatment decision under the Medical Treatment Acts, as above. The legislation would likely still cover these situations, so it would still not be appropriate to rely on the common law doctrine of necessity here.

C *An Acute-on-Chronic Mix of Mental and Physical Health Issues*

The circumstances of a patient presenting with a 'mixed picture' of underlying physical or mental health issues together with new, acute issues at the fore will always be challenging. A patient presenting with purely psychiatric issues would warrant contemplation of the Mental Health Acts, while the Medical Treatment Acts would be more relevant for a patient presenting with physical health issues or longstanding disability. It is important to note that the Medical Treatment Acts will be the 'default' legislation when considering a patient with reduced decision-making ability. The Mental Health Acts will only be enlivened when the patient has 'a mental illness for which the person is in need of treatment' and 'because of that mental illness, there is (i) a significant risk to the health and safety of the person, or the safety of another person, (ii) a significant risk of serious harm to the person, or to another person; or (iii) a significant risk of the person suffering serious physical or mental deterioration'.[94] If these criteria (along with the other criteria for making an order under a Mental Health Act) are met, then

[93] *Re T* (n 17).
[94] See, eg, *Mental Health Act 2014* (WA) s 25.

the practitioner should consider treating the patient under the Mental Health Act for this episode of care. However, if these criteria are not clearly met, but there is still concern that the patient's ability to make decisions about their health care is impaired, then the Medical Treatment Acts should still be considered in the alternative. Either way, it is once again most appropriate for practitioners to act in accordance with the relevant legislation, rather than by attempting to rely upon the common law doctrine of necessity.

D *A Patient Jeopardising the Health and Safety of Others*

One situation was discussed by Kelly, Cockburn and Madden,[95] when responding to a query by senior emergency department doctors about their obligations towards belligerent or dismissive patients who *may* have head injuries. Their hypothetical scenario involved a 29-year-old man who fell from a bicycle, wearing a helmet, with no *obvious* signs of head injury, who was aggressive towards staff. Their conclusion was that, as a starting point, the adult patient must be assumed to have capacity to make decisions about their care. Therefore, if the patient is not showing any signs of reduced decision-making ability which could be due to a head injury, intoxication, or other cause, then they are entitled to refuse further assessment or treatment and leave the hospital of their own volition. Indeed, it is the policy of most (if not all) Australian public health services that if a patient is acting so aggressively that they cannot be de-escalated or treated safely, then it is reasonable for health practitioners to refuse to treat that patient until they are no longer a threat to staff safety.[96] However, what if the belligerent or dismissive patient did have signs of a head injury?

In *Neal v Ambulance Service of NSW*,[97] Mr Neal was wandering the streets at approximately 2 am one Friday morning when he was happened upon by police. They noticed dried blood on his head and were concerned that he had suffered a head injury, and called an ambulance. However, on attempting to examine the injury, and touching the 'egg on his head',[98] the ambulance officers were pushed away by Mr Neal saying words to the effect of 'I haven't given you permission to

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[95] Anne-Maree Kelly, Tina Cockburn and Bill Madden, 'When Patients Behave Badly: Consent, Breach of the Duty of Care and the Law' (2021) 33(1) *Emergency Medicine Australasia* 172.
[96] See, eg, WA Health, *Refusal or Withdrawal of Care for a Patient Exhibiting Aggressive or Violent Behaviour Policy* (Policy Document no MP0174/22, 24 October 2022) <https://www.health.wa.gov.au/About-us/Policy-frameworks/Work-Health-and-Safety/Mandatory-requirements/Refusal-or-Withdrawal-of-Care-for-a-Patient-Exhibiting-Aggressive-or-Violent-Behaviour-Policy>.
[97] *Neal v Ambulance Service of NSW* [2008] NSWCA 346.
[98] Ibid [15].

examine me'.[99] The paramedics explained to Mr Neal that he had suffered a head injury, and needed to go to hospital for further assessment and investigation by medical practitioners, and asked him several times to come to hospital. However, Mr Neal refused each time, pushing the paramedics' hands away and not cooperating with their assessment.[100] Ultimately, the paramedics determined that Mr Neal understood the possibility he had a serious head injury, and had the ability to make the decision to decline to be transported to hospital, so there was no lawful basis for the paramedics to do otherwise. As it happens, the police still took Mr Neal to the police watchhouse as he was intoxicated, where he continued to be 'combative'.[101] While at the police station, officers woke Mr Neal and spoke with him every half an hour to check on his welfare, as per protocol.[102] At one stage later that morning Mr Neal was found to be unrousable, and an ambulance was called to urgently convey him to hospital. Shortly after arriving in the emergency department, a CT-scan was ordered which found a significant extradural haematoma requiring surgery. Mr Neal suffered a variety of ongoing disabilities following the injury, and took action against the State of NSW through its police and ambulance officers for their failure to take him directly to hospital, despite his refusal.

In considering all the circumstances, the Court asked the following hypothetical question: even if paramedics had taken Mr Neal to hospital — without his consent and against his wishes — would he have engaged with the doctors and nurses there, agreed to be examined, undergone blood tests, and remained still for radiological imaging? The Court found that the 'only available inference is that he would not willingly have gone to hospital and submitted to medical assessment'.[103]

I would add to this: even if the paramedics had wanted to convey Mr Neal to hospital without his consent and against his clear wishes, how would they have achieved this practically? Would they have enlisted the support of police officers to restrain Mr Neal to the ambulance stretcher using rescue straps or handcuffs? Would they have collaborated to pin Mr Neal down and inject him with a sedative medication? Would they have anaesthetised Mr Neal completely and inserted a breathing tube to be able to take him to hospital entirely unconscious? The act of sedating a patient is fraught with risk, and not a decision to be made lightly. There

[99] Ibid [14].
[100] Ibid [18].
[101] Ibid [43].
[102] Ibid [55].
[103] Ibid [49].

is always a very real possibility that the patient could become seriously unwell, or even die, as a result of this sedation.[104] At its core, the doctrine of necessity may excuse one harm if it is done to avoid a greater harm. However, in circumstances where Mr Neal was on the roadside at 2 am, walking, talking and explicitly refusing care, it is hard to see how any of these alternative situations could possibly be seen as the lesser harm. Indeed, the best approach to an aggressive patient who is declining care may well be to simply state the medical advice, to explain that staff do not feel safe around them, and to invite them to return if their condition deteriorates (or their mood improves).

Instead, I suggest an alternative example which may enliven consideration of necessity. Perhaps a patient has been brought in by ambulance unwell, and unconscious, due to some suspected physical health issue. They have been received into the emergency department where breathing tubes have been inserted to keep their airways patent, intravenous cannulas have been inserted with medications and fluids, urinary catheters in place as they are unconscious and otherwise liable to soil themselves, and investigations like blood tests and scans are underway to determine the cause of their illness. Suddenly, they wake up, disoriented, confused, likely angry, ready to fight anyone and everyone in sight, demanding to be discharged. This could be a result of their illness, or it may be a normal physiological response to stress, or perhaps they are simply angry. Regardless, it is likely very frightening to staff and other patients, who may fear for their safety. There may be a brief window of opportunity to attempt to verbally de-escalate the situation, but what if that does not work? Given the established presumption that all adult patients have decision-making ability, there is an argument that this now-awake patient ought to be left simply to discharge themselves from hospital (or security could be called to remove them). However, I know few, if any, senior doctors who would be agreeable to letting a patient who was just a few minutes ago unconscious and unwell simply walk out the door, cannulas and lines still connected, while waiting for the results of investigations ordered out of concern for a serious medical condition needing treatment. In this situation, there may instead be an argument, as Kelly and colleagues suggest, for sedating this patient without their consent. The argument would be that the harm caused by such action, being the insult to the patient's autonomy, and the treatment risk inherent to the procedure, would be less than the harm avoided, being the risk of death or disability from whatever illness caused the patient to be brought into hospital in such an unwell state, the risk of serious harm to

[104] Kelly, Cockburn and Madden (n 95) 7.

themselves caused by improper removal of their breathing tubes and catheters, and the real risk that the patient may harm staff or other patients.

As the patient's condition may not have been fully established at this point, it is difficult to say that the sedation would amount to 'urgent treatment' within the meaning of the Medical Treatment Acts,[105] therefore the only other doctrine of law which could conceivably authorise the intervention may be 'necessity'. This would most likely be necessity as a defence against the criminal charge of assault, where these circumstances would arguably fall within the scope of the statutory defences of 'emergency' without evoking the common law defence. Further, in WA specifically, the legislature has provided an exemption for using 'such force as is reasonably necessary in order to prevent a person whom he believes, on reasonable grounds, to be mentally impaired from doing violence to any person or property'.[106] Separately from the criminal defences, we must consider the civil actions and defences. If the actions of health care practitioners in this situation are undertaken in the patient's best interests, and in good faith, then it is highly unlikely that the patient will suffer any harm actionable by way of medical negligence. Therefore, the only remaining cause of action may be in tort for trespass against the person (battery), for treatment or sedation without consent. It is in defence of this action in tort that the civil law doctrine of necessity may be relied upon by the hospital and its practitioners to justify their intervention.

This is the only circumstance I was able to conceive which fell outside the scope of the Medical Treatment Acts, leaving space for the common law doctrine of necessity to operate: to defend a practitioner who has treated, sedated or restrained a patient, in order to prevent that patient from causing harm to other patients, staff, or themselves, but where the patient did not have a mental illness or the Mental Health Act did not otherwise apply.

VII CONCLUSION

Despite various commentators' uncertainty as to the existence of the doctrine of necessity in Australia, the NSW Supreme Court's application of *Re F* and *Re T* in *Hunter and New England Area Health Service v A*, together with the High Court's discussions of the doctrine in *Binsaris* and *Anna Rowan*, demonstrate that the doctrine is still alive in the Australian common law. However, given the existence of the Mental Health Acts, Medical Treatment Acts, and statutory criminal

[105] Or the 'surgical and medical treatment' exception in the WA Criminal Code: see *Criminal Code Act Compilation Act 1913* (WA) s 259. See also Blake (n 38).
[106] *Criminal Code Act Compilation Act 1913* (WA) s 243.

defences, there is such a narrow window for the common law doctrine to operate that, in practical terms, there is almost no work left for the doctrine to do. For these reasons, I agree with the WA Guardianship and Administration Board's assessment that it is 'unwise to conclude that the general law applicable in Western Australia presently permitted a medical practitioner or any other health professional to provide treatment without a patient's consent'[107] (even if I disagree with their suggestion that *Marion's Case* is the basis of this conclusion).

Therefore, health care practitioners contemplating the treatment of patients with reduced decision-making ability should use the language of their local statute. For example, doctors in WA should refer to 'the *Guardianship Act*'[108] rather than 'the doctrine of necessity'. It is possible that when health care practitioners say 'necessity' they are actually referring to the legislation already, and simply say 'necessity' out of habit, or brevity, but this is a poor practice. While the language of the legislation is in some ways similar to the doctrine, the statutory framework differs in more ways than mere semantics.

For example, 'emergency' was not a criterion or even a pre-requisite to the contemplation of necessity,[109] and it was also not a requirement that health care practitioners considered the views of substitute decision-makers. However, under the various Medical Treatment Acts, it is only permissible to provide treatment without consent if the need for treatment is so 'urgent' that it would not be practicable to seek the patient's views or the views of a substitute decision-maker, such as a parent, sibling or adult child of the patient.[110] In circumstances where the treatment is not so 'urgent', a substitute decision-maker must be contacted. Referring broadly to the 'doctrine of necessity' rather than the legislation risks missing opportunities to involve family in these critical health care decisions, which the legislation was specifically designed to facilitate. As necessity cannot be relied upon where the values inherent in the relevant action are 'inconsistent with those implicit in the law',[111] and patient autonomy is an important value in the Medical Treatment Acts, there is even an argument that failing to engage in consultation with the patient's family could even invalidate the application of the doctrine.

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[107] *MW* (n 50) [43].
[108] *Guardianship and Administration Act 1990* (WA).
[109] *Re F* (n 3) 75 (Lord Goff).
[110] See, eg, *Guardianship and Administration Act 1990* (WA) s 110ZD. This requirement has also been conserved in the new Victorian guardianship legislation: *Medical Treatment Planning and Decisions Act 2016* (Vic) s 55(3).
[111] *R v Rogers* (n 67) 546 (Gleeson CJ; Clarke JA and Ireland J agreeing).

So, in response to the questions posed in the introduction:

(1) What is the current status of the common law doctrine of necessity in Australia?

The doctrine of necessity still technically exists within Australian civil law, and likely also exists within the criminal law, however the scope for its application in most jurisdictions is limited by the existence of the Mental Health Acts, Medical Treatment Acts, and statutory criminal defences.

(2) Can the doctrine of necessity be relied upon by health care practitioners when providing treatment to patients with impaired decision-making ability?

The principle of parliamentary sovereignty requires that, where legislation is inconsistent with the common law, the legislation must prevail. Therefore, as Medical Treatment Acts and Mental Health Acts in each state and territory establish statutory frameworks for making health care decisions in respect of patients with impaired decision-making ability, health care practitioners should refer to the language of their local legislation when making any treatment decisions. It is not appropriate to refer to the common law doctrine of necessity in situations appropriately covered by the legislation.

(3) Does it matter?

Yes, it matters. The Medical Treatment Acts establish a criterion of 'urgency' where Lord Goff in *Re F* did not consider this to be a factor.[112] In circumstances where treatment is required and there is enough time to seek a substitute decision-maker (eg, the situation is not 'urgent'), the Medical Treatment Acts require health care practitioners to do so,[113] which also was not a requirement in *Re F*. If health care practitioners continue to use the old language of 'necessity' there is a risk that opportunities to seek input from substitute decision-makers may be missed, contrary to the values inherent in the legislative scheme and therefore, ironically, contrary to the principles underpinning necessity itself.[114]

[112] See, eg, *Guardianship and Administration Act 1990* (WA) s 110ZI(1)(a). Note that in the recent review of the Victorian guardianship legislation, the language of 'urgency' was also conserved: *Medical Treatment Planning and Decisions Act 2016* (Vic) s 53(1).
[113] See above n 110.
[114] *R v Rogers* (n 67) 546 (Gleeson CJ; Clarke JA and Ireland J agreeing).