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THE RIGHT TO REFUSE MEDICAL TREATMENT ON RELIGIOUS GROUNDS: WHOSE IS THE HIGHER LAW?

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TABLE OF CONTENTS

ABSTRACT

This paper examines the developing jurisprudence on the right of a patient to refuse medical treatment on religious grounds, and considers the extent to which these refusals should be honoured.

The paper begins by outlining the rights of the religious patient to refuse medical treatment and to manifest their religious beliefs. It goes on to critically analyse the scope of these rights as defined by the courts and the legislature. Both the right of the adult patient to refuse medical treatment on religious grounds and the ambit of a parent's right to refuse medical treatment on behalf of a minor child are considered. The paper then looks at the state interests that might justify overriding a treatment refusal made on religious grounds. Suggestions are then made about the resolution of the conflicts between the individual rights and state interests outlined in this paper, with particular reference to the New Zealand Bill of Rights Act 1990.

In the conclusion of this paper, it is submitted that the principle of self-determination should apply at first instance to the decision of a religious patient to refuse medical treatment. Thus, there is a presumption that these decisions ought to be honoured. This presumption may be rebutted in appropriate cases, but it must be emphasised that the role of the state in restricting a person's liberty this way ought to be limited to cases where this is necessary to protect the freedom of other individuals.

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I INTRODUCTION

Regardless of religious affiliation, most people choose to submit to medical treatment when they are ill or injured. Commonly, even token religious believers will also appeal to prayer in the hope that this will assist recovery. In a sense then, a great many of us can be considered to be part time faith healers.[1] However, some religious sects[2] believe that, in some or all circumstances, 'treatment' should proceed solely according to prayer and reliance on their faith.

While it is sometimes said of these contrasting opinions that 'one person's heresy may be another's orthodoxy'; in New Zealand's pluralist society, toleration of differences in conviction is encouraged. Consequently, the law allows people the freedom to manifest their religious beliefs and the freedom to make their own choices about whether to submit to medical treatment. However, these freedoms are not absolute. This paper examines the developing jurisprudence on the right of the religious patient to refuse medical treatment, and considers the extent to which these refusals should be honoured.

The problem of balancing the conflicting interests of the state and the individual arises most acutely in cases where the likely consequence of a treatment refusal is the death of a salvageable patient. This is commonly the case where a Jehovah's Witness refuses a blood transfusion. For this reason the focus of this paper is on treatment in the life or death situation.

Chapter II of the paper considers the rights of the religious patient to refuse medical treatment and to manifest their religious beliefs. In this section, the religious patient's rights to religious liberty and to refuse medical treatment

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[1] I have borrowed this suggestion from the introduction to I Dwight "State Interference with Religiously Motivated Decisions on Medical Treatment" (1988) 93 Dickinson Law Review 41.

[2] The most publicised treatment refusals on religious grounds involve Christian Scientists and Jehovah's Witnesses. Christian Scientists rely solely on prayer and spiritual healing. Jehovah's Witnesses refuse blood transfusions because they believe that it violates a biblical injunction against eating blood: See, in particular Acts 15: 28-29, Genesis 9: 3-4, Leviticus 17: 10-14, and Deuteronomy 12: 23-25. Jehovah's Witnesses draw no distinction between taking blood into the mouth and taking it into the blood vessels. Receiving a blood transfusion is considered to be an unpardonable sin which results in the withdrawal of the opportunity to attain eternal life.

are examined. Chapters III and IV then outline the scope of these rights as defined by the courts and the legislature. Chapter III looks at the right of the adult patient to refuse medical treatment on religious grounds and Chapter IV discusses the ambit of a parent's right to refuse medical treatment on behalf of a minor child. Chapter V then outlines the state interests that might justify overriding a treatment refusal made on religious grounds. The penultimate chapter considers how conflicts between the individual rights and state interests outlined in this paper might be resolved, with particular reference to the New Zealand Bill of Rights Act 1990 ("the NZBORA").

In the conclusion of this paper, it is submitted that the principle of self-determination should prima facie apply to the decision of a religious patient to refuse medical treatment. Thus, there is a presumption that these decisions ought to be honoured. This presumption may be rebutted in appropriate cases. However, the role of the state in restricting a person's liberty this way ought to be limited to cases where state action is necessary to protect the freedom of other individuals.

II THE RIGHTS OF THE RELIGIOUS PATIENT

Today, many legal and ethical issues are framed in rights language. Usually, rights terminology is used to refer to standards of behaviour which it is thought of as wrong not to abide by. According to the Shorter Oxford English Dictionary,[3] a right is a justiciable claim on legal or moral grounds to have or obtain something or to act in a certain way. According to this broad definition, rights may refer to 'fundamentals' which represent some kind of underlying morality; but they may also have their basis in statutory creation or arise from the customs of a particular society.

The moral force of arguments based upon rights is often assumed. Yet rights sceptics dismiss the idea that rights have any moral status and the dilemma of defining a right is a perennial problem for jurists. For the purposes of this paper, we can put to one side the question of whether rights can exist independent of legal or social recognition. Perhaps we can do no better than Socrates, who described morality as "no small matter, but how we ought to live".[4] Thus, rights may be viewed as expressions of what a particular society thinks important at a particular time; circumscribing the foundation of the way we ought to live. This definition of rights is adopted for the purposes of the discussion which follows.

If rights are only as significant as the reasons behind the use of the label, we must then analyse their content in order to determine their relative importance. This chapter begins by defining the term 'religious patient'. It then outlines the rights of the religious patient to religious liberty and to refuse medical treatment.

A *"Religious Patient"*

A "religious patient" is a religious person who is undergoing medical treatment, or would be undergoing medical treatment but for a refusal to

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[3] *The Shorter Oxford English Dictionary* (3 ed, Clarendon Press, Oxford, 1950) vol 1, 1831.

[4] As reported by Plato, in Plato *The Republic* (translated by G M A Grube) (Hackett Publishing Co, Indianapolis, 1973).

consent.[5] This definition of a religious patient begs the question "what does it mean to be 'religious'?" or, more precisely "what is a 'religion'?" This has proved a difficult question for the judiciary.

Generally, to be considered religious, one must have a particular system of faith and worship. But what qualifies as "a system of faith and worship"? In the Western world, it is said that characteristically, religious beliefs have a lot to do with matters such as the existence and one's relationship with a supreme being; one's relationship with other human beings and the environment; the nature of human existence; one's place in this world; where people go when their life on Earth is over and how they can get there.[6]

Religious beliefs typically make reference to basic limitations on human life. In an important sense, religion is about 'the meaning of life' in as far as it is to do with:[7]

(i) describing and explaining the human condition at its most fundamental level;
(ii) providing a person with a unique concept of personal identity; and
(iii) assisting people to make sense of themselves and the world that they live in.

However, there is a danger that choosing a substantive definition of the word religion along the lines set out in the above paragraphs will be too narrow. Any definition must strive to include unconventional religions within its ambit and must avoid any majoritarian bias. Thus, religious liberty calls for a wide reading of the word 'religion'. It would be suggestive of religious intolerance if religious liberty was denied to a group with

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[5] As the focus of this paper is the right of a patient to refuse medical treatment on religious grounds, I do not consider the rights of religious patients to manifest their beliefs in other ways. I do not discuss issues such as whether these patients have a right to meet with members of their church. These difficulties are beyond the scope of this paper.

[6] M J Wreen "Autonomy, Religious Values and Refusal of Lifesaving Medical Treatment" (1991) 17 Journal of Medical Ethics 124, 128.

[7] Above n 6.

unorthodox opinions on medical treatment by not defining that group as a religion.[8]

In the United States case of *State* v *Miskimens*,[9] the Ohio State Court held that a statutory provision which drew a distinction between conventional and unconventional religions was unconstitutional.[10] The provision that was called into question in the *Miskimens* case provided an exception to a parent's duty not to create a substantial risk to the health or safety of a child, where the parent treats the child's illness according to the tenets of a 'recognised' religious body. The court found that the provision was too vague to withstand constitutional scrutiny. Furthermore, it was held that by limiting the exception to the followers of *recognised* religions, the state became:[11]

> hopelessly involved... in questions that should not be the subject of governmental inquisition.

Thus, any definition of religion should be drafted widely, so that minority religions are protected to the same degree as established religions. In addition to this, the definition of religion should also be narrow enough to be meaningful. The attempts of the United States Supreme Court and the High Court of Australia to follow these guidelines might justifiably lead some to the conclusion that there is no substantive definition of religion which is not irreducibly subjective.

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[8] St John Robilliard *Religion and the Law* (Manchester, Manchester University Press, 1984) ix. See also *United States* v *Seeger* (1965) 380 US 163, 176; *Welsh* v *United States* (1970) 398 US 333, 339 and *Church of the New Faith* (1983) 57 ALJR 785, 789.

[9] (1984) 490 NE 2d 931, 933-938.

[10] The Ohio Rev Code Ann para 2929. 22 (A) Baldwin (1986) provided that "No person, who is the parent... of a child under eighteen... shall create a substantial risk to the health or safety of the child, by violating a duty of care... when the parent treats the... illness or defect of the child by spiritual means through prayer alone, in accordance with the tenets of a recognised religious body".

[11] Above n 9, 934. The decision of the court in *State* v *Miskimens* acknowledged that the determination of what is a recognised religion would excessively entangle church and state by requiring the courts to answer such questions as what is a recognised religion, by whom must it be recognised, what are its tenets and did the parent act in accordance with them? The *Miskimens* court followed a similar line of reasoning to that adopted by the United States Supreme Court in cases where the Supreme Court ruled that the courts should not inquire into the validity of religious beliefs: See *Lemon* v *Kurtzman* (1971) 403 US 602, 613 and *Walz* v *Tax Commission* (1970) 397 US 664, 674.

In *United States* v *Seeger*,[12] the Supreme Court said that religion includes:[13]

> [A] sincere and meaningful belief which occupies in the life of its possessor a place parallel to that filled by God...

The *Seeger* test for determining whether a sincere and meaningful belief is held is subjective. It simply involves an inquiry into:[14]

> whether the beliefs [of the person claiming to be religious] are sincerely held and whether they are, in his own scheme of things, religious.

The *Seeger* test was explained in *Welsh* v *United States*,[15] where a plurality of the court held that "his own scheme of things" indicated:[16]

> that the central consideration in determining whether ... beliefs are religious is whether these beliefs play the role of a religion and function as a religion in [the believer's] life.

The subjectivist-functionalist approach[17] espoused by the United States Supreme Court has not been followed in the High Court of Australia. In *Church of the New Faith*,[18] the court set out a two-part test to determine whether a person is religious. First, there is a requirement that a person must have a belief in a supernatural Being, Thing or Principle; and secondly, there must be acceptance of canons of conduct in order to give effect to that belief.[19]

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[12] Above n 8.

[13] Above n 12, 176.

[14] Above n 12, 185.

[15] (1970) 398 US 333.

[16] Above n 15, 339.

[17] I adopt the terminology used by Sadurski in W Sadurski "On Legal Definitions of Religion" (1989) 63 ALJ 835, 836.

[18] (1983) 57 ALJR 785, 791.

[19] The test that the High Court proposed in *Church of the New Faith* has been criticised for emphasis on the supernatural. Sadurski suggests that it is unclear whether this is an appropriate criterion for a group to be considered a religion and says that the "superficially innocuous demand that religions appeal to the

Arguably, neither the subjective formulation of the United States Supreme Court nor that of the High Court of Australia is sufficiently narrow to be meaningful and, at the same time, sufficiently broad to encompass minority religions. It may be concluded that it is impossible to define religion.[20] In this case, how do we decide to whom religious liberty is guaranteed? Sadurski concludes that a subjective definition of religion should not be spurned because both 'religious' and non-religious beliefs, if sincerely held by individuals as the motivating grounds of their actions, call for legal protection in a liberal and secular state.[21] Sadurski's compelling logic appears to be reflected in section 15 of the NZBORA, which grants equal protection to those who wish to manifest religious or non-religious beliefs,[22] so the distinction between religious and non-religious beliefs becomes to some extent academic.[23] For this reason, it does not seem necessary to unduly limit our definition of religion and, for the purpose of this paper, a wide (and therefore subjective) definition is proposed.

Notwithstanding the fact that a subjective definition of religion is to be used in this paper, important distinctions can still be made between the religious patient and either the suicidal or the voluntary euthanasia patient. People who intend to commit suicide, for whatever reason, have the direct object in mind of procuring their own death. The voluntary euthanasia patient may wish to die in order to stop suffering. But a fundamental difference exists in the case of the religious patient. Religious patients do not want to die. Their objection to medical treatment follows from a desire to adhere to

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supernatural may be under-inclusive and may leave some 'religions' outside the limits of judicial protection. But, at the same time, it may prove over-inclusive".

[20] This was the position that was argued by G C Freeman "The Misconceived Search for the Constitutional Definition of 'Religion'" (1983) 71 Georgetown LJ 1519.

[21] Sadurski, above n 17, 843. See also N L Cantor *Legal Frontiers of Death and Dying* (Indiana University Press, Bloomington and Indianapolis, 1987) 24: "Normally, religious scruples are not regarded as any more sancrosanct against government interference than any other philosophical or religious scruples".

[22] See below, text to n 29.

[23] Religious rights may have been accorded special significance because of the historical need not to confuse the church with the state and to ensure that religious diversity was acknowledged and accepted. This is evidenced in James Madison's plea that: "In a free government the security for civil rights must be the same as that for religious rights. It consists in the one case in the multiplicity of interests and in the other in the multiplicity of sects": Clinton Rossiter (ed) *The Federalist Papers* (Mentor, New York, 1961) Nos 10 and 51 (James Madison). The need to ensure the separation of church and state is no longer pressing and there may be no need to draw sharp distinctions between true religious beliefs and the disparate ways that people reasonably form their conscience.

the tenets of a particular religion; the desire to manifest their beliefs. Although this desire may cause death, the religious patient wants to live.[24] Both the suicidal patient and the voluntary euthanasia patient have a specific intention to die when they refuse medical treatment. The religious patient wants to live, and cannot be said to have this intention.[25]

In addition to this, the religious convictions of a patient might explain a decision which otherwise might seem irrational. Ordinarily, refusing medical treatment, where such refusal could threaten a person's life or health, could be considered to be a deprecation of life, where it is thought that there is no reason that motivates this action. Society can more easily appreciate that a person might have a reasonable cause to refuse medical treatment if this is based on the tenets of a particular religion, than if treatment is refused by a patient who believes that, for example, because the world is flat - treatment is unnecessary.

B *Religious Liberty*

Patients who refuse to submit to medical treatment on religious grounds may argue that this decision should be honoured because they have a right to religious liberty. While there is no right to freedom of religion or belief at common law,[26] religious liberty has long been recognised as a necessary freedom in a free and democratic society.[27] It comprises both the freedom to adopt and hold religious opinions[28] and the right to manifest one's religion. The second of these two rights encompasses the right to refuse medical treatment on religious grounds.

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[24] See *Malette* v *Shulman* (1990) 67 DLR (4th) 321, 332, where Robins J A made the same distinction. This decision is commented upon below, text to n 68.

[25] It could be said that the religious patient would rather die than not adhere to religious beliefs and that the patient intends to die for those beliefs, but this argument is not convincing. See Cantor, above n 21, 47.

[26] See *Grace Bible Church* v *Reedman* (1984) 54 ALR 571.

[27] The freedom to choose and practice a particular religion has been regarded as a fundamental inherent liberty which has been protected in other statutes, such as the Human Rights Commission Act 1993, which protects the freedom of religion by prohibiting discrimination based on religious belief in relation to, for example, employment.

[28] See s 13 of the NZBORA.

The right to act in accordance with one's religion is often postulated as a basic human right. Statutory recognition of this right can be found in section 15 of the NZBORA.[29] Section 15 of the NZBORA substantially tracks the wording of article 18(1) of the International Covenant on Civil and Political Rights ("the ICCPR").[30] New Zealand's commitment to the ICCPR is affirmed in part (b) of the Long Title to the NZBORA. Accordingly, the interpretation of the ICCPR is a useful extrinsic aid to the interpretation of section 15 of our Act.[31] Further, the legal presumption that Parliament does not intend to breach its obligations under international law also dictates that the ICCPR should be complied with, wherever this is possible.[32]

The constitutional right to manifest one's religion is a requirement that the state should be neutral about the outcomes pertaining to a person's individual choice of religion. However, religious liberty has never been considered to be an absolute value. For example, in the United States, laws which ban religious snake handling rituals are not considered to be

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[29] Section 15 of the NZBORA "Every person has the right to manifest that person's religion or belief in worship, observance, practice or teaching, either individually or in community with others, and either in public or in private". In addition to s 15, s 20 provides that: "A person who belongs to an ethnic, religious or linguistic minority in New Zealand shall not be denied the right, in community with other members of that minority, to enjoy the culture, to profess and practice the religion, or to use the language of that minority." This is not a right to practice religion, but the right of minorities not to be denied the ability to do so.

[30] Article 18 (1) of the ICCPR is set out as follows: "Every one has the freedom of thought, conscience and religion; this right includes freedom to change his religion or belief; and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance". Section 20 of the NZBORA also has an equivalent article in the ICCPR. Article 27 of the ICCPR provides that "In those States in which ethnic, religious or linguistic minorities exist, persons belonging to such minorities shall not be denied the right, in community with other members of their group, to enjoy their own culture, to profess and practice their own religion, or to use their language".

[31] The ICCPR is enforced through the mechanism of a reporting system, whereby each member country is periodically required to furnish a statement reporting on the implementation of the ICCPR by the government of that country. These reports are scrutinised by the Human Rights Committee. States may also bring complaints about other member states to the attention of the Human Rights Committee. In addition to this, the interpretation of the articles in the ICCPR are elucidated upon in the "General Comments" on particular provisions which are published from time to time by the Human Rights Committee.

[32] However, the Human Rights Committee have not made a General Comment about the application of art 18(1) or art 27, and cases brought to the attention of the Human Rights Committee under the Optional Protocol do not provide guidance as to the scope of the article's protection in relation to when a treatment refusal on religious grounds should be upheld. An analysis of virtually identical provisions in the European Covenant on Human Rights is similarly unhelpful.

unconstitutional violations of the right to manifest one's religion.[33] Moreover, in *Reynolds* v *United States*,[34] the Supreme Court asked itself the following rhetorical question:

> [I]f a wife religiously believed it was her duty to burn herself upon the funeral pile of her dead husband, would it be beyond the power of the civil government to prevent her carrying her belief into practice?

The neat point in relation to this paper, is the issue of whether refusals of medical treatment based on religious grounds may be overridden in a like manner. Can any analogy be drawn between the *Reynolds* situation and the religiously motivated treatment refusal that will probably lead to a patient's death?

C The Right to Refuse Medical Treatment

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body...[35]

The principles of bodily integrity and self determination are well established at common law, evidence of which can be seen in the classic statement of Justice Cardozo quoted above.[36] These principles are said to enable a patient to refuse medical treatment. The general proposition that medical treatment may be declined by a patient is recognised in section 11 of the NZBORA,

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[33] See *Lawson* v *Commonwealth* (1942) 164 SW 2d 972, 974.

[34] (1878) 98 US 145, 166. But, see *Morrison* v *State* (1952) 252 SW 2d 97, 103: "[A] religious zealot may have the right to fast until death".

[35] *Schloendorff* v *Society of New York Hospital* (1914) 211 NY 125, 105 NE 92, 93 per Cardozo J. In this case it was decided that operating to remove a tumour after a patient had specifically forbidden surgery was an 'assault'.

[36] See also *Natanson* v *Kline* (1960) 350 2d 1093, 1094 and *Sidaway* v *Bethlem Royal Hospital Governors* [1985] 1 All ER 643, 666. In the New Zealand case of *Smith* v *Auckland Area Health Board* [1965] NZLR 191, 219, T A Gresson J stated in dictum that: "An individual patient must... always retain the right to decline operative investigation or treatment however unreasonable or foolish this may appear in the eyes of his medical advisers".

which provides that: "Everyone has the right to refuse to undergo medical treatment".[37]

The right of the individual to choose what should be done with one's body is embodied in the doctrine of informed consent. The law relating to informed consent in New Zealand is complex and difficult.[38] Basically, informed consent requires that patients are allowed to make their own decisions about whether or not to undergo medical treatment.

A patient's consent is not always required before medical treatment can proceed. There are two principle exceptions to the requirement that consent be obtained before any medical treatment can be performed. These are, first, where there is a statutory exception to consent;[39] and secondly, where an emergency situation arises. In the latter case, medical treatment may be justified on three possible grounds: the common law principle of necessity,[40] implied consent[41] or agency.[42]

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[37] Section 11 of the NZBORA has no equivalent in any human rights instrument. It has been suggested that this provision only permits individuals to be treated against their will where this is necessary to protect the health and safety of others: *A Bill of Rights for New Zealand: A White Paper* [1985] AJHR A6, 109. The White Paper also suggests that "medical treatment" should be interpreted in a comprehensive sense. It is likely that the courts will interpret this phrase widely. The courts have shown that they will give a purposive reading to the NZBORA: See *Flickinger* v *Crown Colony of Hong Kong* [1991] 1 NZLR 439 and *R* v *Accused 227/91* (1991) 7 CRNZ 401. A purposive reading is consistent with Temm J's suggestion in *Cairns* v *James* [1992] NZFLR 353, 355, that a blood test might amount to medical treatment and the decision in *Re H* [1993] NZFLR 225, 241, where Judge Inglis QC held that the sterilisation of a mentally handicapped woman was medical treatment, despite the fact that neither a blood test nor a sterilisation operation could be classed as therapeutic or curative treatment. Compare D B Collins *Medical Law in New Zealand* (Brooker & Friend, Wellington, 1992) 117, who has suggested that, on one reading, diagnostic or preventative 'treatment' may not be medical treatment.

[38] For this reason, this paper does not purport to be an exhaustive exposition of this area of law. Instead, this section will outline the basic requirements of informed consent as they are relevant to this paper.

[39] For example, section 126B of the Health Act 1956. This provision is considered below, text to n 132.

[40] See *Marshall* v *Curry* (1933) 3 DLR (4th) 260 and *F* v *West Berkshire Health Authority* [1989] 2 All ER 545. The application of this doctrine is uncertain in New Zealand. See Collins, above n 37, 69.

[41] Consent may be implied from the surrounding circumstances or from a patient's prior comments. Implied consent could never adequately explain a failure to honour a treatment refusal on religious grounds, as there the circumstances or comments made by the patient would never warrant such a finding.

[42] There is limited authority which suggests that consent to medical treatment is not required if the doctor is acting as the agent of a patient. This is not a widely recognised concept. See *Bennan* v *Parsonett* (1912) 83 NJ Law; cf *Marshall* v *Curry*, above n 40.

Where informed consent is required, this will usually involve the patient's doctor explaining the nature of the proposed treatment and the known risks that are inherent in the procedure:[43]

> Medical consent means a voluntary uncoerced decision made by a legally competent or autonomous person on the basis of adequate information and discussion. This contrasts with the rejection of a proposed course of action, in short, it is a choice.

Informed consent implies that there must be a respectful and broadly rational dialogue between doctor and patient.[44] Treatment decisions must be consensual, rather than imposed on a patient. The patient's role is participatory, not passive. Thus, doctors should not let their own values influence a patient's treatment decision to the extent that effective deliberation is conflated with reaching a decision acceptable to the doctor.

The requirement that there be informed consent to medical decisions does not simply require an analysis of whether sufficient[45] information has been disclosed by the doctor to the patient. In order for consent to be judged as 'informed', patients must be competent to comprehend the information provided to them, must also understand that information and then must arrive at a voluntary decision.[46]

The prerequisite of competence is a legal presumption. Precisely how competency is analysed is uncertain, but there are no grounds for assuming that a patient is incompetent just because their decision to refuse treatment seems irrational. Competency must be assessed independently of the decision reached by a patient and the reasons for that decision. However, if a patient does not have the capacity to render a decision, then informed consent cannot be given.[47]

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[43] See Medical Council of New Zealand *Statement for the Medical Profession on Information and Consent* (June 1990) 20. See also Collins, above n 37, 65.

[44] See A Campbell, G Gillett & G Jones *Practical Medical Ethics* (Oxford University Press, Auckland, 1992) 21-23.

[45] There is no legal definition of "sufficient" information.

[46] V Dharmananda *Informed Consent to Medical Treatment: Processes, Practices and Beliefs* (Law Reform Commission of Western Australia, 1992) 9.

[47] However, a finding that a religious patient is incompetent must not follow from a perception that the decision that patient renders is silly or illogical. See below, text to n 62.

cf PPPkA

If a patient is competent, it is assumed that when provided with information, it will be understood. But if patients do not understand the information they are given, then consent cannot be considered to be informed. If the requisites of information, competency and understanding have been satisfied, then a patient's decision to consent or refuse to submit to medical treatment can be called informed, unless the patient has been coerced or pressured into arriving at a particular decision.[48]

A question which arises out of this analysis of informed consent is how informed must a patient who wishes to refuse consent to medical treatment be in order for that decision to be upheld? In practice, the medical profession follows the same procedures for all patients. If a patient is able to make a treatment decision, then this will be explored as fully as possible with that patient. In ordinary circumstances, this will involve an explanation of the procedures involved and of the consequences of the proposed treatment in order that the patient is made fully aware of the likely outcomes. This reflects the fact that consenting and refusing are flipsides of the same medical decision. The best answer to this question appears to require the application of the same standard to both consents and refusals.

But the position becomes complicated when a patient is not competent to make treatment decisions, by reason of incapacity. In these situations, it has been noted that informed consent is not always required. Similarly, informed refusal need not always be required before a patient should be able to refuse medical treatment. For example, where a patient has made a prior directive in unequivocal language,[49] the requirement that that patient must be informed about the consequences of this refusal is redundant. If this requirement were insisted upon, it would provide an unnecessary barrier to patient autonomy.[50]

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A medical practitioner who fails to honour a patient's decision to refuse medical treatment by undertaking an examination against a person's will, and a surgeon who performs an operation or part of an operation, in spite of the refusal, may each have actions brought against them in court and be subject to medical disciplinary proceedings.

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[48] See below, text to n 63.

[49] As in *Malette*, above n 24.

[50] See below, text to n 68.

A civil suit for assault and battery may be commenced against a doctor who fails to respect a treatment refusal. The significance of these remedies is diminished in New Zealand by virtue of the application of the Accident Rehabilitation Compensation and Insurance Act 1992 ("the ARCI Act"). The commencement of any action for compensatory damages is precluded where cover is provided in the Act.[51] Nevertheless, there is some scope for obtaining a remedy outside the ARCI Act, as a failure by a doctor to obtain a patient's informed consent to treatment will only be medical misadventure, if that failure is caused by negligence.[52] But where the statutory bar applies, the courts will only entertain a claim for exemplary damages for assault or battery and possibly also for negligence or breach of fiduciary duty.[53]

What about
informed
refusal?

It is possible that criminal proceedings may be commenced for assault[54] or unlawfully injuring a person,[55] but it is noted by Collins that criminal actions are unlikely to be commenced unless a member of the profession abuses his or her position to such an extent that it becomes necessary to invoke the criminal law.[56]

Disciplinary proceedings may be invoked against a doctor who fails to honour a treatment refusal. Medical disciplinary proceedings in New Zealand are largely self-regulated by the medical profession. Section 40 of the Medical Practitioners Act 1968 establishes a Medical Practitioners Disciplinary Committee to investigate complaints of medical misconduct that are directed against medical practitioners.[57] This disciplinary Committee is charged with protecting the public through the identification of deficient practitioners.

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[51] See s 14 of the ARCI Act.

[52] See s 5(6) of the ARCI Act.

[53] Collins, above n 37, 179-182.

[54] Section 196, Crimes Act 1961.

[55] Section 190, Crimes Act 1961.

[56] Collins, above n 37, 67.

[57] There are three different categories of medical misconduct. These are, in ascending order of seriousness, "conduct unbecoming of a medical practitioner", "professional misconduct" and "disgraceful conduct". Professional misconduct is determined objectively, by referring to the practice of a doctor's peers: See *Ongley* v *Medical Council of New Zealand* (1984) 4 NZAR 369, 375.

III THE ADULT RELIGIOUS PATIENT

The preceding chapter outlined the prima facie rights that religious patients have to manifest their beliefs and to refuse medical treatment. This chapter considers the scope of these rights as they have been defined by the courts and the legislature. It discusses the exercise of a competent patient's rights and the exercise of an 'incompetent' patient's rights. The question of whether and to what extent incapacitated patients can refuse treatment or have someone else take action for them often arises in the context of an emergency, where the capacity of patients to make treatment decisions is temporarily lost or reduced. Both the emergency and the non emergency situations are discussed below.

A The Competent Patient

While the New Zealand courts have not had the opportunity to comment on the right of an adult patient to refuse consent to medical treatment on religious grounds, the English Court of Appeal recently had occasion to do just that in the case of *Re T*.[58]

The slightly unusual facts of *Re T* are as follows. Miss T was admitted to hospital after being injured in a car accident when she was 34 weeks pregnant. The possibility that she might require a blood transfusion arose, and after discussing this with her mother, she indicated that she would not consent to this procedure. She said that this was because she used to be a Jehovah's Witness and still maintained some of their beliefs. There was some suggestion that this refusal may have been the result of undue influence by her mother, a staunch Jehovah's Witness.[59]

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[58] [1992] 4 All ER 649.

[59] Above n 58, 655 per Lord Donaldson MR: "For some time before 5 pm her mother was alone with Miss T. What passed between them I do not know because Miss T has never been able to say and the mother, although a party to the proceedings, has not seen fit to give evidence. At 5 pm a staff nurse joined Miss T and her mother and Miss T told the staff nurse that she did not want a blood transfusion... The staff nurse said she had thought it strange that this statement should have been volunteered out of the blue moments after her mother had arrived. However, she thought that at that stage Miss T was able to understand what was going on".

Due to her distressed condition, T went into early labour and it was decided that her delivery should be by caesarean section. T blindly signed a form refusing consent to medical treatment. It was not explained to her that a blood transfusion might be necessary to save her life. After the caesarean operation, her condition worsened to the extent that a blood transfusion would "unhesitatingly" have been administered but for T's express refusal.

T's father and boyfriend applied to the court for assistance. The judge in an emergency hearing authorised the administration of the blood transfusion and declared that it would not be unlawful for the hospital to transfuse T despite absence of consent, because the transfusion was manifestly in her best interests. At a second hearing the judge held that T had neither consented nor refused medical treatment in the emergency which had arisen. Thus, the administration of the blood transfusion was not unlawful. T appealed from this decision and the appeal was dismissed.

The Court of Appeal held that the principle of bodily integrity prima facie gives a patient the right to refuse medical treatment on religious grounds, even where this may lead to premature death or permanent damage to one's health.[60] Butler-Sloss L J cited with approval the reasoning of the Ontario Court of Appeal in *Malette* v *Shulman*,[61] where Robins J A said:

> At issue here is the freedom of the patient as an individual to exercise her right to refuse treatment and accept the consequences of her own decision. Competent adults, as I have sought to demonstrate, are generally at liberty to refuse medical treatment even at the risk of death. The right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based. Free individual choice in matters affecting this right should in my opinion, be accorded very high priority.

However, in the opinion of the court, this right can only be exercised when a patient has the *capacity* to make such a decision. Aside from those who permanently lack capacity to make decisions, a lack of capacity may result from a patient's decision being overborne by another or from temporary circumstances such as unconsciousness, shock, confusion or delusion.[62]

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[60] See *Sidaway*, above n 36, 666.

[61] Above n 24.

[62] See A Pavlo, H Burstajn & T Gutheil "Christian Science and Competence to Make Treatment Choices: Clinical Challenges in Assessing Values" (1987) 10 International

From both the legal and clinical perspective, deciding whether a patient is competent to refuse medical treatment is a difficult determination. Lord Donaldson stated that careful and detailed consideration had to be given to the question of capacity and articulated the following test which he thought should be applied:[63]

> What matters is that the doctor should consider whether at that time he had a capacity which was commensurate with the gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required.

Thus, if a patient's decision making capacity is thought to be reduced because of the effects of severe fatigue or shock, then that patient's decision to refuse lifesaving medical treatment need not be honoured in a life threatening situation. However, this analysis of capacity is problematic. If a patient cannot fully comprehend the nature and consequences of refusing treatment where this might cause death or severe damage to health, should it be assumed that the patient is still sufficiently lucid to refuse treatment where the consequences are not so dire? This could result in confusing the patient's *ability* to make a decision with the *consequences* that follow from it.

If it is decided that a patient is competent to make a treatment decision, it must then be decided whether the treatment decision that the patient arrives at is voluntary. The decision of a patient may be set aside if it has been unduly influenced. Where the decision of a patient is said to be vitiated by undue influence, the question which Lord Donaldson said must be addressed by the courts is:[64]

> Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself? In other words, is it a decision expressed in form only, not in reality?

Journal of Law and Psychiatry 395. If a patient's choice of religion occurs while deluded, then that patient's choice to refuse medical treatment on religious grounds might not be competent.

[63] Above n 58, 661.

[64] Above n 58, 661.

As to the question of whether undue influence had vitiated the consent of Miss T, Lord Donaldson found that the mother had so sapped T's will that it had destroyed her volition. His Lordship noted that the degree of persuasion required to turn persuasion and appeals to affection into undue influence may be very little. As Hannen P said in *Wingrove* v *Wingrove*,[65] a case which was cited with approval by Butler-Sloss L J:

> The coercion may of course be of different kinds, it may be in the grossest form, such as actual confinement or violence, or a person in the last two days or hours of life may have become so weak and feeble that a very little pressure will be sufficient to bring about the desired result, and it may even be that the mere talking to him at that stage of illness and pressing something upon him may so fatigue the brain, that the sick person may be induced, for quietness' sake, to do anything. This would equally be coercion, though not actual violence.

An analysis of the decision in *Re T* shows that the courts and the medical profession can restrict the right of a patient to refuse medical treatment on religious grounds in two ways. A challenge may be made to either a patient's competence or the voluntariness of the decision made. It is hoped that these methods of disposing with a religious patient's rights is resorted to in appropriate cases, rather than as ex post facto justifications for overriding what could be classed as an irrational decision by doctors or the courts.[66]

B The 'Incompetent' Patient

When patients become incapable of making their own decisions about whether or not to consent to medical treatment, they should not lose their common law and constitutional rights simply because of their state of incompetence. Traditionally, the patient's family or doctor is turned to to render this decision for an incompetent patient. But turning to these people involves a danger that the patient's own wishes will be ignored. In the United States, Canada and Australia, legislation has been passed to allow

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[65] (1886) 11 PD 81, 82-83.

[66] In *Re W* [1992] 4 All ER 627, 637, Lord Donaldson admitted that he personally considers religious beliefs which bar any medical treatment or treatment of particular kinds to be "irrational".

competent persons to make advance directives concerning medical treatment.[67] These advance directives are intended to influence care should the maker of the directive become incompetent. Advance directives may be of two types: the instruction directive or the proxy directive.

This section of the paper considers the effect of incapacity on a patient's rights. It discusses the power of patients to refuse medical treatment on religious grounds after they become incapacitated and the power of surrogates to refuse treatment on behalf of a religious patient.

1 *The instruction directive*

It has been shown in the preceding part of this paper that competent patients are generally able to exercise their rights to medical self-determination and to manifest their religious beliefs. The danger that these rights may be overridden in the event of incompetence may be guarded against if a patient has made an instruction directive. This instruction directive would dictate the course of medical treatment to be followed when a patient cannot expressly make this known to doctors. The ability of a patient to follow this course of action at common law was recognised in *Malette* v *Shulman*.[68] The *Malette* case considered the right of an unconscious Jehovah's Witness to refuse medical treatment by carrying a card which purported to refuse of all blood transfusions. Mrs Malette suffered serious injuries in a car accident. After she was taken to hospital, she was attended by Dr Shulman, whose initial examination showed that treatment might require blood transfusions. After this examination, a nurse found a card, signed by Mrs Malette, which read:

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[67] These are known as 'Natural Death' or 'Living Will' statutes. 35 states in the United States have enacted provisions for patients to make prior binding instructions regarding medical procedures to be omitted where the patient is extremely debilitated. These statutes have more symbolic than actual value for two reasons. First, these laws usually require that a patient have a prognosis of imminent death before life preserving medical treatment may be refused and secondly, people are not normally oriented toward providing for advance directives, which limits the usefulness of a law that provides for their validity. The requirement that a patient must be terminal before an instruction directive refusing life preserving medical treatment will be honoured is open to criticism. It is submitted that a young, generally healthy person should have the same right to refuse treatment as an elderly terminal patient.

[68] Above n 24.

> NO BLOOD TRANSFUSION!
>
> As one of Jehovah's Witnesses with firm religious convictions, I request that no blood or blood products be administered to me under any circumstances. I fully realise the implications of this position but I have resolutely decided to obey the Bible command: "Keep abstaining... from blood." (Acts 15:28, 29). However, I have no objection to use the non-blood alternatives, such as Dextran, Haemaccel, PVP, Ringer's Lactate or saline solution.

The doctor was advised of the existence and contents of the card, but administered blood transfusions to Mrs Malette in spite of this knowledge. Mrs Malette made a full recovery and then sued Dr Shulman for battery. She was awarded $20,000 in damages by the Ontario High Court of Justice. Dr Shulman appealed this judgment and Mrs Malette cross-appealed for the costs of the action.

In the Ontario Court of Appeal, Robins J A upheld the decision of the lower court. The decision was premised upon the patient's first instance right to self determination which he said "obviously encompasses the right to refuse medical treatment".[69] This was not postulated to be an absolute right; it was noted by Robins J A that it could give way in an emergency situation.[70] Mrs Malette's predicament could be classified as an emergency situation. However, Mrs Malette had anticipated this kind of situation and had given express instructions that in this event, she should not be given a blood transfusion. Because of the card which she carried, a valid restriction was imposed upon the doctor's ability to treat Mrs Malette's injuries, despite the emergency circumstances.

The treatment refusal made by Mrs Malette was upheld by the Ontario Court of Appeal because it was said to be an unequivocal refusal of all blood transfusions. Robins J A rejected the contention that a refusal should always

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[69] Above n 24, 328. Also on that page his honour commented that: "The doctrine of informed consent is plainly intended to ensure the freedom of individuals to make choices concerning their medical care. For this freedom to be meaningful, people must have the right to make choices that accord with their own values regardless of how unwise or foolish those choices may appear to others".

[70] Two bases were articulated for the dispensing of the consent requirement in such a situation. These are 'implied consent' and the principle of necessity. The latter of these bases was recognised as the more usual justification. Robins J A indicated disapproval of reliance upon 'implied consent' as a basis for justifying a lack of consent.

be informed before it can be effective. His honour said that a doctor has no duty to advise a patient of the risks associated with a refusal of treatment. He reasoned that if this were the case, "Mrs Malette's religiously motivated instructions prepared in contemplation of an emergency, directing that she not be given blood transfusions in any circumstances were of no force or effect and could be ignored with impunity".[71]

This does not mean that directions made by a patient prior to becoming incapacitated will always be honoured. In *Re T*,[72] Lord Donaldson opined that the scope and basis of a treatment refusal should be considered before a refusal can be honoured.[73] The articulation of this scope and basis requirement may have been motivated his Lordship's concerns about the proximity and specificity of instruction directives. These directives cannot usually provide guidance in every possible situation and they do not typically take into account how a person's values may change with time.

Where a patient is competent, the scope and basis requirement simply requires asking that patient if treatment is still to be rejected.[74] But where a once competent patient refuses treatment before becoming incapacitated, it must be considered whether the patient's decision is intended to operate in the changed circumstances. Lord Donaldson set out a general requirement that the patient must know "the nature and effect of the procedure for which consent (or refusal) was given".[75] This requirement appears to create a duty to give patients appropriately full information as to:

(i) the nature of the treatment which is proposed; and
(ii) the likely risks, including any special risks attaching to the treatment being administered by particular persons.

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[71] Above n 24, 331.
[72] Above n 61.
[73] Above n 61, 662.
[74] Above n 61, 662. Lord Donaldson said that a doctor could still attempt to get the patient to consent to treatment at this stage, notwithstanding the prior refusal.
[75] Above n 61, 663.

If a doctor fails to adequately inform a patient, this does not necessarily vitiate consent or refusal, but may entitle a patient to bring an action in negligence based on a breach of duty.[76]

In the *Malette* case, a written instruction directive was made representing Mrs Malette's desire not to be transfused. Had this directive been made orally, there would have been a further hurdle to jump before Mrs Malette's wishes could be honoured. The degree of informality of an oral expression has to be considered before it can be said that an oral instruction is intended to take effect. In cases of doubt, it seems understandable that the profession and the courts should err on the side of life and good medical practice. Thus, the evidence required to prove the earnestness of an oral expression must be more than the ordinary civil standard. It is suggested that something between this and the balance of probabilities test required in a criminal action would be appropriate, so as not to rule out the possibility of honouring an oral directive where the circumstances warrant this. The United States requirement of "clear and convincing" evidence merits serious consideration in this context.[77]

Although it is clear that a written instruction directive is more likely to be honoured than an oral expression of a patient's wishes, it is difficult to reconcile the scope and basis requirement in *Re T* with *Malette* v *Shulman*. The court in *Re T* clearly intended to articulate a requirement that doctors ascertain the scope and basis of a treatment refusal in *Re T*. It was suggested that, wherever possible, a patient must know the nature and effect of the refusal of treatment. Therefore, *Malette* v *Shulman* must categorised as an exception to the information requirement in *Re T*. Because the *Malette* case involved an unconditional refusal of treatment it is presumed that the court in *Re T* did not think that any consideration of scope was necessary.

Does this make sense for incompet. patient?

However, if, as was suggested by the court in *Re T*, a doctor can intervene and treat a patient when she has reason to believe that a prior refusal was

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[76] Although his honour noted that misinformation *might* vitiate consent or refusal. See above n 61, 663.

[77] In the case of *In Re Storar* (1981) 420 NE 2d 64, 68, clear and convincing evidence of oral instructions was required. This requirement was satisfied by evidence which showed that formal discussions about a terminal patient's right to die. This can be contrasted with the informality of Karen Quinlan's casual remarks on the same subject, which she made at a social gathering. See *In Re Quinlan* (1976) 355 A 2d 647. See also below, text to n 94.

not fixed and unalterable,[78] this challenges the court's acceptance of Mrs Malette's refusal as unequivocal. Indeed it is open to question whether any prior decision of a patient will ever be fixed and unalterable. In addition to this, as is often the case with legal tests, it is a lack of clarity at the periphery of its application which causes the scope and basis requirement its greatest problems.

While upholding the *Malette* decision may limit doctors from administering medical treatment wherever a patient makes an instruction directive to the effect that 'all' medical treatment should be refused, it is still possible to suggest that other refusals may be intended to have a more limited scope.[79] In all but the most clear cases then, a doctor could treat a patient if satisfied that the patient's predicament was not anticipated when treatment was initially refused.[80] This may be an unintended result of *Re T*.

It is suggested that patients who genuinely wish to make instruction directives that reflect their religious beliefs relating to medical treatment should be careful to phrase any treatment refusals in clear and unconditional language. This will help to ensure that the directive withstands the scrutiny of an analysis of its scope and basis. If an unconditional refusal of medical treatment is not desired, then it would be beneficial for a patient to set out preferred treatment options which would operate in several different scenarios of incapacity.

2 *The surrogate decision*

adult

Under current law, it is not always clear who has authority to step in and make treatment choices for an incapacitated patient. Traditionally, where a patient has not made a proxy directive appointing a surrogate, a patient's family or doctor will approve or disapprove a course of treatment when the patient can no longer do this. But this assignment of decision making power creates the risk that the patient's own wishes will be ignored. This section

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[78] See C Bridge "Refusal of Medical Treatment on Religious Grounds" [1992] NZLJ 341, 343.

[79] For example, it may have been limited to situations where there were other alternatives, or where the refusal was not likely to be life threatening.

[80] Above n 78.

considers the appointment of a surrogate and the surrogate decision making process.

(a) Appointment

In New Zealand law, there is some scope for a patient to appoint a proxy decision maker who may make decisions concerning that patient's care and welfare in the event of mental incapacity. Although at common law, a proxy directive is unlikely to be upheld,[81] statutory provision is made for the creation of enduring power of attorney under the Protection of Personal and Property Rights Act 1988 ("the PPPRA"). Sections 95 and 98 of that Act set out the mechanisms by which a proxy may be appointed.[82]

The power of a proxy decision maker to refuse medical treatment on behalf of an incapacitated person is circumscribed by section 18(1)(c) of the PPPRA. According to that provision, the proxy decision maker is not empowered to refuse consent to any standard medical treatment or procedure intended to save the incapacitated person's life or to prevent serious damage to that person's health. Accordingly, if the patient's prognosis is death without some standard medical treatment,[83] then the proxy has no power to refuse this treatment, even though that decision might represent the wishes of the patient. Where the patient's prognosis is not quite so grim, the proxy may be able to refuse treatment.

The limitation on the proxy's ability to make decisions in the PPPRA may reflect a concern for the proxy decision maker. The burden or a life and death decision is an enormous responsibility. In addition to this, the proxy may not have discussed a range of care preferences with the patient or may

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[81] At common law, the appointment of a proxy is regulated through the laws of agency. According to the rules of agency, when the principal becomes incapacitated, the contract of agency is terminated and the agent no longer has any mandate to act on the principal's behalf. But see M Fowler "Appointing A Medical Agent to Make Treatment Decisions" (1984) 84 Columbia Law Review 985, 1012.

[82] Section 95 of the PPPRA sets out the prerequisites that must be complied with if a power of attorney is to be an enduring power of attorney. Section 98 provides that a person may create an enduring power of attorney in relation to personal care and welfare which will operate in the event of the donor's incapacity

[83] It is submitted that the courts would treat a blood transfusion as "standard medical treatment".

disagree with the patient's wishes. The law may reflect a concern that, in these situations, there is scope for the proxy to undermine the patient's wishes.

However, the state of the law relating to proxy decision making under the PPPRA is unsatisfactory. It is submitted that a proxy should be able to make all the treatment decisions that the patient, if competent, could have. Concern about the burden on the proxy should not be overstated. Simply because a decision is difficult does not mean a proxy should be denied the ability to make it. Furthermore, it is not appropriate to curtail the powers of a proxy because of a concern that a biased decision might be made. This concern will be addressed in the next parts of this paper. If the surrogate must base a treatment decision on the patient's wishes, and consultation is ordinarily required before this decision is implemented, then the possibility of bias is reduced.

If a patient has not given any prior instructions relating to treatment preferences or the appointment of a proxy, then the family of that patient will typically be consulted and asked to perform the function of a surrogate. The legal basis of this deference to the family is unclear, although the practice appears to have been sanctioned by silent acquiescence on the part of the courts and the legislature.[84] While there is no explicit endorsement of the process of looking to a patient's next of kin to provide surrogate decisions, it is presumed that the patient's family will have the patient's welfare at heart and will be best placed to know her wishes.

why

Usually turning to family members means that there will be discussion and consensus between the patient's family and a decision will be made in the patient's best interests or according to the patient's wishes. This will not always be the case. Moreover, next of kin may not be motivated by concern for the patient or may be too distraught to render a treatment decision for an incapacitated patient. Screening next of kin for suitability in court would be both an expensive and time consuming process and it is submitted that it

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[84] The practice may amount to nothing more than medical courtesy. If this is the case, then a large percentage of operations are performed without technically valid consent. See above n 81, 994.

would be excessive to require prior approval of family members as surrogates.[85]

In addition to this,[86] a decision to appoint a surrogate may be made by the courts using one of three methods. First, the court may make an order appointing a welfare guardian under section 12 of the PPPRA. A welfare guardian is empowered to act as an incapacitated patient's surrogate. But the powers of the welfare guardian under the PPPRA is also subject to the operation of section 18(1)(c). For this reason, the powers of a welfare guardian as derived under the PPPRA are, like the powers of a proxy appointed under this Act, closely circumscribed.

In addition to the court's power to appoint a welfare guardian under this Act, it may also make an order in relation to medical treatment under section 10(f) or 10(g). Those provisions allow the court to make the following orders:

> (f) An order that the person be provided with medical advice or treatment of a kind specified in the order:
>
> (g) An order that the person be provided with educational, rehabilitative, therapeutic or other services of a kind specified in the order:

These provisions appear to dictate that such orders can only be made in respect of *providing* medical treatment. However, in the absence of judicial enlightenment regarding the interpretation of these provisions, it may be possible for the court to read them widely so as to enable orders to be made which refuse, rather than provide, medical treatment. If this is the case, then the application of the PPPRA dictates that two primary objectives must govern the decision of a court to grant an order under section 8 of the Act. Section 8(a) provides that the court must make the least restrictive intervention possible in the life of the patient. In addition to section 8(a), section 8(b) must also govern the court's decision. Section 8(b) provides that a decision must enable or encourage the patient to exercise and develop capacity to the greatest possible extent. These provisions appear to dictate

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[85] Above n 81, 995. This may prolong the suffering of the patient and aggravate the distress of the family.

[86] Or when disagreement occurs among family members.

that decisions made by the courts under the PPPRA should be patient oriented.

The final method by which the court may appoint a surrogate decision maker is in the exercise of its inherent jurisdiction as *parens patriae* to give or withhold consent to medical treatment.[87] In the exercise of this jurisdiction, the court has the power to refuse medical treatment on behalf of the patient, even where this would be life threatening.

Brief

Where a patient has not appointed a medical agent, it is submitted that the appointment of a surrogate should be governed by the operation of professional standards. The use of the courts to screen surrogates for suitability and bona fides would be cumbersome and inefficient, particularly where time is of the essence. In this situation, professional guidelines should dictate that a patient's family ought to be used as a surrogate in most cases,[88] unless the patient's doctor believes that family circumstances dictate that this is not the best course of action. For example, difficulty may occur where the family of the religious patient does not share that patient's convictions. In that situation, it may be appropriate that a surrogate who understands the religious patient's treatment convictions and is willing to effect the patient's wishes ought to be appointed.

Where considerations of time are not as pressing, a decision not to appoint a family member as a surrogate should be subject to the approval of an ethics committee. Ethics committees may be better qualified to make recommendations about the suitability of a surrogate in the event of difficulty than the courts if these bodies are representative and accessible. Further, the more informal nature of ethics committee hearings may be a more appropriate way of dealing with any problems involving the appointment of a surrogate. A court hearing will often be an insensitive way of dealing with the family of an incapacitated person.

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[87] See s 17 of the Judicature Act 1908.

[88] In the absence of evidence of a patient's wishes, it is reasonable to infer that the patient's relatives will have a better idea of what the patient would consider to be benefits or burdens than a medical practitioner, whose ideas about the patient's best interests may be dominated by a desire to treat the patient. This is particularly so in the case of a Maori or Pacific Island family, where important decisions are commonly discussed within the family as opposed to made in isolation from this support.

It will not always be possible to seek approval from an ethics committee for every surrogate's appointment. Wherever this is practicable, it is desirable that approval for a decision *not* to appoint a family member as a surrogate be obtained. Where it appears that there is no one available to act as a patient's surrogate, it is submitted that an ethics committee should be able to make a determination relating to the treatment of that patient.

(b) The basis of the surrogate's decision

Once a surrogate has been appointed for a particular patient, it must then be asked whether the surrogate lawfully exercised the decision making power which is granted to the surrogate by virtue of this appointment.[89] United States jurisprudence may be instructive in relation to an analysis of the lawfulness of a surrogate's decision to refuse treatment. There are two main schools of thought regarding the manner in which a surrogate's decision should be exercised. The first is the 'substituted judgment' approach[90] and the second is the 'best interests' approach.[91]

The substituted judgment approach aims to mirror the patient's decision. Where it is clear that the patient would have refused medical treatment if he were competent to make this choice, then the decision of the surrogate should accord with these wishes.[92] Clear and convincing evidence of the patient's wishes may be required before a substituted judgment may be made.[93]

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[89] The New Zealand Bill of Rights Act does not apply to the exercise of a surrogate's discretion: See s 3 which provides that only state action is caught by the operation of the Act.

[90] See *In re Conroy* (1985) 486 A 2d 1209 and *In re Quinlan* above n 78.

[91] See *In re F* [1990] 2 AC 1 and *Airedale NHS Trust Board* v *Bland* [1993] 2 WLR 316, 370, 385, and 398. See also s 18(3) of the PPPRA.

[92] The substituted judgment approach has been curiously described as including an implicit "thank you test", whereby a patient, when again competent would agree with the decision of the surrogate and thank that person for making it: See A A Stone "The right to refuse treatment and the Psychiatric Establishment" (1974) 4 Psychiatric Annals 22.

[93] See *Cruzan* v *Director of Missouri Department of Health* (1990) 110 S Ct 2841, *In re Storar*, above n 78; and *Eichner* v *Dillon* (1981) 420 NE 2d 64; cf *In re Quinlan*, above n 77, where evidence other than the patient's wishes was considered.

Substituted judgment can be exercised only upon the basis that the decision reached by the surrogate is fully informed. The surrogate has to reach a decision that can truly be said to represent what the patient would have chosen. The evidence required to prove that a decision is informed will vary according to the facts of each case. In *Eichner* v *Dillon*,[94] it was suggested that clear and convincing proof of a patient's wishes *could* be established by pointing to the tenets of the religion to which the patient belongs. Or alternatively, an advance directive made either orally or in writing. This general statement must be subject to limitations. For example, pointing to the tenets of a particular religion to which a patient belongs will be insufficient without evidence of how these tenets have been internalised by the patient. The clear and convincing evidence standard is a more stringent standard of proof than the balance of probabilities test ordinarily required by the court. The advantage of using this higher standard of proof is that it balances the patient's probable wishes against the danger of upholding a treatment refusal which was not made after careful consideration or may not represent the patient's wishes anymore.

Doubt about the application of the substituted judgment approach in the life or death situation has been voiced by commentators.[95] It has been argued that when a treatment refusal would result in a patient's death, the patient alone should be able to refuse treatment, and then perhaps only if he is competent at the time the treatment is contemplated. The more extreme version of this view would hold that where someone is unable or not fully competent to decide for himself at the time medical treatment is needed, medical professionals should decide in favour of life-saving treatment. This result would follow regardless of the treatment choice a person would have made prior to an emergency and regardless of what relatives may claim. The rationale behind this approach is the suggestion that it is wrong for others to act in a manner that will probably lead to the death of a patient. In this case, we can see that patient autonomy is equated with 'making the right decision' for the patient, rather than making the decision the patient would have made herself. With respect, the danger of this approach is to compromise the surrogate's power of decision making to the extent that difficult decisions are taken out of that person's hands. This undermines the patient's wishes and religious convictions to an unacceptable degree.

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[94] *Eichner*, above n 92, 72.

[95] See K F Hegland "Unauthorised Rendition of Lifesaving Medical Treatment" 53 California Law Review 860, 871-873.

The second approach looks at the patient's 'best interests'. The application of this approach is far from clear. It is uncertain whether the patient's wishes can be equated with best interests, or whether this test opens the door to paternalism, by allowing the decision maker to override a patient's wishes by considering other criteria. Such other criteria could be economic factors or the decision maker's own perception of the benefits and burdens of the proposed treatment.[96]

Two formulations of the best interests test were outlined in *Conroy*. The first of these is the 'limited objective' test.[97] Where there is some evidence of the patient's wish to forgo treatment and the surrogate is satisfied that the burdens of continued life with treatment outweigh the benefits of that life for the patient, then that decision must be honoured. The second formulation is related to the second. Where there is no trustworthy evidence of the patient's wishes, the burdens and benefits of treatment are weighed against each other.[98]

It is submitted that the best interests test should not be followed. The identification of burdens and benefits is a highly speculative exercise. Rather, it is submitted that the substituted judgment model should determine whether the decision making power of a surrogate has been exercised appropriately. Where there is clear and convincing evidence of the patient's wishes, a surrogate's refusal in accordance with these wishes should be honoured, even when this refusal may be likely to lead to the death of the patient.

Perhaps the most difficult questions relating to honouring a surrogate's decision will arise in relation to the grey area, where there is some, but not sufficient, evidence of a patient's wishes. Such a situation might occur when it is known that a patient belongs to a particular religious sect, but the strength of that patient's religious convictions are not known. In the situation where there is little or no evidence of a patient's desires, it is submitted that the presumption should be in favour of treatment. Erring on

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[96] See R Macklin "Treatment Refusals: Autonomy, Paternalism and the 'Best Interest' of the Patient" in D W Pfaff (ed) *Ethical Questions in Brain and Behaviour: Problems and Opportunities* (Springer-Verlag, New York, 1983) 41, 45.

[97] Above n 89, 1232.

[98] Complete authority could also be given to the proxy, but it is unlikely that this approach could be advocated convincingly.

the side of life and good medical practice does not compromise patient autonomy. Instead, a patient's self-determination is promoted by allowing the patient the best possible chance to recover enough to make decisions for herself.

(c) Consultation and approval

In New Zealand, there is no mechanism for consultation and approval of a surrogate's decision before it takes effect. The decision of a surrogate may be amenable to judicial review, but such action to determine the propriety of a decision maker's actions may be too late for a patient if the decision has already been effected. Where possible then, it is suggested that some mechanism for consultation and approval of the surrogate's decision is desirable.

Several questions arise in relation to consultation and approval processes: Should the court be involved? Should an ethics committee be involved? Should there need to be concurrence between the surrogate and the opinion of the attending doctor before a decision can be implemented? What is to happen to the patient in the event of a disagreement?

At least two different approaches to consultation and approval procedures have been set out by United States courts. In *In re Quinlan*,[99] the court held that a decision to terminate medical treatment can be made by a patient's natural guardian,[100] but this decision must be made with the concurrence of the patient's doctor, family and an ethics committee.

Not NZ

These requirements can be contrasted with the procedure set out in *In re Conroy*,[101] which would require resort to the court to obtain a judicial finding that the patient lacks competence to make a treatment decision. This finding must be supported by two examining doctors. Once a finding of 'incompetence' is made, a guardian who has been appointed by a court after an assessment of that persons bona fides and qualifications to be chosen, may make a decision for the patient to refuse treatment. This decision

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[99] Above n 77, 664.

[100] Typically the patient's next of kin.

[101] Above n 89, 1241.

requires the concurrence of two independent doctors, the patient's attending physician, the patient's family and an investigating ombudsman.

Both the *Quinlan* and the *Conroy* decisions may be criticised for their impractical approaches to the religious patient's situation. Those cases were decided on their particular facts. Both involved patients in irreversible comas and thus, the delay caused by their thoroughgoing requirements was not at issue. Where a surrogate is appointed for the religious patient, there will often be little time for this process to be complied with. This militates against the application of a mandatory requirement of approval by either the courts or an ethics committee.

Before approval should even be considered, consultation between the surrogate and the patient's attending doctor should take place. If there is disagreement between the doctor and the surrogate, then the surrogate should be able to seek approval[102] for a treatment decision from an ethics committee, or if it is critical that a decision be reached immediately, by an independent doctor. However, it must always be borne in mind that the surrogate is standing in the shoes of the patient and the medical profession should remember that there is no justifiable power of veto of a surrogate's decision where that decision represents what would have been the choice of the patient.

Even if there is ample time for approval to be rendered by a court, rather than an ethics committee, it must be asked whether the court is actually the best forum for making approving a surrogate's decision.[103] Two conflicting views about whether the courts should be involved in the decision making procedure are apparent. In the *Quinlan* case, it was held that this would be a "gratuitous encroachment" on the medical profession's competence.[104] This stands in stark contrast with the opinion of another United States court in *Saikewics*,[105] where it was held that the courts can best furnish the "detached but passionate investigation appropriate to [this] critical matter" and that the courts best reflect the morality and conscience of society. For the reasons stated above in Part III *B 2(a)* , it is submitted that the *Quinlan* court

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[102] And the doctor should be able to seek to set this decision aside, if there is reason to suggest that the decision is not appropriate.

[103] See above, text to n 88.

[104] Above n 78, 547.

[105] 370 NE 2d 435, 440.

made the better assessment of the role of the court in approving surrogate decisions and for this reason the utilisation of an ethics committee is recommended when approval is required.

(d) Summary

In general, where an incapacitated patient would have refused medical treatment on religious grounds, it is desirable that this refusal be given effect. This may require better legislative protection for advance directives.[106] In particular, it is suggested that the powers of welfare guardians and proxy decision makers should be extended to include the power to refuse medical treatment, even where this refusal could threaten the life or health of a patient.

Respecting any patient's wishes also dictates that the decision of a surrogate should reflect the decision that the patient would have made, if able. Difficulties will arise where there is little or no evidence of a patient's wish to undergo or refuse treatment. In those situations, identifying the patient's wishes is a speculative, indeed artificial exercise. In such a case there should be a presumption in favour of treatment.[107]

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[106] See R Tobin "The Incompetent Patient's Right to Die: Time for Legislation Allowing for Advance Directives" [1993] NZ Recent Law Review 103, 121 and also below Part III *B 1*.

[107] This presumption may be rebutted. Where, for example, a patient is in a persistent vegetative state, treatment may not be required. This fact situation falls outside the scope of this paper.

IV TREATMENT REFUSALS MADE BY OR ON BEHALF OF CHILDREN

A related and overlapping area of law concerns treatment refusals on religious grounds that are made by or on behalf of children. In these circumstances, the additional rights of both parents and children must be considered. The line between the age at which a child can validly give or withhold consent and the age at which that decision must be made by a child's parent is difficult to draw. This chapter outlines the nature and scope of parental authority and the emerging jurisprudence on children's rights to self determination, which is reflected in the landmark decision of the House of Lords in *Gillick* v *West Norfolk & Wisbech Area Health Board.*[108]

A *Parental Authority*

The common law on parental authority reflects the importance of the nuclear family in Western societies. Parents are granted great power over their minor children. Generally, parents have the primary responsibility for the upbringing and development of their children.[109] They may, within bounds, deprive their children of both liberty and property.[110] It is said that the basis of this authority is the presumption that parents will act in their children's best interests. Looking after the best interests of their children is regarded as primarily a parental concern because of the natural bonds of affection between parents and children:[111]

> [P]arents are [seen as] protectors of the child and responsible for the child's care. This is regarded as the 'natural role' of parents and is recognised universally in legal codes.

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[108] [1985] 4 All ER 402.

[109] However, the Children, Young Persons and their Families Act 1989 gives this authority to the family as a whole, where this is appropriate.

[110] *In Re Clark* (1962) 185 NE 2d 128, 131.

[111] Above n 44, 73. The best interests standard is used in the United Nations Convention on the Rights of the Child. Under art 18, parents have the "primary responsibility" for the upbringing and development of their children and the "best interests" of the child is said to be their "basic concern". Compare article 18(4) of the ICCPR which obliges states to respect the liberty of parents to ensure the education of their children in conformity with their own religious and moral convictions.

Parental authority encompasses the right of parents to make decisions on behalf of their minor children. Parents are empowered as surrogate decision makers because it is thought that they possess what children lack in the capacity required to make difficult choices.

Having rights often goes hand in hand with duties and parental duties may be seen as the concomitant of parental rights. The refusal of treatment by parents could be classified as engaging in a positive act that is harmful or detrimental to the health of their child or as a failure to act in a way which is medically recognised that is harmful or detrimental to their child. If this latter characterisation of a parent's refusal is accepted, then an argument may be advanced that section 152 of the Crimes Act would be breached by a parent who refused treatment on behalf of a child, where this refusal threatens the life of a child. Section 152(1) imposes a legal duty on parents and persons in the place of parents to provide children under the age of 16 with the necessaries of life:

> Every one who as a parent or person in place of a parent is under a legal duty to provide necessaries for any child under the age of 16 years, being a child in his actual custody, is criminally responsible for omitting without lawful excuse to do so, whether the child is helpless or not , if the death of the child is caused, or if his life is endangered or his health permanently injured, by such omission.

It has been held by the courts that the necessaries of life includes medical treatment.[112] If there is a lawful excuse for a parent's failure to provide a minor child with the necessaries of life, then that parent will not be judged to be criminally responsible for the omission. Lawful excuse is a phrase that is incapable of precise legal definition:[113]

> Their Lordships doubt if it is possible to define the expression 'lawful excuse' in a comprehensive and satisfactory manner... [I]t would be undesirable to do so... [E]ach case requires to be examined on its individual facts.

It was suggested in the *Burney* case that the absence of negligence might provide the basis for a finding of lawful excuse.[114] An expansive

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[112] See *R* v *Moore* [1954] NZLR 893 and *R* v *Burney* [1958] NZLR 745.

[113] *Burney*, above n 110, 753, citing a passage from *Wong Pooh Yin* v *Public Prosecutor* [1915] AC 93 with approval.

[114] *Burney*, above n 110 , 753-754.

interpretation of lawful excuse is urged in *Adams on Criminal Law and Practice.*[115]

In *Burney,* the following propositions were laid out concerning the mens rea required to sustain a conviction for failure to provide the necessaries of life. In that case, it was decided that there need not be an intentional omission to provide the necessaries of life; negligence will be sufficient. The requisite negligence must be of a high degree for liability to accrue under the *Burney* test. A lack of awareness that a child needs medical advice might be negligence and this ignorance cannot be invoked as a lawful excuse if negligence is proven.[116]

Section 152 does not impose criminal responsibility wherever there is an omission to perform one's legal duty to provide the necessaries of life. In order to be criminally responsible, the omission must be both "without lawful excuse" and result in the death of the person, or endangering that person's life or permanently injuring that person's health. Criminal responsibility will only occur in these circumstances.

Section 152(2) sets out a maximum penalty of 7 years for failure to observe this duty without lawful excuse, where this neglect causes danger to life or permanent injury to health. Where death is caused by a failure to provide the necessaries of life, then section 160(2)(b) of the Crimes Act provides that this is culpable homicide.[117] Section 160(2)(b) provides that homicide is culpable when it consists of the killing of any person by an omission without lawful excuse to perform or observe any legal duty.

The effect of these provisions may be to limit the scope of parental authority. It could be argued that parental decision making rights do not

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[115] J B Robertson (ed) *Adams on Criminal Law and Practice in New Zealand* (Brooker & Friend, Wellington, 1992) para CA 151. 07. In relation to a doctor's duty to provide the necessaries of life, there will be a lawful excuse for a breach of duty where the doctor acts in good faith and in accordance with good medical practice: *Auckland Area Health Board,* Above n 36, 252-253.

[116] However, the correct approach is to regard section 152 as imposing a duty absent any mens rea. Thus, it should be asked whether the duty was performed. Criminal responsibility then flows from "omitting" to perform the duty. According to comments made in *Adams on Criminal Law,* above n 113, mens rea should be looked at as going to the question of whether there is an omission *without lawful excuse.*

[117] Section 158 of the Crimes Act 1961 provides that homicide is "the killing of a human being by another, directly or indirectly, by any means whatsoever". Culpable homicide is then defined in s 160 of the Act.

extend to allow the refusal of medical treatment where this could cause a child's death, endanger that child's life, or cause permanent injury to that child's health. However, this argument has never been presented to a New Zealand court. This may be because the courts have been willing to override a parent's decision to refuse medical treatment for their child by invoking section 9 of the Guardianship Act 1968. This section enables the court to make a child its ward. It may then order treatment for the child against the wishes of its parents. The use of the court's jurisdiction under section 9 is considered in the next chapter of this paper.

B Children's Rights

The notion that children should be seen but not heard is borne out in law throughout most of recent history. Dharmananda notes that traditionally, the voice of children has been either denied, ignored or subsumed economic or filial duties.[118] Now, there is an increasing awareness of the special individual needs of children and the rights that should be accorded to them if they are to be given the chance to develop. Thus, parental rights may dwindle as a child matures, although they do not evaporate entirely until the age of maturity.[119]

The House of Lords in *Gillick* v *West Norfolk & Wisbech Area Health Authority*[120] declared that the law should recognise a child's choices if that child is sufficiently mature to make decisions. Lord Scarman declared that parental rights "exist only so long as they are needed for the protection of the person and property of the child".[121] This is because, as Lord Fraser explained:

> Parental rights do not exist for the benefit of the parent. They exist for the benefit of the child.

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[118] Above n 40, 23.

[119] See the comments of Lord Denning in *Hewer* v *Bryant* [1969] 3 All ER 578, 582, where he stated that parental authority is a dwindling right which the courts will hesitate to enforce against the wishes of the child, the older he is. "It starts with a right of control and ends with little more than advice".

[120] Above n 108.

[121] Above n 108, 420.

In 1989, the United Nations adopted a Convention on the Rights of the Child.[122] This Convention recognises the importance of the human rights of children and the fact that these rights had not been adequately defined and protected in 'general' human rights documents such as the International Covenant on Civil and Political Rights. Article 14 of the Convention provides for the freedom of thought, conscience and religion. According to this provision, states are to respect the rights and duties of parents "to provide direction to the child in the exercise of [this right] in a manner consistent with the evolving capacities of the child".

It would seem that this provision is intended to operate in the same manner as the *Gillick* decision. This would allow allow the decisions of children to be respected wherever evidence can be shown that a child is sufficiently developed to make them.

The *Gillick* case is not directly binding on New Zealand courts, and the application of *Gillick* in the New Zealand courts has not yet been tested. Whether the *Gillick* competent child exists for the purposes of New Zealand law is unclear. The Guardianship Act 1968 specifically deals with a child's ability to consent to medical treatment in section 25.

Section 25(1) provides that every person over the age of 16 can validly consent to medical treatment, but it is silent on the question of whether or not those under the age of 16 can ever effectively consent or refuse to submit to medical treatment. Only minors who have never been married are expressly given the right to refuse medical treatment.[123] However, section 11 of the NZBORA gives every one the right to refuse medical treatment. The applicability of section 11 is subject to the operation of section 5 of the NZBORA.[124] It is unlikely that the decision of a *Gillick* competent minor child would be validly limited by the application of section 5 of the NZBORA. But in cases where a child's competence to make an informed treatment decision is uncertain, the line between respecting and overriding that decision is fine. However, this may be a necessary

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[122] Also in 1989, the Human Rights Committee adopted a "General Comment" on art 24 of the ICCPR which deals with children's rights.

[123] See s 25(2) of the Guardianship Act.

[124] See below, text to n 175.

concomitant of greater respect for the differing developmental processes of children.

According to section 33(1), the Guardianship Act takes effect as a code except as otherwise provided in the Act. The definition of guardianship in section 3 provides for the express reservation of the common law. In relation to treatment decisions, *Gillick* may have room to operate because of section 25(5)(a) which saves the common law relating to the non-necessity of consent. Section 25(5)(a) provides that:[125]

> (5) Nothing in this section shall limit or affect any enactment or rule of law whereby in any circumstances-
> (a) No consent or no express consent is necessary...

Austin[126] argues that there is also room for the operation of *Gillick* under section 23(3) which provides that:[127]

> (3) Where the consent of any other person to any medical... procedure (including a blood transfusion) to be carried out on a child is *necessary or sufficient*, consent may be given-
> (a) By a guardian of the child; or
> (b) If there is no guardian in New Zealand or no such guardian can be found with reasonable diligence or is capable of giving consent, by a person in New Zealand who has been acting in the place of a parent;
> ...

The operation of *Gillick* would require an assessment of a child's competence. This requires both an understanding of the proposed treatment and an appreciation of the likely effect of this treatment on family relationships. This requirement is said to contextualise the power of a *Gillick* competent child to consent to medical treatment within the family unit.[128] An assessment of the competence of any person is difficult to determine, but in the case of a child this difficulty may be exacerbated. An adult is presumed to be competent, but it must be proven that a minor is

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[125] W Atkin "Parents and Children: Mrs Gillick in the House of Lords" [1986] NZLJ 90, 92.

[126] G Austin "Righting a Child's Right to Refuse Medical Treatment: Section 11 of the New Zealand Bill of Rights and the *Gillick* Competent Child" (1992) 7 Otago LR 578, 581.

[127] My emphasis.

[128] Above n 126, 593.

Gillick competent. An assessment of *Gillick* competence could easily be skewed if the decision of a child is unconventional.

In addition to this, United Kingdom Court of Appeal has now held that the Gillick competent child can consent but not refuse to submit to medical treatment. In *Re R*,[129] Lord Donaldson said:[130]

> [A *Gillick* competent] child can consent [to medical treatment], but if he or she declines to do so or refuses, consent can be given by someone else who has parental rights and responsibilities.

Lord Donaldson reaffirmed his commitment to the principle he laid down in *Re R* in *Re W*.[131] In *Re W*, a Gillick competent child's right to refuse medical treatment was considered. The court held that the court could override this decision in the exercise of its inherent jurisdiction to refuse treatment on behalf of minors. However, Lord Donaldson, in the minority on this point, opined that no minor has the right to refuse consent in the first place. His Lordship's analysis in the cases of *Re R* and *Re W* is patently inconsistent with the spirit of the *Gillick* decision and it is submitted that his reasoning should not be followed by the New Zealand courts. Thus, prima facie, it should be recognised that a *Gillick* competent child has the same power to refuse medical treatment as that of an adult.

There is a statutory exception to the right of a child to refuse medical treatment under section 126B of the Health Act 1956. This section provides that the leave of the High Court must be obtained before civil or criminal proceedings can be brought against any doctor who administers a blood transfusion to a person under 20 without consent if certain conditions are satisfied.[132] Section 126B is an express limitation on the right to refuse

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[129] [1991] 4 All ER 177.

[130] Above n 129, 180.

[131] Above n 66, 637.

[132] First, in the doctor's opinion, the transfusion must have been necessary to save the life of the patient or to prevent permanent injury to his physical or mental health, or to save him from prolonged and avoidable pain and suffering. That opinion must also be reasonable. In addition to this, reasonable attempts must have been made to obtain consent to the transfusion or the circumstances must have been such that it was necessary to administer the transfusion promptly and it was impractical in the time available to obtain consent. Finally, it must have been reasonable in all the circumstances to administer the transfusion. In these circumstances, children may not be able to refuse blood transfusions.

medical treatment on religious grounds, and although it is in violation of this right, cannot be knocked down because of the operation of section 4 of the NZBORA.[133]

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[133] Section 4 of the NZBORA provides that: "No court shall, in relation to any enactment... [h]old any provision of the enactment to be impliedly repealed... or... [d]ecline to apply any provision of the enactment by reason only that he provision is inconsistent with any provision o this Bill of Rights".

V STATE INTERESTS

Prima facie it is the individual who is the subject of a medical decision who has the final say about whether or not to undergo treatment. This requires the greatest possible protection to be given to the individual in the furtherance of that individual's desires.[134] Yet the state may interfere with this decision in an appropriate case.

In exercising its governmental power, the court should not intervene with a treatment refusal made on religious grounds unless there is a compelling reason to do so. These reasons and their sufficiency in relation to overriding a patient's decision are discussed in this chapter.

A *The Preservation of Life*

> However sacred life may be, fair social comment admits that certain aspects of life are properly held to be more important than life itself. Such proud and honourable motivations are long entrenched in society, whether it be for patriotism in war, duty by law enforcement officers, protection of the life of a spouse, son or daughter, death before dishonour, death before loss of liberty, or religious martyrdom. *Refusal of medical treatment on religious grounds is such a value.*[135]

No one would doubt the importance society attributes to the principle of sanctity of life. The state has an indisputable interest in the preservation of life. This is reflected in a plethora of different statutes which provide for, inter alia, the state's provision of police power, cycle helmets, gambling, alcoholism and drug abuse. This state interest is commonly based upon the premise that all lives are valuable. This is reflected in section 8 of the NZBORA, which provides that:

> No one shall be deprived of life except upon such grounds as are established by law and are consistent with the rules of fundamental justice.

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[134] *Erickson* v *Dilgard* (1962) 252 NYS 2d 705.

[135] *Malette*, above n 24, 326, where Robins J A cited with approval a passage from the judgment of Donnelly J in the court below (*Malette* v *Shulman* (1987) 47 DLR (4th) 18, 47).

In international law, provisions similar to section 8 have been interpreted as requiring positive state action to protect life. However, this interpretation must be read in the context that this requirement was made. In its general comments regarding the interpretation of the International Covenant on Civil and Political Rights, the Human Rights Committee discussed the obligation of the state to provide positive action against, for example, allowing the creation of weapons of mass destruction. Thus, it is questionable whether section 8 could extend far enough to compel positive state action to prevent a patient refusing medical treatment where this could be life threatening.

Section 8 aside, the importance of each individual's life is said to preclude allowing a patient to refuse lifesaving medical treatment because it is argued that letting a patient die demeans society's overall respect for life.[136] But a counter-argument to this point may be raised. Respect for life springs from treating everyone as a unique individual.[137] Honouring a patient's choice to refuse medical treatment need not be regarded as a deprecation of life. There is no deprecation of life involved just because the religious patient's refusal of treatment is regarded as silly or inconsequential to others. Rather, it may be seen as a reflection of concern for the individual instead of as a disdain for life. The rejection of medical treatment on religious grounds is a principled decision based upon deeply rooted religious convictions. Moreover, such a decision is unlikely to endanger the lives of others. This is not the kind of decision that, if allowed to stand, would encourage others to blindly refuse treatment.

The state's interest in preserving life is often also linked to an interest in the prevention of suicide.[138] The law has ceased to criminalise both suicide and attempted suicide. It is now recognised that the criminal law is not appropriate in the context of suicide.[139] However, society's concern about

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[136] See, for example, Hegland, above n 95, 866-867.

[137] C Goldberg "Choosing Life After Death: Respecting Religious Beliefs and Moral Convictions in Near Death Decisions" (1988) 39 Syracuse Law Review 1197, 1239; N L Cantor "A Patient's Decision to Decline Lifesaving Medical Treatment: Bodily Integrity Versus the Preservation of Life" 26 Rutgers Law Review 228, 244.

[138] Cantor, above n 21, 45.

[139] Deterrence and punishment are hardly meaningful concepts in connection with suicide.

suicide is still reflected in law.[140] Thus, it may be said that society still has an interest in preventing suicide. It is difficult to argue that refusing life preserving treatment on religious grounds amounts to suicide. Suicide is a self destructive course that is calculated to bring about death. It requires a specific intent to die. Just knowing that death will follow from a treatment refusal does not amount to a specific intent to die.[141]

When a refusal is based upon firmly held religious convictions, it is difficult to conclude that the patient has any specific intent to die. Typically, the patient has no wish to die and hopes that she will be healed. The religious patient is merely adhering to the tenets of his religion in rejecting medical treatment. Thus, it is wrong to suggest that the refusal of medical treatment on religious grounds is tantamount to suicide.[142] Even if it were, anti-suicide laws do not dictate that life is a supreme value. The principle of sanctity of life has always coexisted with, inter alia, the state's authority to wage war.[143]

B The Protection of Public Health

There are precedents in the United States for limitations of religious liberty on this ground, for example, legislation prohibiting snake handling rituals. In *Lawson* v *Commonwealth*,[144] a state court held that:

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[140] For example, prohibitions still exist against aiding and abetting suicide and people are often hospitalised after they attempt suicide in order that they undergo psychological scrutiny.

[141] The law would be loath to treat people who heroically risk their life to save others as suicidal.

[142] See, for example, the reasoning of Judge Skelly Wright in *Application of the President and Director of Georgetown College Inc* (1964) 377 US 978, 1008-1009, where the Judge said that (where attempted suicide is illegal) a person cannot refuse medical treatment when death is likely to ensue without it. His honour dismissed the argument that there is no specific intent to die in this case as a "quibble". Some courts in the United States have even gone further to suggest that treatment may be refused because a patient has a personal distaste for life where life may have become a personal hell for that patient. Arguably in these cases a patient has a specific intent to die. See Cantor, above n 138.

[143] And in the case of *In Re J* [1991] 2 WLR 140 the United Kingdom Court of Appeal stated that although there was a strong presumption in favour of the preservation of life, no principle no principle could override the paramountcy of the ward's best interests.

[144] (1942) 164 SW 2d 972, 974.

> [T]he Federal constitution does not preclude a state from enacting a law prohibiting the practice of a religious rite which endangers the lives, health or safety of the participants, and other persons.

Religious liberty and the right of an individual to refuse medical treatment may be overridden in order to protect public health. The state's purpose in asserting this interest is not to save the life of the patient who is refusing treatment, but to prevent the spread of disease into the community:[145]

> The right to practise religion freely does not include liberty to expose the community to communicable diseases.

In *Jacobson* v *Massachusetts*,[146] a compulsory vaccination law was held to be valid because, in that case, religious liberty was overbalanced by the state's interest in protecting its inhabitants from a dangerous and contagious disease. Where public health is threatened, the danger caused to society by a treatment refusal may be sufficient to outweigh a religious patient's rights.

C *The Protection of Third Parties*

The state may attempt to compel medical treatment where innocent third parties may suffer from a patient's refusal. In *Application of the President and Director of Georgetown College Inc*,[147] a mother with a young child was not able to refuse a blood transfusion because:

> The state, as *parens patriae*, will not allow a parent to abandon a child, and so it should not allow this most voluntary of abandonments. The patient has a responsibility to the community to care for her infant. Thus, the people have an interest in preserving the life of the mother.

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[145] *Prince* v *Massachusetts* (1944) 321 US 158, 166-167.

[146] (1905) 197 US 11, 24-31.

[147] (1964) 377 US 978.

Two separate rationales have been advanced in support of this state interest.[148] The first is the prevention of psychological harm to the religious patient's surviving children. While this may seem to be a compelling reason to override a treatment decision, its application is uncertain because the emotional impact of a parent's death on a child will vary from case to case.[149] The second rationale is the prevention of economic harm to the state. This is said to arise when a child is made a public ward. Obviously this can only apply where a *solo* parent wishes to refuse *lifesaving* treatment.[150] The sufficiency of this latter rationale is also questionable because it is unlikely that many people will refuse medical treatment on religious grounds. For this reason the economic burden placed upon the state is likely to be slight.

The argument that was postulated in *Georgetown* has been invoked to protect unborn children where a pregnant woman refuses medical treatment.[151] In this situation, the rationale behind treating an expectant mother is to allow the unborn child a chance at life. This argument was made in *Raleigh-Fitkin Hospital* v *Anderson*,[152] in the context of a pregnancy in its thirty-second week. This is an unjustifiable infringement on the mother's liberty that is probably best left to more explicit consideration at another time.

An even more difficult argument to run concerns the protection of a third party who cannot be described as innocent. In *R* v *Blaue*,[153] a stab victim was taken to hospital after losing a large quantity of blood. A blood transfusion was refused and the victim died shortly thereafter. It could be suggested that the state should override the victims choice to stop those like Blaue from being convicted of manslaughter. That the state should have an interest in this case is flawed logic. The nature of Blaue's original action would not be changed by compelling victims to be transfused against their wishes. The consequence might change, but this does nothing to stop serious crime being committed. This has no preventative or deterrent effect. The only

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[148] See Cantor, above n 137, 251; and R M Byrn,"Compulsory Lifesaving Medical Treatment for the Competent Adult" (1975) 44 Fordham Law Review 1, 33.

[149] Cantor, above n 137, 251.

[150] D J Sharpe and R F Hargest "Lifesaving Treatment for Unwilling Patients" (1968) 36 Fordham Law Review 695, 697.

[151] Above n 137, 1228.

[152] (1964) 201 A 2d 537.

[153] [1975] 3 All ER 446.

possible justification for transfusing the victim is to prevent long sentences being imposed which are a drain on the state. In the context, this is an insufficient reason. In any event, the court in *Blaue* decided that Blaue had to take his victim as he found her, and he was convicted of manslaughter.

D The Protection of the Ethical Integrity of the Medical Profession

> The health of my patient will be my first consideration.[154]

The Hippocratic Oath[155] establishes in its essence that medical treatment should be for the benefit of the patient. One aspect of this is that doctors ought to act in the best interests of patients. We may extrapolate from this a duty on the part of the profession to determine what the welfare of the patient requires and then treat him or her accordingly. If a paternalistic interpretation of the patient's benefit is adopted, then curing the patient's condition will be considered of primary importance to the profession, to the exclusion or diminution of other relevant concerns. However, it can also be argued that the patient's best interests should be served by maximising the patient's chances of getting the best possible outcome in terms of his or her

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[154] From the *Geneva Convention Code of Medical Ethics* - a modern version of the Hippocratic Oath adopted by the World Medical Association in 1949. The full text to the Geneva Declaration is as follows: "*I solemnly pledge* myself to consecrate my life to the service of humanity; *I will give* to my teachers the respect and gratitude that is their due; *I will practice* my profession with conscience and dignity; *The health of my patient* will be my first consideration; *I will respect* which are confided in me; *I will maintain* by all the means in my power, the honour and the noble traditions of the medical profession; *My colleagues* will be my brothers; *I will not permit* considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient; *I will maintain* the utmost respect for human life from the time of conception; even under threat; I will not use my medical knowledge contrary to the laws of humanity; *I make these promises* solemnly, freely and upon my honour.

[155] The Hippocratic Oath was originally promulgated in order to curb the activities of doctors who had been administering medical treatment allegedly for the betterment of patient health but without proper training or regulation. The relevant part of the oath reads as follows: " The regimen I adopt shall be for the *benefit of the patients* according to my ability and judgement, and not for their hurt or for any wrong... Whatsoever house I enter, there I will go for the *benefit of the sick*, refraining from all wrongdoing or corruption... Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets. Pure and holy will I keep my Life and Art. (emphasis added)

life and purposes.[156] Although historically, doctors have even trained to use all available methods to sustain life, maximising a patient's welfare should be considered from the perspective of the patient.

In a society that has become increasingly aware of individual rights, particularly the right to make one's own choices, the role of the doctor increasingly extends beyond the therapeutic.[157] As a result of this, medical professionals are often faced with a difficult ethical problem. Is respecting a treatment refusal where the consequence may be death to the patient anathema to doctors, who have historically been trained to use all available methods to sustain life? This is just one of a number of difficult medical decisions that a doctor must make.

It is submitted that the general ability of a patient to consent to treatment and to refuse treatment takes the ethical responsibility from the practitioner. Concerns for the unobstructed exercise of medical judgment should not prevail. The doctor's quandary is more apparent than real, because she must honour the patient's wishes. The choice is not the doctor's to make. The doctor has no duty in relation to protecting the patient's health against her wishes, despite paternalistic suggestions that one should exist.[158]

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[156] Campbell, Gillett & Jones, above n 44.

[157] This may be particularly so in cases where a doctor is asked to withdraw, rather than withhold treatment. However, a discussion of this is beyond the scope of this paper.

[158] Above n 95.

E Overriding Parental Authority

Neither the rights of parenthood nor the rights of parents to bring up their children according to their choice of religion are incapable of limitation. The family itself is not beyond regulation in the public interest. The state has a wide range of power for overriding parental authority in situations where a child's life or health might be affected. In *DGSW* v *M*,[159] Tompkins J recognised that the court has power to override a parent's decision where this could save a child's life under both section 9 of the Guardianship Act and as part of its inherent *parens patriae* jurisdiction.

Under section 9 of the Guardianship Act 1968 ("the Guardianship Act"), the High Court can order that an unmarried child under 20 years old be placed under the guardianship of the court. An application under section 9 can be made by a parent, guardian or near relative of the child[160]; the Director General of Social Welfare;[161] the child in question[162] or anyone who obtains the leave of the High Court.[163]

The High Court has extensive powers in relation to its wards. They extend to include the approval or prevention of the performance of medical treatment. In *Re P*[164] Ellis J was decided that:[165]

> [T]he powers set out in the Guardianship Act 1968 clearly anticipate that in appropriate cases orders will be made for the transfusion of children that are directly in conflict with the wishes and sincerely held beliefs of the parents. In circumstances of real and substantial risk of death the wishes of the parent can only be one of the factors weighed against the obligation of the Courts to determine the interests of the children.

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[159] (1991)8 FRNZ 498, 503.

[160] Section 9(2)(a) of the Guardianship Act 1968.

[161] Section 9(2)(b) of the Guardianship Act 1968.

[162] Section 9(2)(c) of the Guardianship Act 1968.

[163] Section 9(2)(d) of the Guardianship Act 1968.

[164] [1992] NZFLR 94. See also s 126B of the Health Act 1956. See also *Re C* (1992) 9 FRNZ 570. In that case, the jurisdiction of the court to make an order that a child be transfused under both the court's inherent parens patriae jurisdiction and s 9 of the Guardianship Act was unsuccessfully challenged by the child's parents.

[165] Above n 164, 96.

Section 23(1) of the Guardianship Act provides that the welfare of the child should be the paramount consideration in determining whether that child should become a ward of the court and in determining whether consent to medical treatment should be given by the courts.

The second weapon in the court's armoury which can be used to override parental authority is the court's inherent duty as *parens patriae*. The *parens patriae* jurisdiction is based on the "obvious necessity that the law should place somewhere the care of individuals who cannot take care of themselves, particularly in cases where it is feared that some care should be thrown around them".[166] This jurisdiction is preserved by section 17 of the Judicature Act 1908 and may be exercised in relation to minors.[167]

The authority of the state to act as parens patriae is not nullified if parents can ground their refusal on a claim to control a child's religious upbringing. The court can override decisions made by parents which would expose a minor child to ill health or death equally by the use of wardship procedures or by the use of its parens patriae jurisdiction.

Whether the court should act under its inherent jurisdiction or under the wardship provisions of the Guardianship Act was a question considered in *DGSW* v *M*. Tompkins J said the appropriate mechanism depends on the individual circumstances of each case. His honour remarked that where consent is sought for a specific single treatment such as a single operation, it is more appropriate for the courts to act under its inherent jurisdiction. He then contrasted the single specific interest with the oversight of continuous treatments likely to extend over a long period of time. In that case, the wardship provisions would be more appropriately exercised because this ensures the continued involvement of the court.[168]

It is submitted that the use of the court to override a parent's decision to refuse medical treatment in the ways which have been suggested above are entirely appropriate. Children should not be sacrificed for their parents'

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[166] *Wellesley* v *Duke of Beaufort* (1827) 2 Russ 1, 20.

[167] It may also be resorted to in relation to the persons and estates of 'idiots', mentally disordered persons and persons of unsound mind.

[168] Above n 159.

religious beliefs. They should be allowed to grow up and decide for themselves whether they are willing to die for a religion:[169]

> A democratic society rests, for its continuance, upon the healthy, well rounded growth of young people into full maturity as citizens with all this implies... Parents may be free to become martyrs themselves. But it does not follow that they are free in identical circumstances, to make martyrs of their children before they have reached the age of full legal discretion when they can make that choice for themselves.

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[169] *Prince* v *Massachusetts*, above n 145, 168-170.

VI HOW SHOULD COMPETING CLAIMS BE RESOLVED?

Often, judges must make decisions against the background of their knowledge that upholding the patient's decision may lead to the death of that person. This may have something to do with the readiness of the court to override treatment decisions for reasons which sometimes can only be described as spurious.[170] This approach to judicial reasoning pays lip service to patient autonomy and the patient's religious convictions. A consequence of this is that careful attention must be given to the balancing of competing claims in this area.

A *The Harm Principle*

> Only those interests of the highest order and those not otherwise served can overbalance legitimate claims to the free exercise of religion.[171]

> No right is more sacred, or more carefully guarded by the common law than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.[172]

The above quotations illustrate the proposition that the common law will defer to religious freedom and the right to self determination unless there is a compelling reason to restrict an individual's liberty. For example, interference may be justified where the exercise of these rights causes harm to others:[173]

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[170] The anguish of the court was well expressed in the decision of Supreme Court of New York State in *Powell* v *Columbian Presbyterian Medical Center* (1965) 267 NYS 2d 450, 452: "Never before had my judicial robe weighed so heavily on my shoulders... I knew that no release - no legal absolution - would absolve me if I, speaking for the court, answered 'No' to the question 'Am I my brother's keeper?' This woman wanted to live. I could not let her die!"

[171] *Wisconsin* v *Yoder* (1972) 406 US 205, 215.

[172] *Union Pacific Railway* v *Botsford* (1891) 141 US 250, at p 251.

[173] *Jacobson* v *Massachusetts* (1905) 197 US 11, 26.

> Real liberty for all could not exist under the operation of a principle which recognises the right of each individual person to use his own, whether in respect of his person or his property, regardless of the injury that may be done to others.

According to the harm principle, interference with individual rights can *only* occur where harm to others is threatened. As Burke said, "Liberty, too must be limited in order to be possessed".[174] Thus, the protection of public health and of innocent third parties may have to be balanced against the rights which could be invoked by the religious patient. This moderate course requires that state intervention should be limited to what is really necessary for the protection of freedom.

B *The New Zealand Bill of Rights Act 1990*

In the New Zealand context, the starting point for assessing whether a religious patient's treatment refusal should be honoured is the NZBORA. This Act affirms and protects the rights and freedoms contained within it against unconstitutional state action. Section 3 provides that:

> This Bill of Rights applies only to acts done -
> (a) By the legislative, executive or judicial branches of the government of New Zealand; or
> (b) By any person or body in the performance of any public function, power or duty conferred or imposed on that person by or pursuant to law.

It has been suggested that the common law should be subject to the application of the Act under section 3(a).[175] If this is so, then decisions of the judiciary must be made consistently with the rights and freedoms affirmed in the Act. In respect to a treatment refusal made on religious grounds, it has been shown above that if this decision is not honoured, sections 11, 15 and possibly also section 20 are the main rights which are prima facie violated. Any limitations on the rights that are enunciated in that

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[174] As quoted in Department of Justice Briefing Papers for the Minister of Justice (vol 1, "Key Policy Issues" 1990) 1.

[175] See A S Butler "The New Zealand Bill of Rights and Private Common Law Litigation" [1991] NZLJ 261.

legislation are only valid if section 5 is first satisfied. Section 5 of the NZBORA provides that:

> Subject to section 4 of this Bill of Rights, the rights and freedoms contained in this Bill of Rights may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

A section 5 analysis is a useful method of assessing the constitutional validity of a decision to override a treatment refusal by a religious patient.It will also indicate whether such a decision comparts with our international obligations under the International Covenant on Civil and Political Rights. In order to determine whether a limit is justified under section 5 it should be considered whether it is prescribed by law and whether it is demonstrably justified in a free and democratic society.

A limitation on the rights set out in the NZBORA will be prescribed by law unless it is arbitrary, or so vague that it is impossible to apply.[176] An intelligible standard must be yielded by a decision to override a right affirmed in the New Zealand Bill of Rights Act. In relation to common law decisions of the judiciary, this requirement will be satisfied if the courts enunciate its reasons for overriding a treatment refusal clearly, and in a form that can be applied in future cases.

Canadian jurisprudence is instructive in determining whether a limit should be seen as "demonstrably justified in a free and democratic society".[177] In *R* v *Oakes*,[178] a two part test was set out. First, the limit must be pressing and substantial; and secondly, there must be proportionality between the limit on the right or freedom and the state's objective in implementing such a limitation.

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[176] *R* v *Therens* [1985] 1 SCR 613, 680; *Osborne* v *Canada (Treasury Board)* [1991] 2 SCR 69, 94.

[177] Section 5 of the New Zealand Act is largely derived from the Canadian Charter, which contains a virtually identical provision.

[178] [1986] 1 SCR 103. This approach was approved in *MOT* v *Noort/Police* v *Curran* (1992) 5 CRNZ 115, 138, per Richardson J. Note that in Canada (and in the judgment of Cooke P, who was a minority judge in the *Noort* decision) the Supreme Court has recently begun to analyse their equivalent of section 5 on an impressionistic basis: See D Paciocco "The New Zealand Bill of Rights Act 1990: Curial Cures for a Debilitated Bill" [1990] NZ Recent Law Review 353, 368. This does not affect the usefulness of applying *Oakes* as a checklist for assessing the constitutional validity of a decision to override a religious patient's treatment decision.

The state's objectives in overriding a treatment refusal have been set out in the previous chapter, where it was suggested that concerns for the protection of public health and the protection of innocent third parties may be pressing and substantial concerns.

The second part of the *Oakes* test is the proportionality requirement. This requires a three-part analysis:

(i) The limit on the right or freedom must be rationally connected to the state's objective;
(ii) the limit must be a minimal impairment of the right or freedom; and
(iii) there must be a proper balance between the limit and the legislative objective.

The first part of the proportionality test simply requires a link between the state's objective (for example, protecting the community from the spread of disease) and the limitation of the right (that is to say, overriding a treatment refusal). The second requirement is that the right in question must be impaired as minimally as possible. This is not a requirement that the state must, in all circumstances, take the least restrictive alternative An element of discretion is left to the state in implementing its decisions.[179] But an overly broad limitation on the right will not be constitutional. This element is not really applicable in the treatment refusal scenario because there is no range of options that could be chosen in relation to a treatment refusal. Either a patient is allowed to refuse treatment, or that refusal is overridden. There is no middle ground; no way that the right could be more minimally impaired.

The final element of the proportionality test is not difficult to satisfy. It is unlikely that a successful argument could be advanced to say that overriding a treatment refusal abridges the religious patient's rights to religious liberty and self-determination altogether.

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[179] *Irwin Toy* v *Quebec (Attorney General)* [1989] 1 SCR 927, 999.

The constitutional analysis of the rights and interests undertaken in this paper highlights the importance of honouring the rights of the religious patient to refuse medical treatment. To override at least two constitutionally protected rights, the sufficiency of countervailing considerations must be carefully analysed. The state must not offer inadequate justifications in order to compel treatment as these will not withstand scrutiny under section 5 of the NZBORA.

VII CONCLUSION

From the discussion in this paper, we can draw a number of conclusions:

1. There should be a presumption that a religiously motivated treatment refusal made by a competent patient should be upheld.

2. People whose religious convictions motivate them to refuse medical treatment should provide specific, preferably written instructions to ensure their religious beliefs are respected in the event that they become incapacitated.

3. A proxy decision maker or welfare guardian appointed under the PPPRA does not have the ability to refuse treatment on behalf of an incapacitated patient, even where this is what that patient would have wanted. It is recommended that this position should be amended, so that the proxy and the welfare guardian can make this decision for a patient.

4. The appointment of a surrogate decision maker, where the patient has not made an instruction directive is shrouded in uncertainty. It is preferable that professional standards should dictate that a patient's family should be asked to consent on behalf of an incompetent patient, unless there is doubt about the bona fides or suitability of the patient's kin. In all cases where it is practicable, an ethics committee should be required to approve a decision not to appoint a family member as a surrogate.

5. Where it appears that there is no one who can act as a surrogate, it may be necessary to have recourse to the courts to make some type of determination that relates to medical treatment. However, it would be preferable that this decision be left to an ethics committee. In an emergency situation, a doctor should be able to act as the patient's surrogate, and should render a treatment decision according to the criteria suggested below.

6. A surrogate decision should be based upon the substituted judgment model where there is clear and convincing evidence of the patient's wishes. Where this evidence is not available, the surrogate has no basis for acting and a decision should be made to err on the side of life and good medical practice. This decision should be reached after consultation with the patient's doctor. If concurrence between the surrogate and the doctor cannot be reached, it should be possible to obtain approval for a decision from an ethics committee.

7. *Gillick* competent children should have the same prima facie right to refuse medical treatment on medical grounds as that of an adult. Parents of minor children who are not *Gillick* competent may, subject to section 152 of the Crimes Act 1961, make treatment choices for their minor children.

8. State interests which could override a treatment refusal are subject to analysis under section 5 of the NZBORA and, in addition to this, should only be regarded as compelling if their rationale is grounded in the protection of harm to others.

Medical treatment which is administered against a religious patient's will should not be viewed as acceptable in a society which professes to cherish religious freedom and self-determination. Consequently, a treatment refusal on religious grounds should be honoured unless an appropriate case for intervention can be made out. Together, the values of autonomy, religious liberty and the right to medical self-determination urge an anti-paternalistic stand on treatment refusals made on religious grounds.

Only where a rigorous analysis of competing rights has been undertaken, should a religious patient's refusal of treatment be overridden. If a person is rational and competent, the risks of refusing medical treatment are that person's alone to take, as long as the liberty of others is not infringed. In the words of John Stuart Mill, which are no less relevant today than in their original context:[180]

> Each is the proper guardian of his own health, whether bodily or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest.

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[180] John Stuart Mill *On Liberty* in M J Adler (ed) *Great Books of the Western World* (Encyclopaedia Britannica Ltd, Chicago, 1982) vol 43, 273.

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Nguyen, Karen
Thanh Mai
The right to
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treatment on
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