Joshua Williams Memorial Essay 1988

Sir Joshua Strange Williams was resident Judge of the Supreme Court in Dunedin from 1875 to 1913, and he left a portion of his estate upon trust for the advancement of legal education. The trustees of his estate, the Council of the Otago District Law Society, have provided from that trust an annual prize for the essay written by a student enrolled in law at the University of Otago which is the opinion of the Council makes the more significant contribution to legal knowledge and meets the requirements of sound legal scholarship.

We publish below the winning entry for 1988.

CONSENT TO MEDICAL PROCEDURES AND THE PROTECTION OF PERSONAL AND PROPERTY RIGHTS ACT 1988

ELIZABETH GRANT*

Introduction

Until the enactment of the Protection of Personal and Property Rights Act 1988, there was little statutory provision for persons to act on behalf of adults who were temporarily or permanently incapable of managing their own affairs.[1] In particular, no-one was able to consent to non-psychiatric medical treatment on behalf of other adults. For doctors and patients alike, this situation was highly unsatisfactory.

If the circumstances were those of an emergency, a doctor was justified in treating a patient without the consent of that patient. This common law justification of emergency was one which is preserved by section 20(1) of the Crimes Act 1961. That section states that:

> All rules and principles of the common law which render any circumstances a justification or excuse for any act or omission, or a defence to any charge, shall remain in force and apply in respect of a charge of any offence,[2] whether under this Act or under any other enactment, except so far as they are altered by or are inconsistent with this Act or any other enactment.

The common law had recognised that a doctor was justified in treating a patient even without that patient's consent, if the patient was unable to

* LLB Honours student, University of Otago. I should like to acknowledge the kind assistance of my supervisor for this paper, Professor PDG Skegg.
[Accepted for publication December 1988.]

1 The principal exceptions were found in the Aged and Infirm Persons Act 1912 and Part VII of the Mental Health Act 1969. The former provided some administrative powers over the estates of those people under its jurisdiction and is repealed by the Protection of Personal and Property Rights Act 1988. The latter allowed the Superintendents of mental hospitals to order psychiatric treatment for committed mental patients.

2 With regard to civil liability, see the discussion below.

give consent (for example, because of being unconscious) and the treatment was necessary to save the person's life. The kind of criminal responsibility which might otherwise be incurred by a doctor or surgeon is for common assault[3] or another of the related assault provisions. The definition of assault in section 2 of the Crimes Act is "intentionally applying . . . force to the person of another", and "force" has been interpreted to mean any physical contact or touching. A surgeon's activities are extremely intrusive upon another person's body and are specifically protected from criminal responsibility by section 61 of the Crimes Act.[4] To qualify for such protection, the surgeon must act with "reasonable care and skill", which is to be assessed objectively with reference to "the patient's state at the time and to all the circumstances of the case". In an emergency, when the life of the patient could be saved by an operation, the patient's state and the circumstances of the case would justify a surgeon in operating upon their patient, regardless of the patient's consent. This situation is not affected by the Protection of Personal and Property Rights Act.

Other than in emergency situations, a surgeon may operate upon a person "with the consent of that person, or of any person lawfully entitled to consent on his behalf to the operation" provided the surgeon performs the operation "with reasonable care and skill" and the operation is "for a lawful purpose".[5] At common law[6] there is no general rule allowing the consent of one person to what would otherwise be an assault upon another person.[7] However, parents and other guardians can give consent to medical, surgical or dental procedures on behalf of minors.[8] For adults, these procedures all require the consent of the prospective patient, unless they fall within one of the limited statutory exceptions.[9]

Concerning civil liability, the tort of battery applies to the unauthorised touching of another, and in the past a doctor or surgeon would incur liability in treating a patient without the consent of the patient. If the treatment resulted in personal injury, such as the wound caused by an operation to which effective consent had not been given, then the only redress the patient would have now for that injury would be under the Accident Compensation Act 1982. Section 27 of that Act excludes proceedings for damages for "personal injury by accident" being brought independently of the Act. From the point of view of the patient who has been treated or operated upon without his or her consent (which is the crucial viewpoint, in this context), the resulting physical injury is an

3 Crimes Act 1961, s 196.

4 This section was probably included to remove surgery from the ambit of Stephen's definition of "bodily harm".

5 Crimes Act 1961, s 61A(1).

6 Statutory exceptions are limited, the most noteworthy being psychiatric treatment for committed mental patients (see supra n1) and the administration of contraceptive treatment and provision of abortions for "mentally subnormal" females: Contraception, Sterilisation and Abortion Act 1977, ss 4, 34.

7 It is only medical treatment which involves a doctor touching the patient without the patient's consent which may be regarded as criminal assault or the tort of battery. Simply prescribing drugs without a physical examination, for example, would normally incur neither civil nor criminal liability.

8 Guardianship Act 1968, s 25(3)(a).

9 See supra n 6.

"accident"[10] and the medical, surgical, dental or first aid misadventure is a "personal injury by accident".[11]

Exemplary or punitive damages are not excluded by the Act, as they are not compensatory in nature.[12] Exemplary damages are awarded to punish what is regarded as an outrage to someone's feelings or person. Regardless of whether or not the patient had suffered any physical or mental injury, a doctor or surgeon who treated or operated upon a patient without the consent of the patient would occasionally be running the risk of this type of action.

As there has been no basic general common law or statutory rule allowing any other person to consent to medical treatment or surgery on behalf of another adult, the position up to now has been fraught with legal difficulties for adults incapable of giving effective legal consent to medical treatment and for their doctors. Obviously there are many non-emergency situations, where there is no real threat to the patient's life, but medical or surgical treatment may be of benefit. It would be unrealistic to consider that those who are incapable of giving effective consent would wish to refuse all routine treatments and elective surgery if they could make their wishes known. Despite the dubious legality of their actions, many doctors would find it ethically repugnant to refuse treatment of a patient's ailments when to do so means that the patient will undergo unnecessary suffering.[13]

Whilst this is only one of the problems which the Protection of Personal and Property Rights Act 1988 ("the Act") was intended to solve, it is obviously a significant one for all those concerned: the adults who are temporarily or permanently incapable of giving consent to medical or surgical procedures, their friends and relatives, doctors and surgeons, and the judiciary which is sometimes called upon to decide particularly contentious issues such as sterilisation in what is virtually a legal vacuum.[14] Thus it might have been expected that the Act would address this issue and supply clear guidelines and a legal framework for substitute consent.

The Act came into force in October 1988, and as the first and only legislation in New Zealand dealing with a whole range of matters affecting those people who are not able to manage aspects of their own care or property, it will be the governing legislation in its area. The Act was intended to reform property management for persons who are not capable of managing their property themselves and to provide proxy decision-making powers in respect of personal care and welfare, while setting clear limits on such powers and reforming the old statutory and common law assumptions. These assumptions included the automatically assumed inability of committed mental patients to manage their own financial affairs. In addition, the Act enables people to make provision for their

10 *G* v *Auckland Hospital Board* [1976] 1 NZLR 638.

11 Accident Compensation Act 1982, s 2; definition of "personal injury by accident" part (a)(ii).

12 *Donselaar* v *Donselaar* [1982] 1 NZLR 97.

13 For example, as in *T* v *T* [1988] 2 WLR 189, 199 per Wood J: ". . . a situation where based upon good medical practice there are really no two views of what course is for the best."

14 *Re F (Mental Patient: Sterilisation)* [1989] 2 WLR 1025 (CA & HL (E)) set out new procedural directions for the Family Division in sterilisation applications.

own foreseeable periods of incapacity by appointing enduring powers of attorney in relation to property or to personal care and welfare.[15] In particular, it is possible under the Act for a person to write specific instructions regarding the medical procedure(s) to which he or she consents in the event of later becoming otherwise incapable of giving a legally effective consent. This aspect of the Act both enables actions which were previously legally impossible, and changes the rule by which any previously-made power of attorney was automatically revoked when the grantor became mentally incompetent. In addition to this and other far-reaching changes to the law of property affecting those not competent to manage their own affairs, the Act gives the Family Court ("the court") jurisdiction to make a wide variety of orders for the personal care of those within the jurisdiction of the Act. For example, the court may make an order under section 10(1)(c) that a parent's arrangements for the care of a person after the parent's death shall be observed or varied. Among the kinds of order which can be made under section 10(1) are two of particular interest in the context of medical treatment for those who come under the jurisdiction of the Act. The first is found in section 10(1)(f): "An order that the person be provided with medical advice or treatment of a kind specified in the order." The second is in section 10(1)(k): "An order under section 12 of this Act appointing a welfare guardian for the person." It is in a detailed examination of these two provisions, and of the powers which a welfare guardian may be given, that an answer to the question which is central to this paper will be sought. That question is:

How does the Act provide for the situation where an adult is incapable of giving a legally effective consent to medical or surgical treatment?

Orders Under Section 10

The wording of section 10(1)(f), that the court may make an order "that the person be provided with medical advice or treatment of a kind specified in the order" may lead one rapidly to the conclusion that when treatment of some kind seems needed and the adult needing it is unable to consent, the Family Court should be approached for this kind of order and the making of the order itself will justify proceeding with the proposed treatment. Alternatively, or in addition, one could seek an order under section 10(1)(d) of the Act, that "the person shall enter, attend at, or leave an institution specified in the order" (where the institution is not a psychiatric hospital).[16] Thus one imagines that the person is brought to a hospital, or clinic, or nursing home, medical treatment or advice is provided for the person, and all the difficulties of the situation disappear. Unfortunately, there is a considerable difference between permitting or ordering the provision of medical advice and authorising the treatment itself. It is possible that a doctor or surgeon can offer to provide medical advice and/or treatment in accordance with such an order but the person

15 See Part IX of the Act and the Third Schedule to the Act.

16 The Mental Health Act 1969 covers all admissions to psychiatric hospitals. See also "Mentally Ill Adults and the Act" below.

on whose behalf the order has been sought may refuse the medical advice and treatment which has been provided. A person can be forced to attend a doctor's office,[17] but not to accept the facilities which have been provided. No doubt, often people subject to the Act will be perfectly happy to accept the medical treatment and advice which has been provided them under such an order, but in other cases the person may refuse to accept the advice or treatment which has been offered.

Supposing that this kind of situation arises, what are the legal options under the Act? The first is that the person seeking the order, the court and the doctor can all ignore the actual wording of the section and interpret it to mean "that the person be given treatment" or "an order that the person receive treatment" or "an order that the person be treated as specified in the order".

A second option is to interpret the provisions on treatment and attendance at institutions as simply enabling the persons seeking the order to seek access to facilities on behalf of a person unable to seek such facilities himself or herself. This interpretation has the advantage of conforming more exactly to a plain reading of the words used, and also places the provisions in question as part of a coherent scheme in the surrounding provisions. Instead of being provisions which automatically override a person's autonomy, the provisions take their place in a series of similar provisions, all concerning services available in the community, which advocates for persons with some degree of mental handicap, for instance, may be seeking for those persons. Often those who try to arrange fair wages or good accommodation for a person who is handicapped find they do not have the legal standing to make such arrangements. It seems likely that sections 10(1)(a) to 10(1)(i) are designed to provide the legal leverage needed by such advocates, in the form of specialised orders.[18] People who need only situational advocacy of this type are unlikely to need any form of guardianship per se, and whilst orders for the appointment of welfare guardians are listed in section 10(1), it is for the sake of providing an exhaustive list of possible orders under the part of the Act dealing with personal care. For the same reason, a personal order for the administration of a particular limited item of property is included in the list of orders possible under this part of the Act.[19]

A third possibility is to treat an order for the provision of medical advice or treatment or an order for attendance at an institution under section

17 If necessary, by conveying the person there by force and against his or her will. The existence of a relevant order under s 10(1)(d) might operate to protect those complying with it from liability for assault, false imprisonment or wrongful arrest when conveying the person to a clinic or similar institution "specified in the order".

18 Another provision also does not fit the scheme of the surrounding provisions: s 10(1)(h), on restricting a person from leaving New Zealand. Submissions on the Bill raised objections to this particular provision, as being unduly restrictive and therefore inconsistent with the spirit of the surrounding provisions. Those objections serve to emphasise that the nature of the statutory scheme at this point is primarily to enable the provision of services, rather than to provide ways of overruling the wishes of the person subject to the court's jurisdiction under this part of the Act.

19 See s 10(1)(j).

10(1)(d) or (f) as sufficient in law only to ensure that the necessary services are provided, but to back up the orders with further directions under section 10(4) which provides that:

> Where a Court makes any personal order, it may also make such other orders and give such directions as may be necessary or expedient to give effect, or better effect, to the personal order.

Thus the Court could direct that the refusal of the person (named in the order to be provided with medical advice or treatment) to consent to the treatment is to be disregarded as of no effect by those providing the advice or treatment.

Whilst in theory this third option is perfectly possible, it seems in principle somewhat at odds with the "primary objectives" of the court in the exercise of its jurisdiction under the part of the Act dealing with personal rights. These objectives are set out in section 8. The first is making "the least restrictive intervention possible in the life of the person in respect of whom the application is made, having regard to the degree of that person's incapacity". The second objective is enabling or encouraging the person "to exercise and develop such capacity as he or she has to the greatest extent possible".[20] Naturally, "having regard to the degree of that person's incapacity" when making "the least restrictive intervention possible" will determine to a large extent how far a court will disregard a person's autonomy. It may well mean that in the case of a person who was, for instance, totally comatose and likely to remain so, or quite incapable of communicating their wishes as the result of a cerebral haemorrhage, or severely and permanently mentally handicapped that it would be artificial to regard the individual's autonomy as much more than an ideal theoretical right. "Autonomy" for such a person could be reduced, for example, to a right of that person to be the central consideration in decisions about medical treatment. Perhaps the court may try to make a fairly "objective" decision based on what treatment a hypothetical "reasonable person" would agree to receiving in the position of the person for whom the order was sought. To some extent also, the court might have regard to any wishes of the person expressed before the onset of the incapacitating condition as to preferences for or aversions to particular types of treatment. Even the previously expressed wishes of the person might not be of very great weight, however, as it is not uncommon for people when well to feel strongly about some kind of treatment, yet to regard the same treatment in a different light when they are ill.

If a person is not totally incapacitated and an application is made for an order for attendance (at a clinic) and/or for the provision of medical advice or treatment, but the person refuses the treatment, should the court seek to override the wishes of the person by resorting to directions to disregard the person's refusal? The objective of the "least restrictive intervention possible" does not seem to support such an interference with a person's autonomy. If the person has the capacity to understand something of what is proposed, but objects to it, what factors should the

20 See s 8(a) and (b).

court consider and what rationale is a court likely to use for giving a direction to ignore the person's refusal? Some factors the court might consider relevant are how serious the person's physical condition is and whether there is unanimity among the medical profession as to the advisability of the proposed treatment. If there is a diversity of view, a conflict of "expert evidence" as to the most suitable treatment, or if the treatment is "elective", the court may be less likely to disregard the objections of the "incapacitated" patient. The rationale which the court is most likely to use to justify overriding a person's refusal is that of acting in the person's "best interests".

Family courts are already familiar with arguments about "best interests", because the principle is paramount in questions about custody and guardianship of, and access to, children.[21] Yet the Protection of Personal and Property Rights Act seems to be seeking to avoid unnecessary paternalism, and in the light of this it would be unfortunate if the expressed wishes of the people under the jurisdiction of the Act were to be treated on a level with those of children, on whose behalf adults use their "better" judgment to decide the best interests of children. Reinforcing the view that it would be unfortunate to use the Act in this way is section 6(3) of the Act, on the jurisdiction of the court. It provides that:

> The fact that the person in respect of whom the application is made . . . has made or is intending to make any decision that a person exercising ordinary prudence would not have made or would not make given the same circumstances is not in itself sufficient ground for the exercise of that jurisdiction by the Court.

This provision should operate as more than simply protecting the eccentric or wilful from the interference of their families. The provision seems to demand that the court respect as far as possible the autonomy of individuals.

What happens if a personal order is made for provision of treatment for a person, perhaps with the extra direction that the person's refusal of the treatment is not to be effective, but that person persists in obdurate refusal of the treatment? In this area, if a person were not subject to any order, flagrant disregard of their wishes could lead to punitive damages. Many doctors might hesitate to insist on treating the patient against his or her will. Section 23 deals with what can happen next: non-compliance with a personal order can lead to the appointment of a welfare guardian, whose function is to take all reasonable steps to ensure compliance. However, if an order had been made under section 10(1)(f) that a person be provided with medical advice, the person "complying" or not with the order is the medical practitioner. The doctor may have already provided the advice and be offering the treatment. Little could be gained by appointing a welfare guardian, particularly if the extra "direction" under section 10(4) had been given already to disregard the person's refusal but the doctor was still reluctant to treat the person against the wishes of that person. Perhaps the welfare guardian could attempt to persuade the person to accept the treatment, but the formality of a welfare guardian's

21 Guardianship Act 1968, s 23.

appointment is hardly necessary to that role. If the original order had been framed under section 10(1)(d), that "the person shall attend . . .", the person would be the non-complier. Thus a welfare guardian's appointment might suffice to ensure a forced attendance at a doctor's office or a hospital, but the refusal of treatment raises all the former problems. Unless the order had contained the direction that the person must permit treatment of himself or herself, the welfare guardian would have nothing futher with which to ensure compliance.

Ultimately, reassurance given by the welfare guardian to the doctor that the person's refusal could be ignored with impunity, or persuasion of the person to accept the treatment, seem the only possible functions for a welfare guardian appointed to ensure compliance. The fundamental problem seems to be that if the court considers that it is in someone's best interests that his or her consent to treatment is unnecessary or that his or her refusal of treatment should be ignored, then the use of these at first apparently suitable provisions is at best a very indirect way of proceeding.

Appointment of a Welfare Guardian

If the court wishes to use an appropriate method for the more direct intervention required to order medical treatment for a person (instead of just ensuring that it is available), the appointment of a welfare guardian to deal with the situation specifically and directly may be required.

The Act makes mention of the term "consent" in the context of medical treatment only in section 18(1). The Minister of Justice, the Rt Hon Geoffrey Palmer described this part of the Bill to Parliament as follows: "Clause 18 deals with the powers and duties of a welfare guardian and in particular, clause 18(1) sets out those powers which may not be bestowed on a welfare guardian."[22] The Minister also said that:[23]

> When a welfare guardian is appointed, the court is required to specify the particular area or areas in which that welfare guardian would have decision-making capacity. The intention is to restrict the appointment of welfare guardians to those times when it is absolutely necessary for the decision-making powers of one person to be exercised by another person.

This is a reference to section 12(1) of the Act.[24] Obviously, the court will seek to tailor such orders to the particular persons and their individual circumstances. That exceptions to the welfare guardian's powers to consent to or refuse specific types of medical treatment are set out in section 18(1) may imply that a welfare guardian ordinarily can consent to medical treatment and procedures other than those specifically excluded.

On the other hand, section 18(2) says that other than the specific exclusions of section 18(1), the welfare guardian

22 New Zealand Parliamentary Debates (Weekly Hansard), No 11, 18 February 1988 2119, 2121.
23 Ibid at 2120.
24 ". . .[T]he Court may make an order appointing a welfare guardian for the person . . . in relation to such aspect or aspects of *the personal care and welfare* of that person as the Court specifies in the order" (emphasis added).

> shall have all such powers as may reasonably be required to enable the welfare guardian to make and implement decisions for the person for whom the welfare guardian is acting *in respect of each aspect specified by the Court in the order* by which the appointment of the welfare guardian is made. (emphasis added)

What "aspects" could be specified by the court? Section 12(2)(a) specifies as one precondition for the appointment of a welfare guardian: an incapacity to make or communicate decisions relating to "any particular aspect or particular aspects of the personal care and welfare of that person". Thus the aspects which can be specified by a court for a welfare guardian's decision-making are aspects of the personal care and welfare of the person. One would assume that many routine medical decisions are aspects of personal care and welfare, so while the court could well specify medical decisions as an aspect of a welfare guardian's appointment, this aspect would require mention in such an order and would not to be an automatic part of the powers of a welfare guardian.

Whether the power of medical decisions passes automatically to a welfare guardian, or must be specified in the order, the statutory limits on a welfare guardian's powers of consent in section 18(1) need closer examination. A general consideration of the operation of section 18(1) follows, with specific references to the issues raised by sterilisation, welfare guardians and minors (married or unmarried) and welfare guardians and the mentally ill.

With regard to medical treatment, the relevant parts of section 18(1) are paragraphs (c), (d), (e) and (f). Of these provisions, (d) and (e) are designed to tie in with the new Mental Health Act and will be discussed under "Mentally Ill Adults and the Act".

Paragraph (c) states that no welfare guardian shall have power

> to refuse consent to the administering to that person of any standard medical treatment or procedure intended to save that person's life or to prevent serious damage to that person's health.

The features of this provision of particular interest are the "lifesaving" term; who must have the necessary intention; what is "serious damage" for the purposes of this provision and what is "standard" medical treatment.

This paragraph places a limit on the discretion of a welfare guardian. The welfare guardian's own judgment of what is in the best interests of the person for whom the welfare guardian is acting is subject to a particular restraint. If the person's life is in danger or his or her health could be seriously damaged, then the welfare guardian cannot refuse a standard medical procedure or treatment intended to obviate that threat to life or serious danger.

In part, this provision operates to continue to protect doctors in the "emergency" situation recognised at common law as an exception to the requirement for consent. Even if a welfare guardian has been appointed for a person, the doctor need not delay treatment of a patient to ascertain whether the person has a welfare guardian or to contact the welfare guardian, since the welfare guardian cannot in any case refuse the necessary life-saving treatment.

It would be irrelevant whether the result of the treatment or procedure

was in fact that the person's life was saved or serious damage to health averted, and similarly it would be irrelevant whether the treatment or procedure was necessary to do so. It is only necessary that the treatment or procedure be "intended" to do so.

Whose intention should this be? It is arguable that the intention should be that of the person who is to receive the treatment. If that person made a personal judgment that he or she required a certain type of medication, and that person intended to receive it, this on the face of it would be enough to override the welfare guardian's contrary personal view.[25] This possibility is supported by the statutory importance in the Act of developing the person's own decision-making capacity.[26]

Similarly, the friends, relatives and social workers who know the person may regard some particular treatment or procedure as potentially lifesaving. This kind of situation arose in the Becker case in the United States[27] when friends of the Becker boy, Phillip, regarded proposed heart surgery in this way. Phillip's parents thought that the heart surgery would cause more harm overall to their son than benefit, and opposed the operation. The heart problem did not create a real medical "emergency". Doctors could not predict with confidence that the operation would be successful or that if it were a success that the boy's life would be significantly lengthened. There were considerable dangers inherent in the surgery itself and the boy had Down's syndrome with its relatively short life-expectancy. Yet if the condition remained untreated, progressive and serious damage would be caused to the boy's health. As this damage was severe in itself and would shorten his lifespan still further, it could be classified as "serious".[28] In a parallel case where a welfare guardian had been appointed for an adult, the procedure proposed by the person's friends could well be intended by them to previous serious damage to the person's health. It could be argued by them, also, that the person's life was threatened, not by an immediate emergency, but by a long-term condition which would eventually lead to a shorter life. Thus the intention of various well-wishers might fulfil the statutory requirements and prevent the welfare guardian from exercising a discretion to refuse the treatment.

Another possible group of people who could hold the necessary intention is the group of health professionals involved with the person who has a welfare guardian. In an emergency situation, the judgment of medical practitioners is likely to lead directly to the administration of medical treatment. Their intention to save the person's life is likely to result in their treating the person. As discussed above, they will be unlikely in a true emergency to give consideration to the possible attitude of the welfare guardian to the treatment, and this paragraph operates to preserve their traditional common law justification for proceeding without consent.

25 Of course, it is possible that the person may wish for totally inappropriate treatment which no competent medical person would regard as potentially life-saving. In such circumstances, the intention of the person to receive such treatment would be irrelevant in practice.

26 See s 8(b) on the primary objectives of the court in this context.

27 *Re Phillip B* (1979) 92 Cal App 3d 796.

28 Eventually another couple, the Heaths, were appointed as Phillip's guardians: *Guardianship of Phillip Becker*, 1983. They authorised the heart surgery, which was successful.

It is in the area of "preventing serious damage to health" that most problems are likely to arise. Does "health" include both physical and mental health? Early versions of the Bill would have prevented the welfare guardian from consenting to the administration of psychotropic drugs to the person for whom the welfare guardian was appointed. The Minister of Justice said of the original provision: "[This] prohibition has been removed as being rather over-cautious in view of the large range of psychotropic drugs used in standard medical treatment."[29] Thus it was accepted in the course of the Bill's history that a welfare guardian could consent to the administration of psychotropic drugs as a standard medical treatment. Such drugs are intended to treat mental health, so the reference to health in paragraph (c) must include a reference to the mental health of the person. Thus a doctor's intention to prevent serious damage to the mental health of the person may be enough to justify the doctor proceeding, and by the fulfilment of the statutory requirements, a welfare guardian would be without power to refuse consent to the procedure or treatment.

Various health practitioners attending a person may disagree on whether a treatment will in fact prevent serious damage to the person's physical or mental health. This could be the case especially in the more debatable areas of health care, such as the value or detriment of sterilisation. There is no consensus in the medical or wider community on this issue and one of the various opinions about sterilisation could be reflected in a strongly-held view that the person's mental or physical health will be seriously damaged without sterilisation. It would seem that the welfare guardian could not refuse to have a sterilisation proceed if a medical practitioner regarded the proposed sterilisation in this way.[30]

It is possible that in some of these situations the welfare guardian's refusal to consent, while based on quite ordinary if not uncontroversial opposition to sterilisation as not being the best available option in the particular case, could be overriden by the judgment of even one doctor or by the social judgment of other persons such as relatives, holding the view that serious damage could be done to the person's health by a failure to sterilise the person.[31]

The issue of sterilisation is one which highlights another problem area of this provision. What is "standard" medical treatment? Also, what is "medical experiment" for the purposes of paragraph 18(1)(f)? The distinction between them is tremendously important for a welfare guardian. This is because a welfare guardian may not refuse consent to any standard

29 Supra n 22 at 2121.

30 It may even be enough if a social welfare agent, for instance, did so and was able to find a surgeon prepared to operate even though the surgeon personally did not hold the view that sterilisation was necessary to prevent serious damage to the person's health.

31 *Re D (a Minor)* Wardship: Sterilisation) [1976] Fam 185; [1976] 2 WLR 279 illustrated a conflict of views regarding the proposed sterilisation of an 11 year old girl. Her mother, a paediatrician and a gynaecologist shared the view that D ought to be sterilised, but an educational psychologist took the opposite view. The matter went to court and Heilbron J refused to sanction the operation. In a similar situation, a welfare guardian appointed to make medical decisions for a person might be unable to refuse consent to sterilisation when other people hold the view that serious preventable damage will be done to the person's physical or mental health by not sterilising the person.

medical treatment or procedure intended to save the life or prevent serious damage to the health of the person for whom the welfare guardian has been appointed, and the welfare guardian may not consent to the person's taking part in any medical experiments unless they are conducted for the purpose of saving the person's life or of preventing serious damage to the person's health.

The difference between "standard medical treatment" and "medical experiments" is one which will be clear enough in many cases. Giving insulin to a diabetic or antibiotics for infections, for instance, could be classified as "standard" treatments. Above all, a constantly-used, well-established method of treatment contrasts vividly with an experimental method which is uncertain in its broadest effects, with no statistical information on the incidence of deleterious side-effects and lacking even minimum reasonably predictable known benefits.[32] There are many treatments, however, which although relatively new have some known benefits but of which the full gamut of effects and side-effects is not yet known. Where is the line to be drawn between standard treatment and taking part in a medical experiment, and on which side of that line will any particular proposed treatment fall? A distinction which would be hard for a medically qualified person to make will nonetheless have to be one about which a welfare guardian (or a doctor) is absolutely clear, as the consequence is that a welfare guardian has no power to refuse consent, or to consent to a treatment or procedure, as a matter of law, depending on whether the treatment is "standard" or "experimental" respectively. Although a welfare guardian may apply to the court for guidance[33] a court may not be in a better position than the welfare guardian to make such a distinction.

Could a welfare guardian consent to the person's participating in controlled trials of two different "standard" procedures or treatment? It would seem to depend on whether the standard procedures were intended to save the person's life or prevent serious damage to the person's health, or not. The welfare guardian probably could not consent to the person taking part in trials of "standard" procedures which did not fulfil those requirements, however innocuous the proposed treatment, as it seems that this would constitute the person's "taking part in medical experiments".

Even within the area of treatment properly designated as "standard", there is a grey area. For any one medical condition, there may be several possible "standard" treatments. The *"Bolam"* test[34] might well be adapted by New Zealand courts to the problem of what constitutes standard medical

32 This provision will operate to protect mentally handicapped persons who have welfare guardians from some of the worst excesses of clearly experimental procedures to which they have been subjected in the past. One potential problem with these provisions is deciding whether the use of artificial ventilation and circulatory machines is "standard" treatment or not for irreversibly comatose patients and if so, at what point (eg "brain-death") does it cease to be standard treatment.

33 Section 18(6).

34 From *Bolam* v *Friern Hospital Management Committee* [1957] 1 WLR 582, 587: for doctors, negligence is determined by whether the doctor acted "as no doctor of ordinary skill . . . acting with ordinary care" would act. See also the House of Lord's discussion in *Sidaway* v *Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital* [1985] AC 871.

treatment. Thus any treatment could be designated "standard" if a body of respected medical practitioners at the time considered it to be normal, usual or simply not exceptionable. That the group of doctors or surgeons who considered it to be so was small would be unimportant, as would the fact that other larger groups held quite different opinions as to the value or normalcy of the treatment. If, for example, a surgeon and a few of his or her colleagues held the view that sterilisation was a standard method of contraception for mentally handicapped, sexually active women and that their physical or mental health would be seriously damaged by childbirth and the responsibilities of child-rearing, a welfare guardian could be prevented from refusing the operation on behalf of the woman by the application of a test like the *"Bolam"* test, which would classify the procedure as a standard one. Although the sterilisation of mentally handicapped men, by application of the same test, might also be found to be a "standard" procedure, it would be less likely to satisfy the conditions of paragraph (c), as the stresses of pregnancy and childbirth, often cited as the danger to mentally handicapped women from non-sterilisation, are absent. Other factors leading to damage to mental health could be invoked, such as for a married mentally handicapped man, that he could not cope with the strain induced by extra financial obligations.

Could a welfare guardian demand an alternative treatment or procedure, such as birth control instruction? If the proposed sterilisation met whatever test is eventually accepted for treatment to be termed "standard", and its proponents intended the sterilisation to prevent serious damage to the person's health, then the welfare guardian may have no discretion to refuse the operation. Similarly, there is no provision for rejection of a particular doctor or surgeon, in order to consult a different one for a "second opinion", with the possible outcome of a different proposal for a less drastic, but equally "standard" treatment.

Sterilisation is a particularly difficult issue, because it is seen as a serious intervention in another person's life. It could be argued that the decision is just as personal and private as the decision to marry, divorce or to have one's child adopted. Those decisions are specifically excepted from the scope of any welfare guardian's decision-making powers.[35] When sterilisation is necessary for some medical condition then the procedure is not controversial. Such "therapeutic" sterilisations should be authorised by welfare guardians if the condition is one which could threaten the person's life or seriously damage his or her health if left untreated. The Act does provide a legal structure for these extreme therapeutic cases. A welfare guardian could be appointed to make the necessary arrangements and give the necessary consent. Somewhat ironically, the consent of the welfare guardian is something which can then be dispensed with more or less automatically, under the terms of paragraph (c).

One thing is made clear by section 18(3). A welfare guardian, in exercising his or her powers, must have as the "first and paramount consideration . . . the promotion and protection of the welfare and best interests of the person for whom the welfare guardian is acting". This ensures that in

35 Section 18(1), (a) and (b).

sterilisation cases, while consideration of the interests of the people surrounding the person in question is not excluded, their worries are not to be the deciding factor. It is frequently the anxieties of parents of the mentally handicapped which lead to applications for their sterilisation.[36] The welfare guardian is obliged to regard such matters as secondary except as they directly affect the best interests of the person for whom he or she is acting. Such matters include quality of life arguments, the risk of surgery and possible adverse psychological effects.

When the Bill was before Parliament, the Minister of Justice seemed to envisage that the really difficult and more controversial sterilisation decisions could be made by the High Court: "[A] person objecting to proposals for sterilisation should be able to invoke the inherent jurisdiction of the High Court in relation to intellectually or mentally disordered persons".[37] This refers to the "parens patriae" jurisdiction of the High Court, a penumbral residual protective capacity of the Court generally applied to minors. It could be invoked for decisions relating to adults on the grounds that if they are mentally incapacitated, they can be seen as requiring the protection of the High Court.[38] It was discussed in a recent English case, *T* v *T*[39] and also in a recent Canadian one.[40] Neither decision is binding on New Zealand courts, yet in many ways the Canadian decision is more persuasive than that of the United Kingdom, as it fully considered the history and nature of the parens patriae jurisdiction. The Canadian case stated clearly that the parens patriae jurisdiction cannot be invoked to permit non-therapeutic sterilisation of the mentally handicapped. As the Act notably does not decide who decides sterilisation questions, there could be great pressure in New Zealand for the exercise of the parens patriae jurisdiction. Family court judges may be unwilling to decide such issues,[41]

36 The case of *Re D (a Minor),* supra n 31, illustrates the kind of anxieties which such parents may feel: that any child may be born with a congenital handicap; that the handicapped parent may be unable to care for the child; and that the grandparent will become responsible for the child's care. Whilst such eventualities and anxieties may have a detrimental effect on the environment of the person for whom sterilisation is proposed, these factors often will be secondary to the likely and more immediate risks and effects of the sterilisation itself upon the person.

37 Supra n 22 at 2121.

38 The basis for the parens patriae jurisdiction of the High Court in New Zealand is s 17 of the Judicature Act 1908 which virtually re-enacts the provisions of the Supreme Court Act 1860. This stated that the Supreme Court of New Zealand "shall have all such equitable jurisdiction as the Lord High Chancellor of Great Britain hath in England" (s 4). Also, the Court was to have "power to appoint and control . . ." Committees of the persons and estates of idiots, lunatics, and such as being of unsound mind, are unable to govern themselves and their Estates" (s 5).
Since 1660 the Lord Chancellor in Great Britain had been the channel (by letters patent under the Sign Manual) of the Crown's parens patriae jurisdiction, which extended well before 1860 to the care and custody of the persons and estates of "persons of unsound mind". An excellent discussion of the history of the parens patriae jurisdiction is found at pages 14-15 of *Re Eve* (infra n 40).

39 Supra n 13 at 195.

40 *Re Eve* (1986) 31 DLR (4th) 1.

41 *Re B* (Wardship: Sterilisation) [1988] AC 199 concerned a sterilisation application for a minor. That case was considered in *Re F* (supra n 14) and Lord Donaldson MR held it to be authority for the proposition that all proposed sterilisations of minors should seek the court's prior approval.

either directly on application by a welfare guardian under section 18(6), or indirectly by appointing a welfare guardian in a sterilisation issue which has already arisen, when the judge is aware that the welfare guardian holds one view or another already upon the issue, thus effectively deciding the issue by the appointment of a particular welfare guardian. Family court judges could choose to refer such cases whenever they arise to the High Court for the exercise of its parens patriae jurisdiction.

Unmarried Minors and the Act

If a minor is not and has never been married, and if the treatment proposed is not psychiatric treatment for a committed minor, the court may appoint a welfare guardian in certain circumstances.[42] If no parent or guardian[43] is alive, a welfare guardian may be appointed. Even if a parent or guardian is alive, the court may do so, but two further conditions must be fulfilled. These are that no parent or guardian is in regular contact with the minor and the court must be satisfied that in all the circumstances the appointment would be in the best interests of the minor.[44]

If it is within the powers of a welfare guardian to give consent to a non-excepted category of treatment, then one would expect that a welfare guardian is entitled to do so for a minor. There is, however, a specific statutory provision for the consent of "any other person to any medical, surgical or dental procedure . . . to be carried out on a child"[45] where that is "necessary or sufficient".[46] This is qualified by section 25(5)(c) of the Guardianship Act, which specifies that "Nothing [in section 25] shall limit or affect any enactment . . . whereby in any circumstances . . . the consent of any other person instead of the consent of the child is sufficient". The Protection of Personal and Property Rights Act, since it would allow a welfare guardian to consent to treatment on behalf of a minor, is such an enactment.

Married Minors and the Act

The Guardianship Act allows the consent or refusal of treatment by "[a] child [who] is [married] or has been married" to have the "same effect as if he were of full age".[47] Before the Protection of Personal and Property Rights Act came into effect, substitute consent for married minors by parents and other guardians under the Guardianship Act was already ruled out by section 25(5)(c). Yet it is possible for someone to be a married minor and unable to give consent to medical treatment. Although minors

42 The court does not in any case have jurisdiction to make orders other than those appointing welfare guardians for unmarried minors: see s 6(2), which excludes the court from jurisdiction in respect of unmarried minors from the "Personal Rights" part of the Act, except for the appointment of welfare guardians under the limited circumstances set out in s 12(3).

43 This would include testamentary guardians: Guardianship Act 1968, s 7(1).

44 Ibid, s 12(3).

45 The definition of child in section 2 of the Guardianship Act is "a person under the age of 20 years".

46 Guardianship Act, s 25(3).

47 Ibid, s 25(2).

who are and always have been severely mentally handicapped are unlikely to have been capable of consenting to marriage, there are many moderately handicapped minors who are quite capable of doing so.[48] They may still be incapable of informed consent to complex medical treatment or surgery, if they are unable to understand its nature and the risks involved. Where the proposed treatment is "elective" or is not required by some immediate threat to life, the doctor is hampered by the lack of consent or proxy consent.

Some married minors may have been formerly of full legal capacity, but as the result of accident or illness, they may become incapable of consent. Even if the person's wishes and attitudes to a particular course of treatment are known, there is no way in which those wishes could be implemented at common law. It is possible for married minors to make provision like any other person for such a situation[49] but it is unlikely that they would have done so, unless for instance they knew themselves to be suffering from a progressive debilitating illness.

It seems however that the court can make the same orders for married minors as for adults under the "Personal Rights" part of the Act. If a minor does not fulfil both conditions of section 6(2)[50] then it seems that the court's jurisdiction for making personal orders in respect of such married minors is not excluded. Section 6(2) is "subject to section 12(3)" of the Act. Section 12(3) deals with the circumstances in which the court is able to appoint welfare guardians for unmarried minors, and does not preclude the court's jurisdiction in respect of married minors. A married minor who is incapable of giving legally effective consent to medical treatment is, as a result of the Act, in the same position as adults are who similarly incapable, and subject to the same advantages or difficulties in respect of its interpretation and application.

Mentally Ill Adults and the Act

At present, those people who are committed psychiatric patients are subject by statute to compulsory treatment. Under section 25 of the Mental Health Act 1969, the superintendent of a psychiatric hospital can authorise their treatment regardless of the competence of the committed patient. This provision for compulsory treatment has been reviewed extensively during the process of preparing the Mental Health Bill 1987. Clauses 40 to 45 of the Bill deal with compulsory treatment and provide different sets of requirements to be fulfilled before compulsory treatment is permitted according to the nature of the psychiatric treatment. The requirements are more stringent for electro-convulsive therapy than for other types of psychiatric treatment. For psychosurgery, not only is compulsory treatment not permitted, but psychosurgery will occupy the unique position in law

48 Among the requirements as to capacity for marriage in s 3 of the Marriage Act 1955 is consent. The test of whether a person has the mental capacity to give legally effective consent to marriage, is whether the person understands the nature of the "contract" he or she is entering upon marriage, and the nature of the duties and responsibilities it creates; *J* v *J* [1974] 2 NZLR 498; cf *McPherson* v *Shepherd* (1984) 3 NZFLR 241.

49 See the Third Schedule to the Act for forms of enduring power of attorney.

50 Ie by being a minor who is or has been married.

of having a statutory requirement for the consent of the patient, and moreover that consent must be in writing.[51] The limits on the powers of welfare guardians in section 18(1)(d) and (e) were written to match the consent requirements of the Mental Health Bill. All the provisions in the Mental Health Bill for compulsory treatment apply only to psychiatric treatment. Thus even for patients undergoing compulsory assessment or subject to a compulsory treatment order, any form of medical treatment which is not for psychiatric illness is subject to the usual requirement for consent to medical treatment in general at common and statute law. Minors who are committed psychiatric patients, unless the treatment is psychiatric treatment, are subject to the same principles as other minors in respect of medical treatment. Committed minors are subject to the same compulsory psychiatric treatment as other committed psychiatric patients. There is no legal need for the consent of any person to such treatment, once it has been authorised by the superintendent of the psychiatric hospital to which the minor has been committed.

In this context, a person who lacks the capacity to consent to medical treatment and who is a committed psychiatric patient (of whatever age) will be able to use the provisions of the Protection of Personal and Property Rights Act to seek orders for his or her personal care and welfare. Other people can act on behalf of the committed psychiatric patient to use the court to ascertain whether the person stands in need of substitute decision-making by the court or by the appointment of a welfare guardian. When the new Mental Health Bill becomes law the presumption of competence in the Act[52] will enable psychiatric patients to manage their own personal care and property unless they are shown to be unable to do so. This situation will provide a pleasing contrast to the present one whereby persons who are committed psychiatric patients are deemed incompetent in decisions relating to all aspects of their personal care and property.

Conclusion

The Protection of Personal and Property Rights Act 1988 has many features which will be of great benefit to those who are within its jurisdiction, as well as being an invaluable aid to all who seek to act on behalf of such persons. In particular, the ability to obtain orders which give people the legal authority to seek services for others is an excellent innovation.

It is in the area of consent to medical treatment that the Act, somewhat disappointingly, does not provide the clear guidance which is needed. The provisions on the orders available under section 10, when interpreted according to the ordinary meaning of the words used and in the context of the surrounding statutory scheme, do not seem appropriate for the difficult cases where a mildly incapacitated person refuses medical treatment of a particular kind. However, they may be effective in providing treatment for a non-objecting mildly incapacitated person, or a person who is totally incapacitated simply because such persons are unable to express

51 Mental Health Bill 1987, clause 43(2)(a).
52 Section 5 of the Act.

any opinion whatsoever on the proposed treatment. Whilst the provisions of section 10 may be used to authorise provision of medical treatment, it is doubtful that they fill any legal gap created by the absence of the person's ability to give legally effective consent to treatment.

Appointing a welfare guardian is not of itself the solution to problems of consent to medical treatment. One matter about which the Act is not specific is whether all welfare guardians have the power to consent to any medical procedures except those specifically excluded by section 18(1), or whether the power of a welfare guardian to make decisions about medical treatment is an aspect of personal care which must be specified in the order appointing the welfare guardian. The latter interpretation is more likely to be correct.

Again, for persons who are totally unable to make or express decisions about medical treatment, the court will have no difficulty in appointing a welfare guardian to make such decisions on behalf of the person. If the treatment proposed is intended to save the person's life or prevent serious damage to his or her health, the welfare guardian's course is clear. The welfare guardian cannot refuse consent to such treatment. Some treatments, however, are controversial, such as the "non-therapeutic" sterilisation of mentally handicapped men and women. A person other than the welfare guardian, such as a doctor, who holds the view that not sterilising a mentally handicapped man or woman would lead to his or her health being seriously damaged, could override the views of the welfare guardian, who may have been appointed to deal with the very issue of sterilisation.

It is only if a person is wholly incapable of making or communicating decisions about medical treatment that a welfare guardian can be appointed to make such decisions for the person. Therefore, whatever the true scope of a welfare guardian's powers may be in regard to such decisions, the option of appointing a welfare guardian is not available to the large group of mentally handicapped persons who are only moderately handicapped. The Act does not provide a framework for substitute consent to medical treatment for that group, since members of the group may be incapable of giving legally effective consent to medical treatment yet not wholly incapable of making decisions about medical treatment.

It is unfortunate that the Act does not deal specifically and comprehensively with the issues of consent to medical treatment in general and to sterilisation in particular. The former issue is one of everyday importance to all those who treat or seek treatment for adults incapable of consenting to medical treatment for themselves. The latter issue is one which has been a recurrent theme in debates about the care of mentally handicapped persons. Whilst the Act provides a good beginning to New Zealand legislation in the area of welfare guardians for adults, it may become necessary to amend the Act itself in order to resolve some outstanding issues which it was hoped this Act would clarify.