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Religious Beliefs and Medical Treatment: The Challenge to Patient Consent

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This paper seeks to explore the legal structure of consent and its particular application to the health care context. The emphasis upon the ethical principles of respect for autonomy and self-determination in this context raises the question of the extent to which current legal norms accommodate the spiritual diversity within the patient population. Whilst the liberal theories upon which the structure of consent have been built suggest that such diversity, as well as more generally multiculturalism, are not only respected but encouraged, it is questionable whether this has occurred in a context which concerns the beginning and ending of life as well as decisions about quality of life. The diversity within the patient population raises the issue of how amenable healthcare law, structured as it is around the ethics and beliefs of a "dominant" white, middle-class culture, is to the challenges presented by "minor" religious and spiritual beliefs. These challenges are most commonly a result of fundamental differences as to the meaning of life and death and what constitutes a "worthwhile" life. It is concluded that the law of consent is dominated by values which do not accord any preference to any faith held by the patient decision-maker. It is contended that this may not be the case in those jurisdictions which have constitutionally entrenched human rights guarantees, but an analysis of the case law in those countries suggests otherwise. It is concluded that the appropriate prescriptive model is one which accords priority to the protection of bodily integrity given the continuing need to resist paternalistic approaches in this context. However it also suggests that an approach to decision making which is more conciliatory is necessary in such a context where the law is often too blunt in its attempts to resolve difficult questions about the ending and quality of life.

Keywords

Religious beliefs, patient consent, medical treatment

RELIGIOUS BELIEFS AND MEDICAL TREATMENT: THE CHALLENGE TO PATIENT CONSENT*

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Abstract

This paper seeks to explore the legal structure of consent and its particular application to the health care context. The emphasis upon the ethical principles of respect for autonomy and self-determination in this context raises the question of the extent to which current legal norms accommodate the spiritual diversity within the patient population. Whilst the liberal theories upon which the structure of consent have been built suggest that such diversity, as well as more generally multiculturalism, are not only respected but encouraged, it is questionable whether this has occurred in a context which concerns the beginning and ending of life as well as decisions about quality of life. The diversity within the patient population raises the issue of how amenable healthcare law, structured as it is around the ethics and beliefs of a "dominant" white, middle-class culture, is to the challenges presented by "minor" religious and spiritual beliefs. These challenges are most commonly a result of fundamental differences as to the meaning of life and death and what constitutes a "worthwhile" life. It is concluded that the law of consent is dominated by values which do not accord any preference to any faith held by the patient decision-maker. It is contended that this may not be the case in those jurisdictions which have constitutionally entrenched human rights guarantees, but an analysis of the case law in those countries suggests otherwise. It is concluded that the appropriate prescriptive model is one which accords priority to the protection of bodily integrity given the continuing need to resist paternalistic approaches in this context. However it also suggests that an approach to decision making which is more conciliatory is necessary in such a context where the law is often too blunt in its attempts to resolve difficult questions about the ending and quality of life.

Introduction

This discussion concerns decision making by patients about their health care. Within this it seeks to explore the impact that different religious beliefs may have upon this process. Throughout this discussion the term 'religion' is used to refer to a group of beliefs and practices structured around spiritual or sacred matters. It therefore is interpreted as encompassing more than beliefs stemming from membership of formally organized religious such as those part of the Judaeo-Christian tradition to include Eastern religions as well as broader spiritual beliefs.¹ This is important in itself because of the different views that Western and Eastern religions take on the control which an individual can assert over the ending of their life, and treatment decisions which may affect the quality and longevity of life. Moreover, some of the observations within this paper extend beyond the notion of religion to include examples of cultural and/or ethnic diversity. It is submitted that such examples of the effects of diversity within the patient population are instructive in terms of the general thesis of this paper. In addition some of the examples will appear to be more appropriately classified as issues of gender inequality, but again, lessons can be learnt here because of the particular challenge to 'minority' groups posed by the traditionally patriarchal medical model.²

Indeed such is the religious and cultural diversity of the Australian population that it would be unrealistic to adopt any other approach.³ The patient population clearly reflects this diversity. As Derek Morgan has claimed:

...the patient has disappeared, if by the 'patient' [is meant] some generic, stand-all representative. In place we have patients who have gender, class, race, ethnicity, age and identity; we have a theatre teeming with peoples of all different constitutions and complexions.⁴

The relevance of religious diversity to health care decision making is both a topical legal issue, and one which has the potential to affect a significant portion of the

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¹ See Weller, P "'Human Rights', 'Religion' and the 'Secular'", Vol 1, Issue 1, (2006) Religion and Human Rights for an insight into the difficulties of defining "religion".

² A detailed assessment of paternalism within medicine can be found in Sheldon, S and Thomson, M, *Feminist Perspectives on Health Care Law*, (Cavendish Publishing, 1998).

³ See Australian Bureau of Statistics, 2006 Report at p

⁴ See Morgan, D 'Frameworks of Analysis for Feminists' Accounts of Reproductive Technology' in Sheldon, S and Thompson, M, *Feminist Perspective on Health Care Law*, (Cavendish Publishing, 1998).

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population. Health is intrinsic to quality of life, and therefore even if the illness or injury is not a life-threatening one, there may be side-effects associated with treatment, or the prospect of a permanent impairment to health, which will prompt a person to review their personal and professional situation. Moreover, it is not contentious that membership of a particular religion or faith may profoundly affect a person's views on the meaning of life and death,⁵ and that a person undergoing medical treatment is often confronting these issues. It is therefore no coincidence that ill health is associated with increased interest in religion and faith.

The Fundamental Role of Consent

Given the above, it is pertinent to examine our legal structure of decision-making in the health-care context, and its capacity to reflect a patient's choice about treatment based on his or her religious beliefs. The western liberal legal tradition in this and other common law countries generally emphasizes the importance of personal autonomy, a value common to deontological and consequential ethics.⁶ In health care this emphasis is expressed through the importance attached to the concept of consent to health care treatment.⁷ It is a development which is both part and product of the increasing secularization of western democracies.⁸

Such an approach would appear to support the expression of religion and wider faith-related beliefs. However the health-care context is complicated by the underlying spectre of death and chronic ill-health, and the ability of medicine to deal with those possibilities. Two interpretations of the function of consent in this context have therefore emerged, each linked to different conceptions of autonomy. The first, represented within Australian and English law, is a narrow conception based around the right to bodily integrity.⁹ On this basis the law of consent reflects the traditional understanding in the common law whereby consent operates as a defence to the crimes and torts of assault and battery.

⁵ See, eg, *The West Australian*, Feb 23, 2005 at p3 – ‘*I put my love for Jehovah above my life.*’

⁶ See Nicholson, D and Webb, J, *Professional Legal Ethics: Critical Interrogations*, (Oxford University Press, 1999).

⁷ See Freeman, M, ‘Legal and Philosophical Frameworks for Medical Decision Making’ in *Medicine, Ethics and the Law*, Current Legal Problems, (Stevens and Sons, London, 1988) and Mason J and McCall Smith A, *Law and Medical Ethics*, (5th ed, OUP, 1999)

⁸ See Weller, P, ‘“Human Rights’, ‘Religion’ and the ‘Secular’’, Vol 1, Issue 1, (2006) *Religion and Human Rights* for a discussion of what is meant by “secular”.

⁹ See, eg, *Rogers v Whittaker* (1992) 175 CLR 479, and *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's case)* (1992) 175 CLR 218.

The other conception is a wider one which is about rights and duties and control of destiny.¹⁰ It is associated with human rights jurisprudence, specifically notions of right to freedom of interference with private life,¹¹ rights to liberty and security of the person,¹² and the substantive right of due process.¹³ This approach reflects a conception of autonomy which is more directly associated with choice. Utilising this approach to autonomy brings with it the potential to expand upon the narrower understanding of consent which centres upon the protection of individual bodily integrity, particularly important where the decision is one which is prompted by the wider cultural implications of belonging to a religious group. This is because it potentially includes both negative and positive aspects in terms of its enforcement (that is the right to have alternative treatment in addition to the right to refuse treatment). Moreover it is arguable that this interpretation of autonomy is more cognizant of group decision-making and the deferring of decision-making to others, a characteristic of some religious groups.¹⁴

This latter approach stresses the role of consent as the vehicle for communication and therefore effective treatment. It is a view supported by Professor Ian Kennedy. He refers to consent as being ultimately about communication between the doctor (although equally, it is suggested, any health professional¹⁵) and the patient:

It is an ethical doctrine about respect for persons and power. It seeks to transfer some power to the patient in areas affecting herself-determination, so as to create the optimal relationship between doctor and patient...namely a partnership of shared endeavour in pursuit of the client's interests.¹⁶

In *Canterbury v Spence* a US District Court recognised the implications of this wider notion of autonomy for the law of consent to medical treatment:

¹⁰ For a discussion of this meaning of autonomy see Dworkin, R, *Life's Dominion: An Argument About Abortion and Euthanasia*, (Harper Collins, 1994).

¹¹ See the European Convention on Human Rights, Article 8 and now the *Human Rights Act* 1998 (UK).

¹² See the Canadian Charter section 7.

¹³ Under the Eighth Amendment to the US Constitution.

¹⁴ See, eg, Mason J and McCall Smith A, *Law and Medical Ethics*, (5th ed, OUP, 1999) and Sheldon, S and Thompson, M, *Feminist Perspective on Health Care Law*, (Cavendish Publishing, 1998).

¹⁵ It is worth noting Jonathon Montgomery's gentle chiding of Kennedy and Grubb for their doctor-centred approach – see Montgomery, J, *Health Care Law*, (OUP, 1997). He advocates recognition of the wider health care context.

¹⁶ Kennedy, I *Treat Me Right, Essays in Medical Law and Ethics*, (Oxford, Clarendon Press, 1991) p178.

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[t]rue consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.¹⁷

There is as yet no such extensive interpretation of the function of consent in Australian law. We have adopted the English position in which in order for consent (or refusal) to be valid the patient need only be informed of the basic nature and purpose of the procedure. If the issue is that the patient was not informed of a risk of a less fundamental nature then the legal recourse is through the law of negligence.¹⁸

It is submitted that the greatest potential in Anglo-Australian law for an adoption of this broader conception of autonomy lies in the general movement towards a human rights perspective in western liberal societies.¹⁹ Such a movement may entail the recognition not only of a more expansive notion of autonomy but also of a person's right to expression of their religious beliefs insofar as this does not unduly hamper the state's duty to protect various interests.²⁰ It is important therefore, in considering the issue of decision-making by patients, to appreciate any impact which developments in human rights law may have upon this.²¹

Aside from any developments to this effect in those jurisdictions where there are entrenched human rights guarantees,²² the notion of patients' 'rights' both to and within health care provision is already finding acceptance.²³ In Australia this has been reflected in the development of various statements or charters of patient 'rights' prompted by consumer groups.²⁴ In the Victorian *Health Services Act 1988* (Vic), there

¹⁷ *Canterbury v Spence* 464 F 2d 77, 780 (DC cir. 1972).

¹⁸ *Rogers v Whittaker* (1992) 175 CLR 479

¹⁹ Particularly evident in the UK since the introduction of the *Human Rights Act 1998* (UK). In Australia there is mounting pressure to introduce a Bill of Rights – this has already occurred in the ACT (*Human Rights Act 2004* (ACT)).

²⁰ Such as the protection of the rights of the vulnerable members of the population and other public interests – see, eg, Article 8 of the European Convention of Human Rights.

²¹ See *The Human Rights Act 1998* (UK) section 9.

²² Such as the UK and Canada.

²³ That is a point which has been latched on to by the UK Government in the production of the Patient's Charter. (*The Patient's Charter and You*, 1995, London, DoH). This states that patients have a pre-existing right to be given a clear explanation of any treatment proposed, including any risks and any alternatives before deciding whether to agree to the treatment. But see Montgomery, *J Health Care Law*, (OUP, 1997) pp60-61 where he notes that the Charter functions primarily to define targets for NHS bodies rather than conferring a set of enforceable rights upon patients.

²⁴ See, eg, the Queensland and ACT Codes of Health Rights and Responsibilities, and the Victorian Department of Human Services Public Hospital Patient Charter.

is evidence of the incorporation of these 'rights'. Section 9 of that Act states that one of the objectives of that Act is:

To ensure that...

(g) users of health services are able to choose the type of health care most appropriate to their needs.

Both that Act and the *Mental Health Act 1986* (Vic) state that a person's religious and cultural rights should be respected, although these are generally regarded as an example of normative or aspirational rights rather than legally enforceable.²⁵ Nonetheless it is suggested that such provisions are indicative of the possible implications of developments in human rights for the present and future legal construct of consent.

There are two preliminary points which need to be made before subjecting the law of consent to more specific analysis.

Consent as a legislative term.

It should be noted at this point that whilst the legal substance of consent remains largely a matter for the common law, a number of legislative provisions relevant to health care treatment utilise the term 'consent' as a pre-requisite to decision-making, and that some of these even attempt to put into a legislative format the 'elements' of a valid consent. For example, 'consent' is a necessary pre-requisite for the donation of organs under the human tissue legislation as it is enacted in the various Australian jurisdictions.²⁶ In relation to reproductive technology legislation, there are detailed provisions relating to the need for donors of genetic material and participants in treatment to have given a valid consent. Pertinently for this paper, given its emphasis upon the non-administration of life-sustaining or saving treatment, there are in most jurisdictions in Australia now statutes which formalise the ability of a person to make a 'living will', and the ability of a person to appoint an agent by way of a power of attorney with the intention that that agent make fundamental health care decisions on the basis of substituted judgement.²⁷ A recurring theme in this legislation is that the person exercise valid consent in relation to such measures. Finally, the concept of consent to medical treatment as it relates to minors is captured in several pieces of

²⁵ See Skene, L *Law and Medical Practice*, (Butterworths Lexis Nexis, 2004) p72. She is of the view that 'A patient can probably not seek a legal remedy if, for example, if religious or cultural beliefs are not taken into account.' That view is explored and challenged in the latter part of this paper.

²⁶ Eg the *Human Tissue Act 1982* (Vic), the *Human Tissue and Transplant Act 1982* (WA).

²⁷ See, for example, the *Medical Treatment Act 1988* (Vic), and the *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

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legislation which seek either to confer rights on minors or take them away, a classic example of the latter being the Human Tissue legislation, a point which will be revisited later in this paper.

The fact that consent features as a legislative term is significant for the purposes of this paper, because the question of how entrenched human rights guarantees may or may not assist the recognition of decisions made by persons from minority religions will be explored at a later point. Such guarantees are only effective in connection with the striking down or interpretation of legislation, so reference to any case law concerning human rights guarantees will be indicative of the compatibility of the Australian legislation with the human rights perspective.²⁸

Consent and best interests

The second preliminary point of importance concerns recognition of the impact that the law relating to best interests may have on the questions asked by this paper. Decision making in relation to medical treatment centres around two bases for decision-making – consent and the concept of best interests. The legislation which allows a person to appoint an agent to make decisions on the basis of what that person *would have done* in the circumstances has seen Australia adopt (for limited purposes²⁹) the American doctrine of substituted judgement, seen in that jurisdiction as constitutionally required by the fourteenth amendment to the US constitution relating to substantive due process (and therefore reflecting the arguments in favour of respecting autonomy in this context).³⁰

Outside of this development, consent and best interests are the dominant models for decision making in health care. Given that there is a substantial body of case law associated with refusal of treatment on religious grounds in relation to competent and incompetent minors, it is worth considering these ‘best interests’ decisions as they provide significant insight into the accommodation of religious diversity within the process of health care decision-making.

²⁸ For example query the provisions in the Human Tissue Act with respect to lawful organ donation.

²⁹ Specifically in connection with the withdrawal of life-sustaining treatment from incompetent adults – see note 21 (above)

³⁰ See *Cruzan v Missouri* (1990) 497 US 261. Substituted judgement is not accepted by the common law of Australia and the UK as a basis for decision-making – see *Airedale NHS Trust v Bland* [1993] 1 All ER 821. For a more detailed discussion of the doctrine see Blake, M, ‘Whose Life is it Anyway? A Comment on the Terri Schiavo Case’, (2006) International Trade and Business Law Review.

General Implications of the Current Law of Consent for a Religiously Diverse Patient Population

Under Australian law, the validity of a consent to or refusal of health care is established if given by a competent person who has been informed of the basic nature and purpose of the act, and who has made that decision voluntarily.³¹ Once the consent or refusal is valid then this must be respected with the clear exception that a person cannot request assistance in bringing about their death. The law therefore relies upon the deontological act/omission distinction in drawing the boundaries of the legal efficacy of consent.³² It reflects a narrow meaning of autonomy – one which is concerned with protecting the right of a person to their bodily integrity.

Assessment of competence

It is evident that one of the main issues arising in connection with the operation of consent in a religiously diverse population is the assessment of competence. This is structured around the concept of the ability to make a rational decision, weighing up the risks and benefits associated with the decision.³³ Given that medical treatment is often concerned with the beginning, prolongation or ending of life, the impact of religious beliefs on those matters has implications for the assessments of competence, particularly within those beliefs which do not conform to the western orthodox traditions. This is because the test for competence is based on the need for understanding, the key requirement being an existing ability to exercise rational thought processes (if not give a rational decision).³⁴ Although there is a presumption of competence, evidence of bizarre or even unusual thought processes will trigger the application of the legal criteria, which are that the patient is capable of understanding the information, believing it and weighing the risks and benefits of the treatment in question.

This test allows for a finding of competence even in the presence of psychiatric disorder and deluded thinking. In *Re C*,³⁵ an elderly Jamaican man suffering from paranoid schizophrenia, and who had grandiose delusions to the effect that he was a world famous surgeon, was found competent to refuse the amputation of his gangrenous foot. In this instance, therefore, the law applied to respect his belief in the value of his life - he preferred to die with two feet rather than survive with one.

³¹ See *Re T* (1992) 4 All ER 649.

³² See *Airedale NHS Trust v Bland* [1993] All ER

³³ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

³⁴ See *Re C* (1994) 1 WLR 290 and *Re MB* (1997) 2 FLR 426.

³⁵ *Re C* (1994) 1 WLR 290.

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However, in the later case of *Re MB*³⁶ Butler Sloss LJ, whilst substantially agreeing with the *Re C* criteria, included factors such as fatigue, pain, confusion and shock as those which could completely erode capacity:

Irrationality is here used to connote a decision which is so outrageous in its defiance of logic, or of accepted moral standards, that no sensible person, who had applied his mind to the question to be decided, could have arrived at it...Although it might be thought that irrationality sits uneasily with incompetence to decide, panic, indecisiveness and irrationality, in themselves, do not as such amount to incompetence, but they may be symptoms or evidence of incompetence.

The court found that a pregnant woman who had a needle phobia such that she refused a caesarean section was incompetent on the basis of her fear. It is clearly not stretching the facts to suggest that a person from a faith unfamiliar with the interventionalist nature of western medicine could have a similar 'phobia', and would therefore be found incompetent to refuse treatment which medical staff felt was clinically necessary. Moreover a finding of incompetence paves the way for treatment in the patient's best interests, a test which is centred around the patient's medical interests, and which is unlikely to take account of their best interests according to their cultural and spiritual beliefs.³⁷

Although it is capacity to understand rather than actual understanding which is important,³⁸ that proposition is severely tested when linguistic differences impede an assessment of capacity. Even unusual hand movements and terminology have influenced conclusions on capacity.³⁹ Both of these possibilities are relevant to this discussion given the strong connection with cultural practices which some spiritual beliefs entail. Unless the health professional is particularly pro-active, and has time to spend on the communication process, there may be an inaccurate assessment of capacity in these instances.

Sufficient information

In Australian law information as to risks does not fall to be considered in the question of whether consent is lawful, but at the less fundamental stage of whether

³⁶ *Re MB* (1997) 2 FLR 426.

³⁷ Although see *Re T*(1997) 35 BMLR 63 in which the court had regard to wider factors in deciding whether it was in the best interests of the child to have liver transplant surgery.

³⁸ *Re C* (1994) 1 WLR 290.

³⁹ Evidence given by nurses at conference on spiritual, ethnic and cultural diversity in health care, City University, London, 2003.

the failure to disclose the risk constitutes negligence.⁴⁰ What is important to the legal validity of the consent or refusal is whether the patient understands the basic or fundamental nature of the act in question.

This requires that the patient identify the act not in terms of its effects, but in terms of what it essentially means. This notion of 'understanding' adopted by our common law is arguably easier to convey to those familiar with the dominant culture's understanding of the essence of the act in question. Several of the case authorities, for example, indicate that an act done with knowledge of sexual motives is fundamentally different from an act done without knowledge of those motives,⁴¹ whilst a patient who is under the mistaken belief that a certain person is performing the procedure in question *does* have an understanding of the nature and purpose of the act.⁴² Therefore the identity of the person carrying out the treatment does not usually constitute fundamental information for the purposes of a valid consent.⁴³ In most of the case law lack of understanding has been tied to a finding of fraud on the part of the defendant.⁴⁴

Clearly this poses a problem where there are language differences between the primary health carer and the patient. As already noted, membership of a particular religion may be associated with distinctive linguistic and other cultural differences central to communication of information. The use of minors as interpreters is not uncommon,⁴⁵ but, in addition to the other problems which this option raises, the health professional remains in the unenviable position of deciding whether the patient actually understands the true nature of the act.

A final point to note in connection with information-giving is that of disclosure of risks. As indicated above, the failure to disclose attendant risks or side-effects of medical treatment does not invalidate consent, but rather may indicate negligence in connection with an action in negligence. The common law of negligence requires the health professional to have regard to the 'reasonable patient in that patient's position'

⁴⁰ See *Rogers v Whittaker* (1992) 175 CLR 479, following that part of the decision in *Sidaway v Governors of Bethlem Royal Hospital* [1985] 1 All ER 643 which stated that non-disclosure of risks or side-effects does not affect the validity of the consent, following the Canadian case of *Malette v Shulman* (1991) 2 Med LR 162.

⁴¹ See, for example, *R v Williams* [1923] 1 KB 340 and *R v Flattery* (1977) 2 QB 410. Also note *Appleton v Garrett* (1995) 34 BMLR 23 where the patients were found to be lacking fundamental information when they were led to believe that they were having therapeutic dental treatment when it was in fact non-therapeutic.

⁴² See *R v Richardson (Diane)* [1999] QB 444

⁴³ Although see *R v Tabussum* (200) 2 Cr App R 36.

⁴⁴ *Appleton v Garrett* (1995) 34 BMLR 23.

⁴⁵ ABC documentary, 2002.

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or in some circumstances to the 'particular patient' in determining what constitutes a 'material risk'.⁴⁶ The recently enacted civil liability legislation does not appear to change this position,⁴⁷ which would seem to entail regard for any particular religious values and beliefs held by a patient. However the fact remains that the common law of consent does not require disclosure of information beyond that regarded as fundamental to the nature of the act. This is potentially problematic given that the significance of a risk may vary according to the spiritual beliefs which a person holds - for example a religion in which the possession of certain physical attributes or capacities is highly valued.⁴⁸ It also fails to accommodate those faiths or religions in which the identity of the person carrying out the act is central to the understanding of the act.⁴⁹ The presence of a fraudulent motive is, whilst central to our western society's appreciation of the act in question, perhaps less so in connection with other religions, particularly those based on more consequentialist views.

The notion of 'informed consent' brings with it the promise of patient choice, and therefore a full recognition of self-determination in clinical care. In reality this is not part of Australian law.

Voluntariness

This third requirement of a valid consent has particular ramifications in the health care context where the pressure on a patient to make a decision may be subtle, brought about by the nature of the circumstances as much as any active pressure, manipulation or coercion.⁵⁰

It is well documented that patients may feel that they have to agree with a course of treatment suggested by their doctor, or that the influence of medication, illness and exhaustion may equally make a patient overly compliant. The important English decision of *Re T*⁵¹ involved an anticipatory refusal of a blood transfusion by a woman. Her decision was held to have been not voluntary on the grounds that she was unduly influenced in making that decision⁵² by her mother, a devout Jehovah's

⁴⁶ See *Rogers v Whittaker* (1992) 175 CLR 479 and *Chappel v Hart* (1998) 195 CLR 232.

⁴⁷ Although arguably it does in relation to negligence related to diagnosis and treatment – see the *Civil Liability Act 2002* (WA) s5PB (1).

⁴⁸ In two Australian decisions, the court recognized that the Aboriginal plaintiffs' damage suffered as a result of the defendants' negligence required compensation for loss of cultural fulfillment – *Namala v NT* (1996) 131 FLR 468 and *Napaluma v Baker* (1982) 29 SASR 192.

⁴⁹ For example in the Jewish culture and some indigeneous cultures.

⁵⁰ See the President's Commission, *Making Health Care Decisions* (1983).

⁵¹ *Re T (adult: refusal of treatment)* [1993] Fam 96.

⁵² But now see *U v Centre for Reproductive Medicine* [2002] Lloyd's Rep. Med. 259 which appears to suggest that undue influence may not vitiate a decision.

Witness. The Court of Appeal referred to the particularly penetrative effect of religious beliefs, and of the views of the patient's relatives:

Persuasion based upon religious beliefs can also be much more compelling and the fact that arguments based upon religious beliefs are being deployed by someone in a very close relationship with the patient will give them added force and should alert the doctors to the possibility – no more – that the patient's capacity or will to decide has been overborne. In other words the patient may not mean what he says.⁵³

This emphasis on the need for the patient's decision to be free from external influence and pressure therefore has clear ramifications for patients who are members of certain religious groups. In the wider cultural context, in several Indian, Arabic and Asian cultures, for example, medical decision making, like all other decisions, appears to lie in the hands of the male elder(s) of the group. In this situation the requirement for an independent decision is fundamentally challenged, particularly where the patient is young and accompanied by older persons from the same group. In this respect a decision which appears to be taken by the patient him or herself may nevertheless be one significantly influenced by others.

Overriding of valid consents/refusals

Even if a person is found to have given a valid consent or refusal to treatment it may be that the decision can be overridden by the court in a bid to respect other, detrimentally affected, interests. In *Re S*,⁵⁴ an English High Court judge made the decision that a Seventh Day Adventist woman's decision to refuse a caesarean section on the basis of her faith should be disregarded on the medical evidence that her life and the life of her unborn child were at risk if the procedure was not carried out. The decision was subsequently criticized and overruled in the previously mentioned *Re MB* decision in which Butler-Sloss LJ stated:

The law is, in our judgement, clear that a competent woman who has the capacity to decide may, for religious reasons, other reasons, or no reasons at all, choose not to have medical intervention even though...the consequence may be the death or serious handicap of the child she bears or her own death.⁵⁵

⁵³ See *Re T (adult: refusal of treatment)* [1993] Fam 96 per Lord Donaldson MR at 104.

⁵⁴ [1993] Fam 123

⁵⁵ See *Re MB* (1997) 2 FLR 426 per Butler-Sloss LJ at 448.

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However, as earlier noted, there is always the possibility of a patient being ruled to be incompetent where the decision has such serious implications. It is therefore arguable that the 'reversal' of *Re S* is one of rhetoric not reality.⁵⁶

It has been suggested that Australian courts would still override a competent decision by an adult in such circumstances.⁵⁷ The issue is clearly closely tied to religious and cultural perceptions of the relationship between the woman and the foetus⁵⁸ and the significance attached to the unborn child. The idea, for example, that a woman would risk her health and that of her child, by refusing what is medically regarded as a necessary caesarean section, seems anathema to a cultural environment which attaches great value to the unborn and newborn child, and the value of medicine in interventions for the benefit of the unborn child.⁵⁹ Whilst ideological clashes in modern democracies can be presented as between a Christian minority and a secular, liberal majority, it is suggested that the position with respect, at least, to the issue of the pregnant woman reflects a Christian, more specifically Roman Catholic Christian, perspective.⁶⁰

The only Australian case of note did not involve an enforced caesarean section but a blood transfusion, but it is arguably of great significance that the transfusion took place in the course of a caesarean section. In *Qumsieh v GAB and Pilgrim*,⁶¹ the Victorian Court of Appeal refused an application for judicial review of the decision of the Guardianship and Administration Board to appoint an agent to take a decision as to whether the plaintiff, who was a Jehovah's Witness, should be given a blood transfusion. This was despite the fact that she had filled in a form under the Victorian *Medical Treatment Act* indicating her refusal of blood products should she require them during the course of the caesarean delivery of her child.

⁵⁶ See Kennedy, I, and Grubb, A, *Medical Law*, (3rd ed, Butterworths, 2000).

⁵⁷ See, eg, Skene, L *Law and Medical Practice*, (2nd ed, Butterworths Lexis Nexis, 2004).

⁵⁸ See Seymour, J *Fetal Welfare and the Law*, (Australian Medical Association, 1995).

⁵⁹ Although note that in one of the more recent English decisions the Court of Appeal declared that the sectioning of a pregnant woman under Mental Health legislation and the subsequent carrying out of a caesarean section was unlawful. The woman had a deeply held mistrust of the medical profession, and wanted a natural birth in the face of diagnosed pre-eclampsia. The court declared her detention unlawful, and went on to comment that she appeared completely competent to make that decision.- *St George's Healthcare NHS Trust v S* (1997) 3 All ER 673.

⁶⁰ Although modern democracies have been regarded as 'secular' in their approach to the law, there is no doubting that perceptions about the value of life and the meaning of death continue to be influenced by Christian beliefs. See Weller, P "'Human Rights', 'Religion' and the 'Secular'", Vol 1, Issue 1, (2006) *Religion and Human Rights* for a discussion of what is meant by 'secular'.

⁶¹ (1998) VAR 45.

Outside of the cases involving pregnancy, the case law has clearly established that certain spiritual beliefs, although they entail refusal of life-saving treatment, will be respected. Jehovahs' Witnesses are members of a faith which is familiar to most of the populace⁶² and it is a matter of general knowledge that members of this sect cannot take blood products as part of their faith. The courts have accepted such a decision as one that is consistent with competence.⁶³ The clearest statement to this effect is made in the Canadian case of *Malette v Shulman*⁶⁴ by Robins JA where he stated that however sacred life may be, our society accepts that other aspects of life may be regarded as more important. He went on to state:

The patient manifestly made the decision on the basis of her religious convictions. It is not for the doctor to second-guess the reasonableness of the decision or to pass judgement on the religious principles which motivated it.⁶⁵

In the same case Donnelly J stated that objection to treatment for religious reasons does not allow the

scrutiny of reasonableness which is a transitory standard dependent upon the norms of the day.⁶⁶

However, it is not clear whether this same respect would be accorded to members of a faith or a spiritual belief which is less well known. Such a faith might mandate the refusal of antibiotic treatment on the basis that antibiotics introduce poisons into the body. Let us suppose that this same faith subscribes to a lifestyle which adheres to strict vegetarianism and opposition to GM farming and environmental destruction. Can the refusal of antibiotics in those circumstances found evidence of incompetence? The answer is currently unclear, at least in this jurisdiction. In *Re Hofbauer*⁶⁷ the New York Court of Appeal was faced with a leukaemic child whose parents had rejected chemotherapy and conventional medicine in favour of the use of laetrile (a natural substance derived from apricot pits). Strictly speaking this case is not about the operation of consent, but about the operation of the best interests test. Nonetheless the court's willingness to consider the proposed alternative treatment is instructive for present purposes. It found that because the parents had 'sought accredited medical advice' and were aware of their child's serious health condition, that their decision could stand. The case indicates that the court there was prepared

⁶² Query whether Born Again Christians enjoy such status - In *Re S* [1993] Fam 123, the pregnant woman's competence was not questioned.

⁶³ See *Re T (adult: refusal of treatment)* [1993] Fam 96.

⁶⁴ [1991] 2 Med LR 162.

⁶⁵ *Malette v Schulman* [1991] 2 Med LR 162 at 170.

⁶⁶ Note 65 at 175.

⁶⁷ (1979) 395 NE 2d 1109 (NY CA).

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to accept that a rejection of conventional treatment did not constitute grounds for the impeachment of the parents' consent.⁶⁸

A final point to consider here is in connection with decisions taken by patients who no longer wish to continue living given their poor quality of life (taking the existence of consistent pain and the inability to enjoy that part of living which these patients attach value to as indicators of this⁶⁹). The quality of someone's life is an assessment most immediately referable to one's own values and beliefs, and a person's religious beliefs may be highly influential in defining what that person feels makes life worthwhile.⁷⁰ Relevant examples for the present discussion comes from native American Indian and Inuit tribes where women have a central function as the carer for their families. Research has shown that these women may become suicidal once their function as carer has been brought to an end (usually by the death of the husband or children).⁷¹ This sort of suicidal belief in such circumstances would probably be regarded by many as an irrational belief, but, put in its religious and cultural context, it arguably ceases to be.

Minors and Religiously Motivated Decisions in Medical Treatment

Mature Minors

The judicial trumping of a treatment decision based on religion or faith is more evidenced in those situations concerning children. In a series of cases, the English High Court decided that a competent child's decision could be disregarded if that decision entailed a threat to the child's health or their long term health. In the case of *Re M*,⁷² the English courts decided that a fifteen year old girl's decision to refuse a heart transplant, on the grounds that she would rather die with her own heart than

⁶⁸ Also see *Re T (a minor)* (1996) 35 BMLR 63. Although, for a conclusion to the contrary note the decision in *Re A (conjoined twins)* [2001] 2 WLR 480.

⁶⁹ The inability to communicate in any meaningful fashion with others has been regarded as an indicator of a very poor quality of life in incompetent patients (*Re J (a minor)* [1990] 3 All ER 930, *Re R* (1996) 31 BMLR 127), although this is not relevant to the competent patient.

⁷⁰ Note Dworkin's distinction between critical; and experiential interests in connection with his approach to dementia - Dworkin, R, *Life's Dominion: An Argument About Abortion and Euthanasia*, (Harper Collins, 1994), p201.

⁷¹ See Field, Hockey and Small, *Making Sense of Difference: Death, Gender and Ethnicity in Modern Britain*, (London, 1997) - 'the ways in which a society dealt with death reveal a great deal about that society, especially about the ways in which individuals are valued'. Also see the discussion in Biggs, H 'A Feminist Reflects on Women's Experiences of Death and Dying' in Sheldon, S and Thompson, M, *Feminist Perspective on Health Care Law*, (Cavendish Publishing, 1998).

⁷² [1999] 2 FCR 577.

live with someone else's heart, should be overridden. This was despite the fact that the court found her to be a mature and intelligent young woman. Although strictly speaking not a decision based on a religious belief, her words resonate with her spiritual perception of the meaning of life. She stated:

Death is final. I know I can't change my mind. I don't want to die, but I would rather die than have the transplant and have someone else's heart. I would rather die with fifteen years of my own heart. I would feel different with someone else's heart. That's a good enough reason not to have a heart transplant, even if it saved my life.⁷³

In both *Re E*⁷⁴ and *Re S*,⁷⁵ the English courts were faced with refusals by two fifteen year olds in relation to blood transfusions required for their chronic illnesses. E was a Jehovah's Witness, S's mother was a Jehovah's Witness. In both cases the courts decided that the minors, whilst competent to make some decisions, were not capable of understanding the gravity of their condition and the consequences of their decision, including an understanding of the emotional pain which their refusal was causing to their families. In both cases only S's father opposed their children's stance on refusal of the treatment. Ward J in *Re E* rejected the position taken by the parents:

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.⁷⁶

These cases illustrate the willingness of the courts to find young adults incompetent in circumstances where the refused treatment has a good chance of saving their lives notwithstanding the competence of the individual in question to refuse the treatment.

In this country there are numerous statutory provisions relating to the ability of a court to override the decision of a competent minor.⁷⁷ In *Minister for Health v AS & ANOR*⁷⁸ the Supreme Court of Western Australia considered one such provision under the *Human Tissue and Transplant Act 1982* (WA). That provision was to the effect that a blood transfusion can be given to a child in the absence of consent (of anyone legally entitled to give consent) where two medical practitioners agree that without a blood transfusion the child would be likely to die. The case concerned an application in relation to the legality of giving a 15 year old Jehovah's Witness boy a

⁷³ Note 71 at 582.

⁷⁴ [1993] 1 FLR 386

⁷⁵ [1994] 2 FLR 1065

⁷⁶ *Re E* [1993] 1 FLR 386 at 395.

⁷⁷ See, eg, the *Human Tissue Act 1982* (Vic) s 24 and the *Children and Young Persons (Care and Protection) Act 1988* (NSW) s174. Such legislation is limited to the administration of blood transfusions.

⁷⁸ [2004] WASC 286

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blood transfusion in the face of his competent refusal of any blood products. The court decided on the basis of the evidence that the child was indeed 'likely to die' without the transfusion, and that the fact that the refusal was based in religious conviction did not affect the application of the Act. In fact the court stated:

L and his parents simply say that their religious beliefs preclude them from giving consent to a transfusion if it is offered when thought to be the appropriate treatment. This is precisely the type of case where s21 applies.⁷⁹

The court further suggested that even in the absence of the legislation his refusal (or that of his parents) would be overridden:

Likewise, the fact that the child refusing to consent to treatment may be of sufficient maturity and intelligence to understand the nature and implications of the proposed treatment...while relevant and important does not prevent the court from authorizing medical treatment where the best interests of the child require.⁸⁰

Commenting on the case AMA ethics spokeswoman Rosanna Capolingua stated:

The family has a particular belief system which conflicted with what is the best and appropriate treatment...You would not expect doctors to do any less but strive to save someone appropriately.⁸¹

What is evident from these cases is that where the refusal will result in avoidable death or serious illness of the child, the courts will either find the child incompetent to refuse the treatment or, even if competent, overrule that decision because that treatment which is not simply prolonging life but will provide a good chance of good health is in the best interests of that child.

The young child

Young children will generally be (depending on the nature of the treatment) regarded as incompetent to make decisions about their treatment and their parents or guardians regarded as the proxy decision-makers.⁸² There have been several cases in which the courts have addressed the situation where the parents, for religious reasons, have wanted particular treatment for their child, and that has been challenged by the treating doctors. The court has the power to override the parent's consent or refusal both in its' *parens patriae* jurisdiction or the specific jurisdiction

⁷⁹ Note 78 at 293.

⁸⁰ Note 79 at 290.

⁸¹ See *The West Australian*, Feb 23, 2005 at p3.

⁸² The common law has been statutorily enshrined on this point – see the *Family Law Act 1975* (Cth).

conferred on the Family Court.⁸³ The court does not simply review the parental decision but makes a *de novo* decision as to what it believes is in that child's best interests.⁸⁴ The following cases indicate that whilst the court considers more than what is in the child's medical best interests, the parents' religious convictions are not usually factored into this assessment.

In the case of *Re J (child's religious upbringing and circumcision)*⁸⁵ the English Court of Appeal found that the question of whether a boy with a Muslim father should have a circumcision was a question to be decided by reference to a wide application of the best interests test which took account not just of the child's medical best interests but also of the wider familial context including the fact that the child was caught in a 'hostile battle between his parents over contact'. On the facts, therefore, Thorpe LJ⁸⁶ found that on the facts the procedure was not in the child's best interests, but did not dismiss the possibility that a court would never find that circumcision was a child's best interests:

I do not think it can be said that the court would not, in any circumstances, order a child to be circumcised. The example which was put in argument was that of a Jewish mother and an agnostic father with a number of sons, all of whom, by agreement had been circumcised as infants in accordance with Jewish laws; the parents then have another son who is born after they have separated; the mother wishes him to be circumcised like his brothers; the father, for no good reason, refused his agreement. In circumstances such as these, it seems to me that the court would be likely to grant the mother a specific issue order.⁸⁷

In the case of *Re A (Conjoined Twins: Separation)*⁸⁸ the parents of Siamese twin girls refused, on the basis of their strong Catholic faith, the separation of their twins. The medical evidence was to the effect that if the girls were not separated then both would die within a matter of weeks or months. However a separation, whilst it would save the life of one child, would necessarily result in the immediate death of the weaker twin. The English Court of Appeal decided that the parents of the

⁸³ *Family Law Rules 1984* (Cth) O 23B r2.

⁸⁴ *Re A (conjoined twins)* [2001] 2 WLR 480.

⁸⁵ (1999) 52 BMLR 82.

⁸⁶ With whom Schiemann LJ and Dame Butler-Sloss agreed.

⁸⁷ *Re J* (1999) 52 BMLR 82 at 96.

⁸⁸ [2001] 2 WLR 480.

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children had not had sufficient regard to the interests of the stronger twin because their religious beliefs precluded them from making an objective decision.⁸⁹

I would wish to state emphatically that this is not a case where opposition is prompted by scruple or dogma...

(iv) In their natural repugnance at the idea of killing Mary they fail to recognize their conflicting duty to save Jodie and they seem to exculpate themselves from, or at least fail fully to face up to, the consequence of the failure to separate the twins, namely death for Jodie."⁹⁰

A series of New Zealand cases have addressed situations in which the religiously motivated decisions of parents in relation to their child's medical treatment were challenged. For example in *Re J (An Infant)*⁹¹ the court issued orders authorizing a blood transfusion to a three-year-old boy suffering from a life-threatening nose bleed. In *Re P*⁹² the court made orders authorising blood transfusions in respect of premature twins and in *Re CL*⁹³ the court appointed the surgeon performing a procedure to correct a congenital heart defect in a four-year-old boy as agent with power to authorize the administration of blood products if necessary because of an imminently life-threatening situation. Furthermore in *D-GSW v B*⁹⁴ Fisher J authorized urgent surgery to remove a cancerous tumour, overriding the mother's sincerely held objections that her child may not have a life-threatening cancer to being with, and in any event that the condition would heal naturally by God's power.⁹⁵

⁸⁹ In a similar factual situation which arose in Queensland – *State of Queensland v Nolan* [2001] 122 A Crim R 517 - was not faced with parental opposition to the separation and so the influence of parental religious beliefs was not addressed.

⁹⁰ Per Ward LJ at p528.

⁹¹ [1996] 2 NZLR 134.

⁹² [1992] NZFLR 95.

⁹³ [1992] NZFLR 352.

⁹⁴ [1994] NZFLR 516.

⁹⁵ Also see *Auckland Healthcare Services Ltd v T* [1996] NZFLR 670 where the court authorized the administration of chemotherapy to a 12 year old girl suffering from malignant lymphoma, on the basis of a 60 to 70 per cent chance of long-term survival if she had the treatment, without which she would die, the girl and her parents having refused consent because of genuine and sincere religious beliefs. In *Auckland Healthcare Services Ltd v Liu* (HC, Auckland, 1996) the court authorized surgery to reattach a 12 year old boy's partially detached retina, without which he would be rendered totally blind. His parents had lost confidence in the procedure after similar treatment of his other eye had been unsuccessful. Both parents and son were convinced that God had already begun to heal the eye.

It is difficult to conclude what weight, if any, parental religious belief was given in these decisions. This problem largely stems from the best interests test, a test which has been criticized both judicially⁹⁶ and extra-judicially⁹⁷ as encouraging subjective decision-making through its lack of underlying normative principle:

The courts are much inclined to speak of the welfare principle as an absolute standard and an unproblematic concept which can act as a panacea for all ills affecting children. This is not altogether surprising since it is they who get to define its content in any given situation.⁹⁸

This fundamental problem with the best interests test aside, it has been claimed that the results of these cases are unsurprising in our current society:

Perhaps reflecting a more secular society, courts have felt comparatively free to sweep aside parental refusals based on religious objections...the courts have been prepared to limit parental rights and set aside reasons, such as that blood transfusion will result in the forfeiture of eternal life, or that God or prayer will heal the child, as valid reasons preventing treatment of the child.⁹⁹

To this extent these incompetent minors provide some insight into how the law of consent approaches a religiously motivated decision to refuse life-saving treatment. More specifically, it is evident that certain clinical situations present important implications for those patients with religious beliefs, particularly those from non Judaeo-Christian faiths.

Summary of the current approach to consent and its implications for a religiously diverse population.

Canvassing these decisions leads inexorably to a conclusion that the structure of the law of the consent is fundamentally shaped by the ethical and legal principle of the sanctity of life and the principle of autonomy, and that this does not permit for any serious consideration of religious beliefs *per se*. Therefore the construction of consent around a model of western liberal rationality may support faith-based decision-making but also may not. Because the law of consent is structured around a particular conception of what is harmful and what is good (notably the value of life

⁹⁶ See *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's case)* (1992) 175 CLR 218 per Brennan J.

⁹⁷ See Kennedy, I and Grubb, A, *Medical Law*, (3rd ed, Butterworths, 2000).

⁹⁸ See Bainham, A, 'Handicapped Girls and Judicial Parents' (1987) 103 LQR 334 at 339.

⁹⁹ See Manning, J 'Parental Refusal of Life-prolonging Medical Treatment for Children: A Report from New Zealand' Vol 8, *Journal of Law and Medicine*, February 2001.

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and the unborn child), it does not cater for other faiths which place less or no emphasis upon such concerns.¹⁰⁰

In other words, in a situation where the treatment consented to, or not consented to, does not involve a risk of death or serious health consequences, the fact that the decision is affected by the patient's religious beliefs is neither here nor there. The principle of autonomy in that sense reflects a secular notion of the value of self. However where the decision does have such serious consequences, the law of consent is shaped to protect life, and becomes infused by non-secular values central to the Judaeo-Christian tradition. On this point the law of consent reflects the teachings of the Western religions¹⁰¹ to the effect that people only have stewardship of their lives, and that the creator alone decides when people are born and will die.¹⁰² The commission of suicide is therefore contrary to these teachings. This affects the law as it has developed with refusal of life saving/sustaining treatment, no matter that the courts in several jurisdictions have claimed that the persons in questions are not committing suicide.¹⁰³ Moreover, notwithstanding the rhetoric about upholding the right of a competent person to refuse treatment for whatever reason, the rubric of rationality is evident in the ability of the law to make a finding of incapacity. This is particularly so in relation to minors where the central concern is the preservation of life notwithstanding clear evidence of a reasoned decision to reject life-saving or sustaining treatment. Even given the presence of capacity, it may be decided that the decision is invalid for reasons that relate to the lack of information upon which the decision is based or the lack of voluntariness of the decision-maker. At all of these stages it is evident that a person's religious beliefs may be influential.

This model of autonomy is one that stresses the importance of rationality and rejects the place that emotion may play in a person's decision about health care. Given that judges (who with doctors are paradigm examples of the dominant culture) have been given the task of developing the law of consent, this observation is important, if unsurprising. The need for rational thought processes is reflected in the test for competence, and in the process for deciding whether the patient is sufficiently informed. In relation to the latter the 'fundamental nature of the act' test does not allow for differing interpretations of actions, and in this respect fails to acknowledge that patients may have quite different ideas about what is 'fundamental' (for example attendant risks or side-effects associated with the treatment).

¹⁰⁰ Consider here the Buddhist attitude towards death.

¹⁰¹ Judaism, Christianity and Islam.

¹⁰² See Cosic, M, *The Right to Die?* (New Holland Publishers (Australia) Pty Ltd, 2003) p52.

¹⁰³ See the House of Lords' rationalisation in *Airedale NHS Trust v Bland* [1993] 1 All ER 821.

This moves the discussion on to the second major point to be made in relation to the law of consent as a purely individualistic model for decision-making. In this particular conception of bodily autonomy the *'collective is construed as the enduring threat to the isolated individual'*.¹⁰⁴ Reflecting this, the law of consent seeks to ensure that the decision made about health care is a voluntary one, uninfluenced by other persons. The cases considering the refusals of older children to consent demonstrates the limitation of this model, based as it is upon abstract individuals.¹⁰⁵ Moreover it has particular ramifications for those cultures and religions for which collective decision making is a norm, and where the process of decision-making may be, as a matter of cultural and religious diversity, threatened by an individualistic model.

Perhaps what is most notable about the law of consent is that the notion of autonomy upon which it is predicated is one derived from the common law of criminal law and torts. It therefore prioritises the protection of individual bodily integrity from threatened and aggressive invasions, such as criminal assaults. The context of health care, however, is quite different from a typical crime scene; it is one in which significant decisions are made about the future quality of life of an individual, and which may involve choosing death over life. Professionals in healthcare are generally not aggressors in the sense that someone who commits an assault offence under the Criminal Code or common law is. Of course, non-therapeutic 'treatment' done with a motive to harm, not heal, would not fall within this category - but that sort of conduct could hardly be described as 'health care' in any event.

Human Rights – Championing Religious Choice?

It was suggested earlier that human rights law might provide the means by which faith could assume a determinative role in decisions about health care. In the sense that entrenched human rights documents generally include separate guarantees relating to autonomy or privacy and religious freedom, this raises the possibility of a person arguing in a particular case that the failure of the law to recognize their faith-driven belief is in breach of that guarantee.

Some scholars have doubted the utility of human rights arguments to legal issues arising from diversity in the population (whether based in religion, gender, race or culture). This view maintains that human rights law is another product of western liberal thought, and therefore brings no relief to minority religions and cultures. It claims that human rights law only serves to further empower the already powerful

¹⁰⁴ See Nedelsky, J, 'Property in Potential Life' (1993) 6 *Canadian Journal of Law and Jurisprudence* 343.

¹⁰⁵ Bridgeman, J, 'Because We Care: The Medical Treatment of Children', in Sheldon, S, and Thompson, M, *Feminist Perspectives On Health Care Law*, (Cavendish, 1997).

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and that its emphasis on rights neglects non-western cultures which place a high value on collective practices and decision-making.¹⁰⁶

It is submitted, however, that, whilst the product of a western liberal approach, human rights law has within it the capacity to address the challenges raised by different racial groups, different cultural traditions and different spiritual beliefs.¹⁰⁷ On this view the discourse of rights is not itself the problem:

the problem with rights discourse is not that the discourse is itself constricting but that it exists in a constricted referential universe.¹⁰⁸

This suggests that a rights-based approach can be utilized to support those previously excluded and disempowered; what is central to the outcome is context.¹⁰⁹

Looking Elsewhere

It is suggested that the jurisdictions of the USA, Canada, UK and New Zealand all merit consideration in the question of how entrenched human rights might affect the patient who makes a treatment decision based on his or her religious beliefs. These jurisdictions offer varying levels of protection of human rights¹¹⁰ and therefore together provide an insight into the way in which religious diversity has featured as a human rights issue. How then does a context concerned with the protection of health sit with a rights-based perspective? In attempting to answer this question there are three rights which appear most relevant to the issue of faith-based decisions taken within the health care context.

The right to privacy/liberty.

In the sense that a person's decision about medical treatment may not conform to the expected in terms of conventional medical treatment it might be possible to argue that the meaning of liberty or privacy as used in the various human rights instruments encompasses a broad conception of autonomy, one which reflects choice in the broader sense (as opposed to autonomy in the narrower sense of the right to

¹⁰⁶ See McColgan, A, *Women under the law: The false promise of human rights*, (Longman, 2000).

¹⁰⁷ For an essay specifically focussing on the possible contribution of human rights to women's health see Cook, RJ, *Women's Health and Human Rights*, (Philadelphia and Pennsylvania Press, 1994).

¹⁰⁸ *The Alchemy of Race and Rights*, 1991, Harvard University Press, p159.

¹⁰⁹ See D Morgan, 'Frameworks of Analysis for Feminists' Accounts of Reproductive Technology' in S Sheldon and M Thompson, 'Feminist Perspective on Health Care Law', Cavendish Publishing, 1998.2w.

¹¹⁰ See on the general nature of the protections offered see Steiuer and Alston, *International Human rights in Context*, OUP.

reject interventions against unwanted intrusions into bodily integrity). Given that the law of consent is legally and ethically represented as the means of ensuring respect for bodily autonomy, this appears to be a natural point of reference in relation to decision-making in the health care context.

In the US, the relevant clause relating to liberty or privacy has been judicially developed within the fourteenth amendment to the Constitution, specifically the substantive aspect of the due process clause. In fact it is within US case law that such a right was first utilized so as to change the law of consent from a process in minimal information giving to a vehicle for patient choice.¹¹¹

There is some evidence of this being utilized so as to promote a patient's religious-motivated choice. In 1994 a Pentecostal Christian from Romania insisted upon a vaginal delivery even though she was informed that the foetus would die or be born with brain damage unless delivered by caesarean section.¹¹² The Illinois Appellate Court upheld the first instance decision to refuse to interfere¹¹³ on the basis of the Supreme Court ruling in *Re AC*¹¹⁴ where the court found that it was a violation of the due process clause to perform a caesarian section on a terminally ill young woman against her wishes.

However it has subsequently become clear that the notion of 'privacy' or autonomy as protected under the due process clause is a paradigm of individual bodily rights. In 1997 six of America's leading moral and political philosophers submitted a brief to the US Supreme court as *amicus curiae* in support of the applicants who were seeking the right to assisted suicide.¹¹⁵ Ronald Dworkin's introductory comments are particularly relevant to the relationship between human rights law and the expression of religious beliefs. He submitted that there is:

...a very general moral and constitutional principle – that every competent person has the right to make momentous personal decision which invoke fundamental religious or philosophical questions about life's values for himself...¹¹⁶

¹¹¹ See *Canterbury v Spence* (1972) 464 F 2d 772. Also see *Roe v Wade* (1973) 410 US 113.

¹¹² C Dyer, 'Colleges say no to forced caesarean sections', *BMJ* 1994; 308:224 (22 January).

¹¹³ The US Supreme Court refused to hear further appeals.

¹¹⁴ (1990) 573 A 2d 1235.

¹¹⁵ *State of Washington v Glucksberg et al* (1997) 138 L.Ed 2d 777; *Vacco v Quill et al* (1997) 138 L. Ed.2d 834.

¹¹⁶ See Sheldon, S, and Thomson, M, *Feminist Perspectives on Health Care*, (Cavendish Publishing, 1998).

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Phrased in this way, it appears that the right of a competent person to choose is not about religious principle or the moral fabric of society; it is about protecting the individual person. The brief went on to state:

These cases do not invite or require the Court to make moral, ethical or religious judgments about how people should approach or confront their death or about when it is ethically appropriate to hasten one's death or ask others for help in doing so...On the contrary they ask the Court to recognize that individuals have a constitutionally protected interest in making those grave judgments for themselves, free from the imposition of any religious or philosophical orthodoxy by court or legislature.¹¹⁷

In the UK the *Human Rights Act 1998* Article 8 states that persons have the right to respect for their family, home and private life. The term 'privacy' has been interpreted as enshrining the right to make decisions about one's quality of life, as well as the timing of death. This point was considered by both the House of Lords and the European Court of Human Rights in *Pretty v DPP*.¹¹⁸ Dianne Pretty claimed that the failure of the DPP to guarantee her husband immunity from prosecution under the *Suicide Act 1961* (UK) was a breach of several of the Articles of the European Convention on Human Rights. In considering the function of Article 8, the European Court concluded that it was the right ultimately concerned with quality of life, and that therefore it protected an individual's right to decide how to die.¹¹⁹ In this respect the Article would seem to have ramifications for refusals of life-saving treatment by persons for reasons perhaps not conventionally acceptable (for example the person who believes their life no longer has any value because they are no longer needed as a carer; or the choice to refuse certain treatments based on general mistrust of modern medical methods). This more expansive interpretation of the meaning of 'respect for private life' could provide a catalyst for revision of the law of patient consent such that it enables more informed decision making.¹²⁰ For example, the patient who wishes to refuse a traditional course of medication for a complaint, and instead opt for a dietary based treatment, or the patient who opts for alternatives to blood transfusions, might be accommodated by this interpretation of 'private life'.

¹¹⁷ Note 116.

¹¹⁸ *Pretty v DPP* (2002) All ER, *Pretty v UK* (2002) 35 EHRR 1.

¹¹⁹ Although the Court found that the infringement was justified under paragraph 2 of the Article as being necessary for the protection of others.

¹²⁰ Although the House of Lords did not accept that Article 8 protected a choice about how one wanted to die, this was as much to do with the fact that the claim required action on the part of others, rather than an omission. Outside of the controversial context of active euthanasia and assisted suicide, however, Article 8 could potentially protect unconventional decisions about medical treatment.

However the second paragraph of Article 8 provides for circumstances in which an infringement of a person's family, home or family life will be regarded as justified. Essentially that is where the interference is

prescribed by law and is necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

In *Pretty* the European Court found that the applicant failed in her claim on the basis of this paragraph. Having accepted that there was on the facts an interference with Mrs Pretty's 'private life', it went on to find that this was justified under paragraph two in the interests of 'the protection and freedoms of others', these being vulnerable or elderly persons who might be 'forced' by relatives into seeking help in bringing about their deaths. Therefore it is likely that an expansive interpretation of the first part of Article 8 is likely to be constrained by the second paragraph.

In Canada, the Canadian Charter has addressed the issue of consent and refusal to medical treatment within Section 7 of the Canadian Charter, which upholds the individual's right to 'life, liberty and security of the person' (except where that is inconsistent with 'principles of fundamental justice'). In the case of *Rodriguez v British Columbia (AG)*¹²¹ the applicant was a woman suffering from motor neurone disease who petitioned the Canadian Supreme Court on the basis that s241(b) of the Canadian Criminal Code, which makes aiding and abetting suicide a criminal offence, violated the Canadian Charter of Rights and Freedoms. She lost her appeal by a narrow majority, all of the judges agreeing that security of the person encompasses a notion of personal autonomy involving control over one's bodily integrity. Argument therefore centred on whether Parliament nevertheless had acted in a manner consistent with 'principles of fundamental justice'.¹²² The majority's reasoning was similar to that later adopted by the European Court in *Pretty* – the recognition of the right was constrained by fear that vulnerable persons' rights to bodily integrity would be violated.

It is evident from these decisions that the substantive right to privacy is not focused on the notion of faith and how this may affect decision-making, but is ultimately concerned with the protection of individual bodily integrity. Moreover it is also evident that when the question concerns the provision of active assistance in ending life (for whatever reason) this is most likely to be resolved in favour of perceived societal interests.

¹²¹ 107 DLR (4th) 342 (SCC, 1993).

¹²² Note the different approaches taken by Sopinka J (majority) and McLachlin J (minority) to this question.

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The right to religious freedom

On the face of it this guarantee would seem the most appropriate to utilize in support of an argument that faith-led decisions should be respected. It has only rarely been examined in the context of religiously-based decisions regarding medical treatment.

In the US, whilst the First Amendment to the US Constitution has been utilized in several other contexts to support religious freedom,¹²³ it has rarely been considered in the context of decisions relating to health care. Indeed the bulk of the US Supreme Court jurisprudence on this guarantee has concerned the relationship between the Establishment and the Free Exercise Clauses of that guarantee.¹²⁴

In the UK Article 9 of the European Convention on Human Rights, protecting as it does the right to freedom of thought, conscience and religion, could be applied in a similar, if more context specific, manner. The main issue lies with the current limited scope given by the European Court to the terms 'manifest' and 'practice' as used in the first paragraph. In the *Pretty* case, it was submitted that the *Suicide Act* infringed Article 9 because Dianne Pretty's belief in how she wanted to die was a matter of thought, conscience or religion for the purposes of Article 9. The House of Lords did not accept this submission, but did not elucidate on what was protected by the Article. The conclusion of the European Court was little more enlightening, stating that a '*practice does not cover each act which is motivated by a religion or belief*'.

The relevance of Article 9 was considered in the male circumcision case of *Re J* (1999),¹²⁵ considered above. At first instance Wall J appeared to accept that refusing the father's submission represented an infringement of Article 9, but that it was justified under the second paragraph because the operation was not, given all the circumstances, in the child's best interests:

Where, as here, two parents have identical rights under Article 9 of the Convention (and also, for that matter, under Article 8) I see no difficulty in imposing limitations on the right of one parent to manifest his religion if the exercise of that right (a) infringes or conflicts with the rights and freedoms of

¹²³ Particularly in relation to the education context – for example see *Rosenberjjer v Rector & Visitors of the University of Virginia*, *Board of Education v Mergens*, *Good News Club v Milford Central School*. These cases raised questions as to the relationship between this guarantee and that of free speech.

¹²⁴ See Moens, G, 'The Menace of Neutrality in Religion' (2004) *Brigham Young University Law Review*.

¹²⁵ *Re J (child's religious upbringing and circumcision)* (1999) 52 BMLR 82.

the other parent or the child, and (b) is found by the court not to be in the best interests of the child.¹²⁶

Clearly the relevance of this case is affected by the fact that the decision was in relation to the best interests of the child. It is nevertheless instructive in assessing how Article 9 might be used to support a religious based decision. Were the claimant a competent adult, for example, it is less clear that any infringement could be justified under the second paragraph. So whilst the problem of what constitutes a matter of 'conscience' and 'religion' remains an issue for those from spiritual minority groups,¹²⁷ there may yet be scope for exploitation of this Article by persons from spiritual minorities.

In New Zealand the *Bill of Rights Act 1990*, section 13 protects the right to freedom of subjective thought, conscience and religion and belief. In addition section 15 protects the right to manifest religion and belief in practice. It is fairly clear that manifestation of religion must include the right to bring up and educate a child in accordance with that religion, and that this would also include making health care decisions.¹²⁸ However parental refusal of life-saving treatment based on religious grounds, whether on the basis that a blood transfusion will result in the forfeiture of eternal life, or that God will heal the child, has not been accepted by the courts,. Clearly where parental opposition is prompted by:

scruple or dogma of a kind which is patently irreconcilable with principles of child health and welfare widely accepted by the generality of mankind.¹²⁹

the courts have had little reservation in overruling the parental decision.

In *Re J*¹³⁰ the court discussed the relationship between the right to religious freedom and the right of the parents to consent to and refuse treatment for their children in more detail:

¹²⁶ In the Court of Appeal, Thorpe LJ stated that the '*judge correctly held that the father's right to manifest his religion had to be balanced against the welfare of the child and the rights of the mother*'. Wall J's approach is consistent with that of La Forest J's in *B v Children's Aid Society* (1995) in which the parents' religious beliefs meant that they objected to the use of blood products in treating the child. The majority concluded in that case that the parents had a right to rear their children according to their religious beliefs but that the breach was justified under the Charter to protect the child.

¹²⁷ Also see the *Re A* [2001] 2 WLR 480 decision. The issue of Article 9 was not raised but it is submitted that it was relevant on the facts given that the parents' refusal to sanction the separation of the twins was a product of their strong Roman Catholic faith.

¹²⁸ See Manning, J, 'Parental Refusal of Life-Prolonging Medical Treatment for Children: A Report from New Zealand' (2001) 8 *JLM* 263 at 278.

¹²⁹ *Re T (A Minor)* (Wardship: Medical Treatment) (1997) 1 WLR 242 at 253.

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If the parental right to manifest religion in practice is taken as extending to the right to consent to and refuse medical treatment for a child, there is a potential overlap between that right and the child's fundamental right to life...We prefer to approach this conflict...directly by reference to the scope of the [parental right]. The parents' right to practice their religion cannot extend to imperil the life or health of the child.¹³¹

Section 20 of the *Bill of Rights* protects the right of ethnic, religious or linguistic minorities 'in community with other members of that minority, to enjoy the culture, to profess and practice the religion, or to use the language', of the minority. Presumably this section would apply to those situations where a person makes a decision in accordance with a community culture (albeit not an individually autonomous decision in the strict sense). However on the above evidence it would not assist the parent who refuses treatment which risks the life, health or welfare of the child.¹³²

Again it would seem that the right to religious freedom has rarely been successfully utilized to support a person's faith-led decision regarding health care. It is apparent that other considerations more specific to the health care environment have dominated the courts' reasoning. Therefore context seems all important; whilst it may be possible to utilize this right successfully in the school environment or the workplace, the courts are sensitive to the subtle issues raised by clinical situations.

The right to equal treatment

Given that the current law of consent appears to reflect, if not a secular position, then one consistent with Judaeo-Christian values, it is arguable that this guarantee (in its various forms) is relevant to those from minority religions in asserting their right to have or to refuse certain treatment. The problem with most entrenched human rights documents is that the right to equal treatment is a parasitic right, in the sense that it is necessary to show that a 'substantive' right (such as the right to privacy) is engaged in order to invoke the equal treatment guarantee.¹³³ In the UK, for example, Article 14 of the *Human Rights Act 1998*, concerned as it is with the prohibition of discrimination, has potential relevance for those persons whose cultural and religious background and beliefs lead them to make decisions which are not consistent with the dominant culture's values. If another Article of the Convention is engaged, then it

¹³⁰ [1996] 2 NZLR 134 – the case involved a blood transfusion case involving Jehovah's Witness parents.

¹³¹ At 146.

¹³² See *Re Norma* NZLR where the court found that the child's physical safety prevailed over the parents' desire to treat their children in accordance with cultural medical practices.

¹³³ This is clearly the case with the *Human Rights Act 1998* (UK).

might be possible to suggest that, for example, a finding of incompetence by a court might evidence a difference of treatment based on the patient's language, religion or national or social origin (to cite three of the several grounds articulated in Article 14). Given that assessments of competence are patient specific, however, it might prove difficult to link any one decision to a discriminatory approach, although a continued approach in relation to a certain religious group, or a certain cultural practice might raise such evidence. In both the US and Canada the equal treatment clauses¹³⁴ have been invoked in cases where the respective applicants were claiming that the prohibition on assisted suicide violated these clauses. In *Rodriguez*,¹³⁵ the applicant argued that this right was engaged on the basis that the applicant was prevented from committing suicide when able-bodied persons could do so, whilst in *Quill*¹³⁶ the gist of the submission was that, unlike terminally ill persons dependent upon life-support machinery, they were denied the right to choose an inevitable death by directing termination of the treatment.¹³⁷ In both cases these submissions were unsuccessful,¹³⁸ but it is not inconceivable that an argument based around the non-recognition of a specific religious belief might establish a violation of this clause. However, as with the other clauses it is also the case that even if a prima facie breach of the clause is established, this might be regarded as justified on the basis of various societal interests, most notably the protection of the vulnerable, or the preservation of life.

Where to from here?

As Justice Michael Kirby has stated,¹³⁹ Australia has:

...neither a general statute of human rights, nor a constitutional charter of rights, nor access to a regional court of human rights to uphold the principles of liability that conform to general rules protective of human rights.

It is therefore difficult to predict with any certainty the weight which any of these decisions from other jurisdictions would have in a legal challenge to medical treatment either provided or not provided in violation of a patient's religious beliefs.

¹³⁴ See the Equal Protection clause of the US ('all persons similarly circumstanced shall be treated alike') and section 15 of the Canadian Charter.

¹³⁵ *Rodriguez v British Columbia (AG)* 107 D.L.R. (4th) 342 (S.C.C. 1993).

¹³⁶ *Vacco et al v Quill et al* (1997) 138 L. Ed. 2d 777.

¹³⁷ In *Bouvia v Superior Court* (1986) 225 Cal. Rptr. 297 the US court accepted that the removal of a naso-gastric tube was not unlawful.

¹³⁸ In *Quill* the Supreme Court found that there was no differential treatment on the basis that everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted treatment, and equally no-one is permitted to assist a suicide.

¹³⁹ Occasional Address, Melbourne, 19 November 2002.

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Although Australia has enacted anti-discrimination legislation at both Commonwealth and state/territory levels,¹⁴⁰ this has not been applied in the health care context outside of challenges relating to access to health care.¹⁴¹ Furthermore the High Court of Australia has stated that declaratory relief will not be granted in test cases in which the applicant has no legitimate interest in claiming such a right.¹⁴² It is possible that the recently enacted *Human Rights Act 2004* (ACT) might provide purchase for an argument that a patient's religious-based decisions about health care have not been respected,¹⁴³ however the fact that interference with such rights may be justified¹⁴⁴ suggests that the potential for the success of such arguments is limited on the basis of what has happened in other jurisdictions.

So despite the absence of any entrenched human rights guarantees in most Australian jurisdictions, it is unlikely, given the experience of the UK, Canada and the US, that this would in any event make a difference to those seeking to challenge the law of consent on the basis of their religious beliefs. The particular nature of the clinical context with its emphasis upon the preservation of life and the ability of modern medicine to treat serious illness and death, has led to a legal structure which promotes the values of autonomy, best interests and the deontological act/omission distinction. To this extent it might be argued that the law is, at best, incomplete, or, at worst, discriminatory in its failure to accord any prominence to the link between faith and decisions about health care. However any such conclusion ignores the the prescriptive question – *should* the law on consent be applied so that it can reflect these choices? There is a strong case for saying that the current focus of the law upon a particular conception of autonomy is appropriate given that the clinical setting is a context traditionally dominated by paternalism. On this view any change which risks the re-entry or compounding of such attitudes must be resisted. Although not truly secular, a model of autonomy which promotes individual bodily integrity is appropriate in a situation where, historically, due respect has not always been given to this interest. Whilst this means that not all choices driven by religious beliefs can be respected, it equally means that the risk that a person will be given or not given

¹⁴⁰ *Human Rights and Equal Opportunity Commission Act 1986* (Cth); *Racial Discrimination Act 1975* (Cth), *Equal Opportunity Act 1995* (Vic), *Equal Opportunity Act 1984* (WA).

¹⁴¹ See *Pearce v South Australia Health Commission* (1996) SASR 486 and *McBain v State of Victoria* (2000) 117 ALR 320. Both of these cases concerned challenges to reproductive technology legislation, and in particular the exclusion of single and homosexual women from accessing the services.

¹⁴² *Breen v Williams* 138 ALR 259 per Dawson and Toohey JJ.

¹⁴³ See section 12 (protection of privacy), section 14 (freedom of thought, conscience, religion and belief), and section 27 (rights of minorities).

¹⁴⁴ See section 28.

treatment on the basis of what the collective says should happen as a matter of faith is minimised. The long and continuing battle to escape paternalism in health care requires that the letter of the law promote the value of autonomy in a way which gives priority to the protection of bodily integrity. Moreover, it is debatable whether the law should condone those decisions which, although based in religious belief, threaten the very purpose which health care seeks to carry out. If there is one common feature between diverse religions and cultures it is that health care professionals are there to help save lives and improve quality of life through the provision of treatment.

Promoting the *Ethic of Care*

That the law should remain tied to this conception of autonomy in order to protect the basic right of bodily integrity does not diminish the need for better communication in a patient population which is not only religiously diverse, but also diverse in the cultural and ethnic sense. It is suggested that the way to achieve this is not through any wholesale changes in the law, for the reason just suggested, and also for practical purposes. Any change needs to occur at a grass roots level, and therefore requires a revision of the ethics dominating this context. It is entirely appropriate that considerations of the ethical perspective precede legal change in the health care context. With this in mind it is useful to consider how this issue of autonomy has been dealt with in ethical argument.

Some aspects of the broader notion of autonomy are reflected in the writings of some feminist legal theorists who argue that it is necessary for the law to embrace a 'softer' notion of autonomy, one which is less individualistic in nature, and which is grounded in the interdependence of human beings.¹⁴⁵ Such an approach is found in Gilligan's 'ethic of care' which has at its heart the value of caring, the process of communication and mutual dependence upon the maintenance of relationships.¹⁴⁶

¹⁴⁵ Nedelsky calls for a reconception of autonomy which is not modelled on the isolated individual but on a more integrated notion of the self. Such an understanding would recognise our 'embeddedness in relations' and that what enables the individual to experience autonomy is not isolation but relationships with others. In order for this to be achieved, she argues that a 'social component' must be incorporated into the very meaning of autonomy, in order to move away from the isolated individual, towards an alternative conception. She uses the experience of child-raising, which she argues captures the experience of autonomy through connectivity – see Nedelsky, J, 'Reconceiving autonomy: sources, thoughts and possibilities' (1989) *1 Yale Journal of law and Feminism* 7, p20.

¹⁴⁶ Also see West, R, 'Jurisprudence and Gender' (1988) *55 Uni of Chicago L R* 1 for an argument that the value placed within liberal democracies upon autonomy follows from the perception of the individual as first and foremost a separate being who then reaches

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This approach argues that interdependency is central to autonomy, a perspective which enables recognition of minority religious and faith-led beliefs in the decision-making process. In relation to those cases where an older child has refused life-saving treatment on the basis of a religious belief, and is supported by the parents in taking this stance, it has been suggested that an ethic of care approach would recognize that the parents' position:

...balances the sacrifice of their own emotions of love and affection and need for a continuing relationship with their child against the tenets of their faith directly relating to his or her future quality of life.¹⁴⁷

It is not suggested that the courtroom would accept this '*feminist construction of connection and continuity*'¹⁴⁸ but that is not what is being suggested. Right at the outset of this paper consent was identified as an ethical doctrine above and beyond its legal structure. Therefore any concerns that promoting this ethic would allow the law to collapse into paternalism¹⁴⁹ are not necessarily well founded. The communication process in health care should be able to accommodate different approaches depending on the particular cultural, ethnic and religious characteristics of the individual patient. As part of a consultative process, this ethic recognizes that respecting faith-based decisions taken in the course of health care treatment are essential to the recognition of the patient as a person:

...the recovery of the human being is the recovery, at the same time, of the values which form the framework of his life as a moral being, or as a member of a moral community...structural features of our everyday moral life...¹⁵⁰

Conclusion

It is hoped that the above discussion has indicated that decision-making in health care raises questions about whether the law currently accommodates treatment decisions motivated by religious belief, and, if it does not, whether it should be driven by such considerations. It is apparent that the current emphasis upon the protection of individual bodily integrity means that a valid refusal of life-saving treatment will be respected. Equally, it is evident that the law does not extend to give

out to make contact with others. For women, as opposed to men, caring, nurturance and ethic of love and responsibility for life is second nature.

¹⁴⁷ See Bridgeman, J, 'Because we Care: The Medical Treatment of Children', in Sheldon, S, and Thompson, M, *Feminist Perspectives On Health Care Law*, (Cavendish, 1997).

¹⁴⁸ See de Gama, K, 'Posthumous Pregnancies: Some Thoughts on Life and Death' in Sheldon, S and Thompson, M, *Feminist Perspectives On Health Care Law*, (Cavendish, 1997).

¹⁴⁹ Note 148.

¹⁵⁰ See Maclean, *The Alchemy of Race and Rights*, (Harvard University Press, 1991) p159.

patients a right to demand treatment – wither assistance in dying, or the provision of alternative treatment.¹⁵¹ Although this position has implications for some patients from religious groups, the main issue arising in connection with treatment decisions motivated by religious belief is the question of the validity of that consent or refusal. The emphasis upon an individual-centric model based in rationality means that a person making a decision for such reasons is probably more likely to be found incompetent or to have made that decision involuntarily, particularly where the religious group in question has a cultural practice of collective decision making.

It is also apparent that whilst human rights guarantees can be interpreted to provide a wider conception of autonomy, and a specific right to freedom of religious expression, these rights are subject to trumping by the wider public interest. In other words, despite the wording of those guarantees, in fact they are likely to be interpreted in the common law tradition.

Whilst it is important to minimize the risk of paternalism in the practice of medicine, it is equally clear that a more nuanced approach to medical decision making, and one that is particularly cogniscent of the family dynamic may not only help in those situations where the patient is from a minority religious group but also more broader concerns arising within our multi-cultural community. Given that here we are concerned with the ending and beginning of human life, and often a compromised quality of life by reason of poor health, it is important that support mechanisms are respected and that litigation is regarded as absolutely the last resort. Such an approach was supported by Waddell CJ in the case of *Marchant v Finney*,¹⁵² a case in which the court heard an application concerning a child with spina bifida and where the parent objected to a procedure to close the lesion on the basis that this might involve a blood transfusion. In finding that such a procedure fell within the relevant statutory provision¹⁵³ and that the procedure should take place, the judge commented that it was highly desirable that court intervention be avoided by adequate counseling as to the effect of the relevant statutory provision.¹⁵⁴ It is also evident from the English cases in which the courts are dealing with parental refusal of treatment for their young child on the basis of their religious convictions (usually blood transfusions) that court intervention is not sought until after alternative treatment has been attempted.¹⁵⁵ Such processes are already in evidence in relation to the treatment

¹⁵¹ For example, alternative blood products.

¹⁵² (unrep) NSWSC, 31 July 1992, No. 3599 of 1992.

¹⁵³ S20A of the *Children (Care and Protection) Act 1987* (NSW).

¹⁵⁴ Also see the court's comments in *AS v ANOR* [2004] WASC 286.

¹⁵⁵ See Pei-Teing Kee, 'Refusal to Consent to Treatment on Religious Grounds', [1995] *MurUEJL* 21.

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of newborn babies with congenital and other disorders.¹⁵⁶ Perhaps it is a model of consultation which can be adopted on a more widespread basis.

¹⁵⁶ Such as the unit operating at King Edward memorial Hospital Perth.