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1. An Introduction to New Zealand Health Law

New Zealand’s health care law is drawn from a wide variety of statutes and legislation. The key legislative framework for the provision of publicly funded health care is the New Zealand Public Health and Disability Act 2000. Also of vital importance is the Code of Health and Disability Services Consumers’ Rights (“the Code”). Unlike many other countries, where medical negligence lawsuits are common, victims of medical misadventure are nearly entirely barred from suing for common law damages in civil proceedings in New Zealand.¹ Potential claimants are instead compensated by this country’s comprehensive no-fault accident compensation scheme.

1.1 KEY Features OF THE PUBLICLY FUNDED HEALTH SYSTEM

- Health care in New Zealand is essentially a tax-based, government funded system.
- If you are an “eligible person” your hospital and mental health treatment is generally free of charge. However, things such as pharmaceuticals are usually only partially funded by the government, if at all.
- A District Health Board is responsible for the residents in its region. Responsibilities include funding the services provided by community and primary organisations, providing hospital care, and planning and organising services in its district.² In a nutshell, the Ministry of Health determines healthcare policy, and this policy is then pursued by the DHBs.
- A number of ministerial advisory committees on health care have been established through the New Zealand Public Health and Disability Act 2000. These include the National Advisory Committee on Health and Disability, the National Ethics Advisory Committee, mortality review committees, and the Health Workforce Advisory Committee.

1.2 REGULATION

Health services are regulated by legislation such as the Code, the Health and Disability Commissioner Act 1994, the Health Practitioners Competence Assurance Act 2003, and the Health and Disability Services (Safety) Act 2001. This legislation is meant to ensure (amongst other things) that consumers receive an acceptable standard of health care, and that health care practitioners are competent to carry out the duties which their profession demands of them.

While a range of legislation regulates the provision of health care services, the conduct of health care practitioners is governed by one statute: the Health Practitioners Competence Assurance Act 2003. According to this, the competence of practitioners is meant to be

¹ See Injury Prevention, Rehabilitation, and Compensation Act 2001, s317(1)
assured by a registration and certification process, as well as by the Health Practitioners Disciplinary Tribunal. If there are concerns about a practitioner’s competence then another practitioner or an employer or the Health and Disability Commissioner can report those concerns. If a concern is reported to the appropriate authority then there is a rigid procedure that must be followed if the authority wishes to investigate the practitioner’s competence. If the concerns are found to be justified following investigation, the authority must make sure that the practitioner does one of the following things: sit an examination or assessment; take part in a programme; have conditions imposed on the scope of their practice; or be counselled or assisted.

2. The Code of Health and Disability Services Consumers’ Rights

2.1 INTRODUCTION

“The Code” is New Zealand’s Code of Patients’ Rights. In 1998 it was suggested by the “Cartwright Report” into cervical cancer treatment that a statement of patients’ rights should be introduced. A major reform of health and disability services in New Zealand followed this, after which the Health and Disability Commissioner Act 1994 was passed into law. The Code was developed according to the procedure set out in the Health and Disability Commissioner Act, and came into force on July 1 1996.

2.2 STATUTORY REQUIREMENTS AND LEGAL STATUS OF THE CODE

When the first Health and Disability Commissioner (Robyn Stent) was appointed in 1994, her first priority under the Health and Disability Commissioner Act was to draw up a draft copy of the Code. The Code would have to include provisions relating to the following: informed consent; duties and obligations of health care providers; rights of health consumers and disability services’ consumers; procedures for dealing with complaints against health care and disability care providers; provision of services of an appropriate standard; and respecting the dignity and independence of the individual. In addition to this, the Commissioner also had a wide ambit to include anything in the Code that she considered to be either particularly important to the rights of disability consumers, or to otherwise impact on the rights of health or disability services’ consumers.

The Code’s legal status stems from section 74(1) of the Health and Disability Commissioner Act 1994, which states that the Governor-General may make regulations which prescribe a Code of Health and Disability Services Consumers’ Rights. Because the Code was

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3 Health Practitioners Competence Assurance Act 2003, s118(f)
4 Health Practitioners Competence Assurance Act 2003, s36(1)
5 Health Practitioners Competence Assurance Act 2003, s38(1)
6 Health and Disability Commissioner Act 1994, s14(1)(a)
7 Health and Disability Commissioner Act 1994, s20(1)
developed through an exercise of Parliament’s conferred powers, it is subordinate legislation and thus has full legal effect.\(^8\)

### 2.3 KEY DEFINITIONS AND THE RANGE OF APPLICATION

In order to understand the Code, we must first define three important terms: “providers”; “consumers”; and “services”. The definitions of these words are found in the Health and Disability Commissioner Act 1994, and thus apply to the Code.\(^9\)

**‘Provider’**

According to Clause 4 of the Code, ‘Provider’ means a health care provider or a disability services provider. Turning to the Health and Disability Commissioner Act, we then find that the term ‘health care provider’ covers a wide ambit,\(^10\) including:

- A person in charge of providing health care services, if those services come within the meaning of the Health and Disability Services (Safety) Act 2001;\(^11\)
- Any health practitioner;\(^12\)
- Any person who provides, or holds himself or herself or itself out as providing, health services to the public or to any section of the public, whether or not any charge is made for those services;\(^13\)

It is obvious from this that the definition of a ‘health care provider’ is very broad, especially in light of the catch-all provision in section 3(k). For example, one interpretation of ‘health care provider’ was broad enough to cover a person who offered beauty treatments and massage therapy.\(^14\)

Continuing with our definition of ‘provider’, the term ‘disability services provider’ covers an even broader range of activities. Anyone who provides, or holds himself/itself out as providing, disability services is covered. Disability services include goods, services, and facilities which are provided either to people with disabilities for their care or support or the promotion of their independence, or for purposes which are related to this goal.\(^15\) This definition is fairly all-encompassing, and could include some very unlikely people, such as a person who drives a taxi specifically designed for disabled passengers.

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\(^9\) See Interpretation Act 1999, s34: “A word or expression used in a regulation, Order in Council, Proclamation, notice, rule, bylaw, Warrant, or other instrument made under an enactment has the same meaning as it has in the enactment under which it is made.”

\(^10\) For the full definition of ‘health care provider’, see Health and Disability Commissioner Act 1994, s3

\(^11\) Health and Disability Commissioner Act 1994, s3(a)

\(^12\) Health and Disability Commissioner Act 1994, s3(h); for a further definition of ‘health practitioner’ see the Health and Disability Commissioner Act 1994, s2(1)

\(^13\) Health and Disability Commissioner Act 1994, s3(k)

\(^14\) Opinion 02HDC18117 (Health and Disability Commissioner, 4/2/04)

\(^15\) Health and Disability Commissioner Act 1994, s2(1)
‘Consumer’

Section 4 of the Code states that a ‘consumer’ is a health or disability services’ consumer. For the purposes of rights 5, 6, 7(1), 7(7) to 7(10), and 10, this includes a person entitled to give consent on behalf of that consumer.

Once more we must turn to the Health and Disability Commissioner Act for a more detailed definition. According to this, a ‘health consumer’ is someone on or in respect of whom any health care procedure is carried out.16 ‘Health care procedure’ means “any health treatment, health examination, health teaching, or health research administered to or carried out on or in respect of any person by any health care provider; and includes any provision of health services to any person by any health care provider”.17 While this definition is, again, very broad, it is interesting to note that a dead person is no longer considered to be a ‘consumer’.16

A ‘disability services’ consumer is any person who, because they have a disability, has a reduced ability to function independently, or is likely to need support for an indefinite period.19

‘Services’

‘Services’ include both ‘health services’ and ‘disability services’.20 According to section 2(1) of the Health and Disability Commissioner Act 1994, ‘health services’ are:

- Services to promote health;
- Services to protect health;
- Services to prevent disease or ill-health;
- Treatment services;
- Nursing services;
- Rehabilitative services;
- Diagnostic services.

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16 Health and Disability Commissioner Act 1994, s2(1).
17 Health and Disability Commissioner Act 1994, s2(1)
19 Health and Disability Commissioner Act 1994, s2(1)
20 The Code, Clause 4.
2.4 THE RIGHTS CONTAINED IN THE CODE

Clause one of the Code sets out the general rights of consumers and duties of providers. The clause two rights discussed below examine the general clause one rights in more detail.

Right 1: the right to be treated with respect

The rights set out here are relatively self-explanatory. Right 1(1) simply reiterates that every health or disability services’ consumer should be treated with respect. Right 1(2) then deals with privacy. It is important to note that the Code refers only to physical privacy, and not to information privacy. Thus, the Code contains no right to confidentiality. Right 1(3) covers provider sensitivity towards different consumers’ cultures, religions, societies and ethnic groups. The needs, values and beliefs of Maori and singled out for special attention. However, consumers only have a right to services which “take into account” these things. Because of this, the services provided to a Polynesian or lesbian or Jewish consumer will not necessarily vary. It is enough that the consumers’ differences have been taken into account.

Right 2: right to freedom from discrimination, coercion, harassment, and exploitation

Again this right is self-explanatory. ‘Exploitation’ means “any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence”. The mention of fiduciary relationships is consistent with the type of relationship that exists between doctors and patients. 

Right 3: right to dignity and independence

Right 4: right to services of an appropriate standard

When discussing Right 4, it is important to note that, despite the words “every consumer has the right to have services provided”, the Code does not support a right to access health or disability care. Thus Right 4 only applies to situations in which services are already being provided to a consumer.

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21 The subject of information privacy is dealt with by the Privacy Act 1994.
22 The Code, Clause 4.
Brookers., p37
Brookers, p37
4(1): The “reasonable care and skill” provision in Right 4(1) is not limited to the standard considered acceptable by health and disability care professionals.\textsuperscript{25} The standard of care required for the purposes of the Code is sometimes higher than this.

4(2): This requires services to comply with legal, professional, ethical, and other relevant standards. In practice, most breaches of this right are brought about because of a failure by providers to keep adequate notes.\textsuperscript{26}

4(3): Consumers have the right to have services provided in a way that is consistent with their needs.

4(4): While providers are not expected to guarantee a successful outcome to treatment, they do have to provide services in a manner that minimises harm and optimises the consumer’s quality of life.\textsuperscript{27} If a provider were to breach right 4(4) they may also be in breach of right 4(1), as that right also deals with harm minimisation.

4(5): This is one of the most significant Code provisions. Consumers have a right to cooperation among providers to ensure quality and continuity of services. In practice this generally relates to times when a consumer’s care must be coordinated, for example when a patient transfers from one GP’s care to another’s.

**Right 5: right to effective communication**

This covers a consumer’s entitlement to receive information in the correct manner (including the possibility of an interpreter). The environment must be such as to allow for open, honest and effective communication. Providers must be alert to signs that a consumer has problems with communication.

**Right 6: right to be fully informed**

Despite the title of this right, the duty is to provide a reasonable level of information in the particular situation. This includes an information about the consumer’s condition, an explanation of the options available to them (including an assessment of risks, benefits, side effects and cost), an estimated time frame for the provision of services, whether the services will involve any participation in teaching or research, the results of tests and procedures, and any other required information. The combination of objective and subjective terminology in right 6(1) (the “consumer has the right to the information that a reasonable consumer, in that consumer’s circumstances, would expect to receive”) comes from the Australian case of Rogers v Whitaker.\textsuperscript{28}

\textsuperscript{25} See Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 for more information on this test.

\textsuperscript{26} Skegg, PDG, Paterson, Ron, eds (2006) Medical Law in New Zealand, Wellington: Thomson Brookers, p39

\textsuperscript{27} Optimising quality of life is defined in clause 4 as “to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances.”

\textsuperscript{28} Rogers v Whitaker (1992) 175 CLR 479 (HCA)
A provider is required to supply the information described in rights 6(1) and 6(2), and a failure to do so is a breach of those rights, even if the information would have made no difference to a consumer’s decision. The specific examples mentioned above are by no means exhaustive.

Right 6(3) states that consumers have the right to honest and accurate answers to any questions they may have regarding services. Somewhat surprisingly, this means that if a patient asks a doctor to recommend which course of action they should take, that doctor can be legally required to do so.

Finally, right 6(4) means that a consumer is entitled to a written summary of information that has been provided to them.

Right 7: right to make an informed choice and give informed consent

The consumer’s right to make an informed choice and to give informed consent to the provision of services is protected by right 7(1). This is further enforced by right 7(7) which essentially allows the consumer to change their mind about the provision of a service and withdraw their consent. Note that right 7(1) will be breached if a consumer’s consent to a procedure is invalid. This could come about if insufficient information has been given to a consumer in terms of right 6. Right 7(1) allows for some exceptions to the rule, with the most noteworthy being the common law concept of ‘necessity’. Right 7(4) deals with the other main exception to the need for consent.

Every consumer is presumed competent to give consent, unless there are reasonable grounds to believe to the contrary. However, even if a consumer is not fully competent, right 7(3) means that they may consent to the extent that their incapacity enables them to. What about situations where a consumer is incompetent to make an informed choice and there is no one who can consent on their behalf? A provider may still provide a service if it is in the best interests of the consumer, and the provider has made a reasonable effort to ascertain the consumer’s views and to check whether these conform with the views of the consumer when they were fully competent. If the consumer’s views are unable to be ascertained, the provider must take into account the views of ‘suitable people’. All consumers are allowed to use advanced directives. These are directives whereby a consumer makes a choice about a possible future health care procedure, intending that the directive should only take effect if the consumer was to become incompetent.

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30 In clause 4 of the Code, ‘choice’ is defined as a decision to receive services, refuse services or withdraw consent to services.
31 This means that a doctor may treat a patient who is unconscious or incapacitated in an emergency situation or a time of ‘necessity’.
32 The Code, Right 7(2)
33 The Code, Right 7(4)
While oral consent will generally suffice, there are certain circumstances in which written consent is required.\textsuperscript{35}

Consumers also have the right to express preferences about who will provide services to them\textsuperscript{36} and to decide what will happen to any body parts or bodily substances that were removed or obtained during a health care procedure.\textsuperscript{37} Right 7(10) gives further weight to the right to choose what is done with your body parts of bodily substances, although there are some circumstances in which these items can be used without the informed consent of the consumer.

**Right 8: right to support**

This means that a consumer is allowed to have one or more support persons with them, except if their presence would compromise safety or infringe unreasonably upon another consumer’s rights.

**Right 9: rights in respect of teaching or research**

The rights in the Code extend to situations in which a consumer is participating in teaching or research.

**Right 10: right to complain**

Consumers can complain either to the provider directly, or to the Health and Disability Commissioner, or to an independent health and disability services consumer advocate.

### 2.5 CLAUSE 3 OF THE CODE

Perhaps because of its comprehensive nature, the Code recognises that, in reality, no provider will be able to give full effect to all of its specified rights. Clause 3 states that a provider will not be in breach of the Code if they have “taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties”\textsuperscript{38} in the Code. “The circumstances” are defined as “all the relevant circumstances, including the consumer’s clinical circumstances and the provider’s resource constraints.”\textsuperscript{39} Given this, there can be no doubt that the Code’s rights are not absolute, and that compliance with them is situation dependent.

\begin{footnotesize}
\begin{enumerate}
\item The Code, right 7(6)
\item The Code, right 7(8)
\item The Code, right 7(9)
\item The Code, Clause 3(1).
\item The Code, Clause 3(3).
\end{enumerate}
\end{footnotesize}
2.6 COMPLAINTS AND INVESTIGATION PROCEDURE

The Code and the Health and Disability Commissioner Act 1994 are designed to promote resolution of problems at the lowest possible level. While consumers are encouraged to deal with the provider directly (with the hope being that the issue can be resolved promptly), Right 10 also gives them the right to complain to the Health and Disability Commissioner or to a registered health professional’s professional body. If a consumer does choose to complain to the professional body, their complaint will be referred back to the Health and Disability Commissioner. It should also be noted that the consumer does not have to be the one to make the complaint: anyone can make a complaint on behalf of a consumer.

When a complaint is made to the Health and Disability Commissioner, he or she decides whether to undertake an investigation to determine if there has been a breach of the Code. Any such investigation is an independent and impartial process. If a breach has taken place, the Commissioner has four options:

- Report the opinion and subsequent recommendations to the provider;
- Report the opinion and recommendations to the Ministry of Health;
- Complain to a professional body;
- Refer the matter to the Director of Proceedings.

The Commissioner’s recommendations might include (among other things):

- That the provider apologise to the consumer;
- That the provider implement systems to prevent the problem from recurring;
- That extra training be given;
- That the complainant’s costs are paid.

If the Commissioner refers a complaint to the Director of Proceedings, the Director has the discretion to decide what, if any, action to take. If a proceeding is undertaken, it will be brought before either, or both, the Human Rights Review Tribunal or the health practitioner’s professional body.

If the Human Rights Review Tribunal finds that the Code has been breached, it can take steps such as preventing the provider from continuing the actions that caused the breach, declaring that the provider is in breach of the Code, or awarding damages. It is to be noted that damages will not be awarded (apart from exemplary damages) if the consumer’s injury is covered by the Injury Prevention, Rehabilitation, and Compensation Act 2001. The remedies available to the Tribunal are wide ranging: aside from the remedies mentioned above, it may also award any other relief that it thinks fit.

According to the Health Practitioners Competence Assurance Act 2003, disciplinary hearings are conducted before the Health Practitioners Disciplinary Tribunal. In order for the HPDT to

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42 The Human Rights Review Tribunal is established by the Human Rights Act 1993.
determine whether the practitioner’s acts or omissions constitute malpractice, it must refer to the common law, as there is no legislation for it to refer to. As a general rule, in order for a practitioner to be found negligent, their conduct must have been below the standard reasonably expected of a practitioner in their circumstances. The standards of the practitioner’s colleagues are used to determine what is considered reasonably competent in the given situation. If the HDPT is satisfied that the practitioner’s behaviour requires disciplinary sanctions, it may:

- Censure the practitioner;
- Place a condition on the practitioner’s practice;
- Cancel or suspend the practitioner’s registration;
- Order the practitioner to pay some or all of the legal costs.

\footnote{Collie \textit{v} Nursing Council of New Zealand [2001] NZAR 74.}
3. The Required Standard of Care

3.1 THE TEST OF REASONABLE CARE AND SKILL

There is a legal requirement for health practitioners to perform their professional duties to the standard of reasonable care and skill.\(^{45}\)

Forms of Liability

Tort of negligence

According to the common law, a practitioner may be held liable under the tort of negligence if (taking the circumstances into account) they fail to exercise reasonable care and skill, and the patient suffers death, injury or other damage because of that failure.

*Bolam v Friern Hospital Management Committee* [1957] sets out the test for negligence:

“...The test is the standard of the ordinary skilled man exercising and professing to have special skill...In the case of a medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time...as long as it is remembered that there may be one or more perfectly proper standards; and if he conforms with one of those proper standards, then he is not negligent.”\(^{46}\)

Under New Zealand’s comprehensive no-fault accident compensation scheme, victims of treatment injury (medical accidents) are covered and have access to statutory compensation. In return for this, such victims are virtually entirely barred from suing for common law damages in civil proceedings. As a result, if a health practitioner’s failure to exercise reasonable care and skill causes a patient’s death or physical injury, that patient cannot bring a civil claim in negligence against the practitioner (except for cases of claims for exemplary damages and other unusual situations).

This statutory bar does not apply to personal injury cases where the plaintiffs claim exemplary damages.\(^{47}\) Exemplary damages are only awarded in exceptional cases, such as that of *A v Bottrill*, where the test for exemplary damages was described as a “criterion of outrageousness.”\(^{48}\) However, it is not necessary that there be intentional wrongdoing or

\(^{46}\) *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118
\(^{47}\) *Donselaar v Donselaar* [1982] NZLR 622 (CA)
\(^{48}\) *A v Bottrill* [2003] 1 AC 449
conscious recklessness (although this will often be the case) for exemplary damages to be awarded.\textsuperscript{49}

**Right 4 of the Code of Health and Disability Services Consumers’ Rights**

Right 4(1) is discussed at 2.4 detail above. It is the statutory embodiment of the common law standard of care in negligence cases, and the Health and Disability Commissioner and Human Rights Review Tribunal will apply those principles when determining if there has been a breach of the right.\textsuperscript{50}

**The Crimes Act 1961**

“S150A. Standard of care required of persons under legal duties

(2) For the purposes of this Part, a person is criminally responsible for –

(a) Omitting to discharge or perform a legal duty to which this section applies; or

(b) Neglecting a legal duty to which this section applies – only if, in the circumstances of the particular case, the omission or neglect is a major departure from the standard of care expected of a reasonable person to whom that legal duty applies in those circumstances.”

Section 150A, and the “major departure” test apply to all legal duties in Part 8 of the Act. For our purposes, section 155 is particularly relevant:

“S155. Duty of persons doing dangerous acts

Every one who undertakes (except in case of necessity) to administer surgical or medical treatment, or to do any other lawful act the doing of which is or may be dangerous to life, is under a legal duty to have and use reasonable knowledge, skill, and care in the doing of any such act, and is criminally responsible for the consequences of omitting without lawful excuse to discharge that duty.”

The first part of the section 150A test involves determining whether the practitioner has failed to exercise reasonable care and skill. They will have failed in this regard if the mistake would not have been made by a practitioner who was acting with reasonable competence and skill in the same circumstances.\textsuperscript{51}

\textsuperscript{49} Skegg, PDG, Paterson, Ron, eds (2006) \textit{Medical Law in New Zealand}, Wellington: Thomson Brokers, p65
\textsuperscript{50} Skegg, PDG, Paterson, Ron, eds (2006) \textit{Medical Law in New Zealand}, Wellington: Thomson Brokers, p64
\textsuperscript{51} R v Yogasakaran [1990] 1 NZLR 339 (CA), p405.
Secondly, the practitioner’s behaviour must have been such to be considered a “major departure” from the reasonable standard of care. While it is impossible to define exactly what is meant by this, *R v Prentice* set out a number of criteria that might be considered:

- Whether the practitioner was indifferent to an obvious risk of injury to health;
- Going ahead with the procedure even though there was actual foresight of the risks it entailed;
- A very high degree of negligence in attempting to avoid the foreseen risk;
- Failure to draw attention to a serious risk which the practitioner’s duty demanded that he should address.\(^{52}\)

The “necessity” exception in section 155 of the Crimes Act applies to a person who undertakes medical treatment in an emergency when they are not qualified to do so.\(^{53}\) For example, this could cover a bystander who cares for someone at the scene of a car accident. It does not excuse a medical practitioner from acting without reasonable care and skill in the case of an emergency.\(^{54}\)

### 3.2 APPLYING THE TEST OF REASONABLE CARE AND SKILL

**Specialists**

A specialist doctor will be held to a higher level of accountability than a general practitioner. This is because the standard of care expected of the practitioner corresponds to the practitioner’s level of expertise and skill.\(^{55}\) The standard of care expected is determined with reference to an “average” specialist in the practitioner’s particular field. Thus, if a practitioner is the leading authority on neurosurgery (for example) he will be expected to provide the same standard of care as an ordinary neurosurgeon.\(^{56}\)

**Inexperienced providers**

Determining what (if any) the effect of inexperience should be on the standard of care required of practitioners is a balancing act. On one hand it is desirable that junior doctors, and the like, are allowed to improve their practical skills by working on live patients. On the other hand, patients need to be provided with reasonably skilful care, regardless of who their practitioner is. While there is debate surrounding this subject, it appears that a practitioner’s

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\(^{52}\) *R v Prentice* [1993] 4 All ER 935 (CA), pp943-944


\(^{54}\) *R v Yogasakaran* [1990] 1 NZLR 399 (CA), p405


\(^{56}\) *Lillywhite v University College London Hospitals’ NHS Trust* [2005] Lloyd’s Rep Med 268 (CA)
failure to meet the proper standards of reasonable care and skill will not be excused by their lack of experience or expertise.\textsuperscript{57}

\textsuperscript{57} Skegg, PDG, Paterson, Ron, eds (2006) \textit{Medical Law in New Zealand}, Wellington: Thomson Brokers, p85
4. Consent to Medical Procedures

The work of a health practitioner necessarily involves touching, and performing procedures on, consumers. None of this action may take place without the consumer’s consent.

4.1 CONSENT TO TREATMENT

There are a number of legal reasons why consent to medical treatment is (usually) necessary. They fall into five broad categories of liability:

- Assault
- Battery
- Code liability
- New Zealand Bill of Rights Act 1990

Assault

The term ‘assault’ encompasses not only the act of intentionally applying force to someone else’s body, but also threatening to apply force to someone else’s body. This means that if a consumer believes that they are going to be touched or treated against their will, and the means of doing do are reasonably available to the practitioner, it may be possible for the consumer to sue in assault.\(^{58}\)

Battery

If the practitioner’s actions were to go beyond a mere threat and actual touching without the consumer’s consent occurred, this would be classed as battery. Both assault and battery can be the basis for a civil action, whereby the plaintiff can claim damages without having to show that any harm was suffered as a result of the defendant’s actions.\(^{59}\) Furthermore, battery may occur even if the person who acts unlawfully did so with the best of intentions.\(^{60}\) Battery may also take place when the consumer is unconscious: they do not need to be aware that the touching or treatment is taking place. The only exception to this is if the touching or treatment is considered necessary in an emergency situation.\(^{61}\)

The Code of Health and Disability Services Consumers’ Rights

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\(^{59}\) *Malette v Shulman* (1991) 2 Med LR 162

\(^{60}\) See *Mohr v Williams* 104 NW 12 (1905) in which a surgeon was found guilty of battery after performing an operation on a woman’s ear without her consent.

Right 7 of the Code states:

“Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.”

A consumer’s consent to the provision of services must be given voluntarily, and without any pressure or coercion from the provider. Consent may be considered involuntary if it is given while the consumer is under the effects of medication.  

Consent must be given by the consumer, unless there are reasonable grounds for believing that the consumer is incompetent to make an informed choice. A person is incompetent if they cannot comprehend and retain the relevant information, and are unable to arrive at a choice by weighing the pros and cons of the proposed service. If the consumer is not competent to give consent, consent must be given by someone who is entitled to act on the consumer’s behalf.

The consumer’s consent must be obtained in accordance with the relevant requirements of the Code. Right 5 (the right to effective communication) and Right 6 (the right to be fully informed) are crucial to this consideration.

**Advanced Directives**

Consumers are given the right to use advanced directives under Right 7(5). ‘Advanced directive’ is defined in clause 4 of the Code. Essentially it is a process by which a person can make a declaration about the type of treatment they would want should they find themselves incapacitated in a life-threatening situation. Right 7(5) states that advanced directives can be used in accordance with the common law. Unfortunately New Zealand law has no fixed guidelines for determining the validity of an advanced directive. However, the author must have been competent and fully informed of the consequences of the directive at the time of the declaration, and their decision must have been made without any undue influence. When deciding if an advance directive is valid, it may also be taken into account whether family or a lawyer were involved in the preparation of the directive, and how recently the directive was made.

**The New Zealand Bill of Rights Act 1990**

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62 Beausoleil v La Communauté des Soeurs de la Providence (1964) 53 DLR 2d 65 (CA)
63 The Code, Right 7(2). The Code presumes that consumers are competent to make choices for themselves, unless there are reasonable grounds for believing otherwise.
64 Re C (adult; refusal of medical treatment) [1994] 1 A; ER 819
65 See 2.4 above for a full discussion on Rights 5 and 6.

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The New Zealand Bill of Rights Act 1990 confers the right not to be subjected to medical or scientific experimentation without consent, and the right for everyone to refuse to undergo any medical treatment. In terms of the latter, 'everyone' has been interpreted as every person who is competent to give consent.

However, it is to be noted that according to section 3 of the Act, the Bill of Rights only applies to:

(a) Acts done by the various branches of the New Zealand government; or
(b) Acts done by any person or body in the performance of any public function, power, or duty conferred or imposed on that person or body by or pursuant to the law.

4.2 LIMITATIONS OF CONSENT

Consent Expressly Irrelevant

Consenting to one’s own death

This is prohibited under section 63 of the Crimes Act 1961:

“No one has the right to consent to the infliction of death upon himself, and if any person is killed, the fact that he gave any such consent shall not affect the criminal responsibility of any person who is a party to the killing.”

This section must be interpreted in a way that is consistent with the New Zealand Bill of Rights’ stipulation that patients have the right to refuse medical treatment.

Consenting to female genital mutilation

Section 204A(2) of the Crimes Act 1961 prohibits this. This does not, however, affect sexual realignment surgery or medical or surgical procedures carried out a person giving birth.

Consent Impliedly Irrelevant

Attempted abortion

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67 The New Zealand Bill of Rights Act 1990, s10
68 The New Zealand Bill of Rights Act 1990, s11
69 Re S [1992] NZLR 363
70 New Zealand Bill of Rights Act 1990, s11.
The Crimes Act prohibits a person from unlawfully procuring an abortion.\textsuperscript{71} The consent of either parent has no bearing on whether a crime of attempted abortion has been committed.

\textit{Killing an unborn child}

It is a crime under section 82 of the Crimes Act 1961 for a person to cause the death of “any child that has not become a human being in such a manner that would amount to murder had the child become a human being.”

In this situation, consent of the unborn child is impossible, and parental consent is irrelevant.

\textit{Surgical Operations generally}

New Zealand’s criminal law provides specifically for surgical operations in the following sections of the Crimes Act 1961:

\begin{quote}
Section 61. “Every one is protected from criminal responsibility for performing with reasonable care and skill any surgical operation upon any person for his benefit, if the performance of the operation was reasonable, having regard to the patient’s state at the time and to all the circumstances of the case.”
\end{quote}

\begin{quote}
Section 61A. “Every one is protected from criminal responsibility for performing with reasonable care and skill any surgical operation upon any person if the operation is performed with the consent of that person, or of any person lawfully entitled to consent on his behalf to the operation, and for a lawful purpose.”\textsuperscript{72}
\end{quote}

\textsuperscript{71} New Zealand Crimes Act 1961, s183
\textsuperscript{72} For a more complete discussion of these two provisions, see Skegg, PDG, Paterson, Ron, eds (2006) \textit{Medical Law in New Zealand}, Wellington: Thomson Brookers, pp 165-168.
5. Capacity to Consent

5.1 CAPACITY OF ADULTS TO CONSENT

Right 7 of the Code is central to the question of capacity or competency to consent. It provides that services can only be provided to a consumer if the consumer has made an informed choice and gives informed consent. Part 7 of this guide deals with the question of whether the consumer has been fully informed and has thus given legally effective consent. This chapter of the guide discusses whether a consumer has the capacity to consent to a procedure in the first place.

General Principles

There is no one test that determines whether or not a person has the capacity to consent. Courts have tended to give weight to factual issues rather than legal ones. However, there are a couple of particularly helpful cases in this area.

In *Re T (Adult: Refusal of Treatment)* Lord Donaldson said:

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

This means that while a patient might be competent to consent to basic pain relief drugs being administered, he or she might be considered incompetent to consent to a complex surgery. In other words, whether or not a person has the capacity to consent to a procedure may well depend on the procedure itself.

The presumption that the consumer has the right of self-determination remains in place. Even when a consumer has diminished competence, they retain the right to make informed choices and give informed consent to the degree appropriate given their level of competence. Thus the question of capacity is not an all or nothing matter.

The Role of Mental Illness and Intellectual Disability

People do not lose the capacity to consent simply by virtue of the fact that they are mentally ill. Most of the mental health treatment in New Zealand is carried out with the patient’s

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73 *Re T (Adult: Refusal of Treatment)* [1992] 4 All ER 649 (CA)
75 *Re C (Adult: Refusal of Treatment)* 1994 1 WLR 290
76 The Code, Right 7(3)
consent, and the Mental Health (Compulsory Assessment and Treatment) Act 1992 specifically provides for patients to consent to treatment in several situations.\textsuperscript{77} While mental illness can sometimes make it impossible for a person to consent to treatment, this is not the case for the majority of mental health patients. Various factors (such as drug and alcohol abuse) may also cause a patient’s capacity to consent to fluctuate. In \textit{Re C} it was stated that the question that must be asked when determining competence to consent is whether it has been established that the patient’s capacity is so reduced by mental illness that he or she does not sufficiently understand the nature, purpose and effects of the proposed treatment.\textsuperscript{78}

Similar principles apply to cases of intellectual disability. The High Court of Australia stated in “\textit{Marion’s Case}” that:

“The fact that a child is disabled does not of itself mean that he or she cannot give informed consent...”\textsuperscript{79}

These principles relating to mental illness and intellectual disability are consistent with Right 7(3) of the Code:

“Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.”

5.2 CONSENT OF OTHERS TO THE TREATMENT OF ADULTS

Welfare Guardians of Incapacitated Adults

There is no automatic right for a spouse or next of kin to give legally effective consent for the treatment of another adult. The Protection of Personal and Property Rights Act 1988 (the PPPRA) sets out the process by which a person can be authorised to consent (or refuse consent) to the treatment of an adult lacking capacity to make the decision themselves.\textsuperscript{80} The PPPRA allows for the Family Court to appoint a welfare guardian to act in respect of another person’s personal care and welfare.\textsuperscript{81} However, such an appointment may only be made if the patient is wholly lacking in the capacity to make or communicate decisions about their personal care and welfare, and if the appointment of a welfare guardian is the only way to ensure that the correct decisions are made about the patient’s personal care and welfare. As a general rule a welfare guardian’s decisions will have “the same effect as it would have had if it had been made or done by the person for whom the welfare guardian is acting and

\textsuperscript{77} Skegg, PDG, Paterson, Ron, eds (2006) \textit{Medical Law in New Zealand}, Wellington: Thomson Brookers, p176
\textsuperscript{78} \textit{Re C (Adult: Refusal of Treatment)} 1994 1 WLR 290
\textsuperscript{79} Secretary, \textit{Department of Health and Community Services v JWB and SMB [Marion’s case]} (1992) CLR 218 (HCA)
\textsuperscript{80} Skegg, PDG, Paterson, Ron, eds (2006) \textit{Medical Law in New Zealand}, Wellington: Thomson Brookers, p181
\textsuperscript{81} The Protection of Personal and Property Rights Act 1988, s12(2)
that person had had full capacity to make or do it". However, section 18(1) of the PPPRA sets out a number of exceptions to this. A welfare guardian cannot:

- Refuse life saving treatment;
- Consent to electro-convulsive treatment;
- Consent to brain destroying surgery;
- Consent to experiments other than those that may save the patient’s life.

In addition to this, section 18(3) of the PPPRA states that the foremost consideration (for the guardian’s actions) shall be the best interests of the patient.

**Attorneys, under Enduring Power of Attorney**

Part 9 of the PPPRA allows a competent person to give powers in relation to their personal care and welfare to another person (the ‘attorney’). Enduring powers of attorney only come into force when the formerly competent person either wholly or partly lacks the capacity to understand a decision about their personal care or welfare, or when they understand the decision, but are unable to communicate their views on it.

Much like welfare guardians, the decisions made by attorneys about the patient’s personal care and welfare will generally have the same effect as if they had been made by the patient when fully competent. (Of course, as discussed above, this only applies if the patient lacks the capacity to consent on their own behalf.) The same limits apply to this rule as apply to the powers of welfare guardians.

**5.3 COURT AUTHORISATION**

New Zealand courts can, in some circumstances, authorise the provision of medical treatment for adults.

**High Court**

New Zealand courts have retained their ‘parens patriae’ powers, meaning that they will sometimes have the power to give or refuse consent to medical procedures on behalf of an adult lacking the capacity to decide for himself. For example, in *Re X* the High Court used this power to authorise a hysterectomy operation on a mentally handicapped 15 year old.

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82 The PPPRA 1988, s19(1)
83 The PPPRA 1988, s94(1)(b).
84 The PPPRA 1988, s98(3)
85 Section 98(4) of the PPPRA states that an attorney may not act in a situation which s18 of the PPPRA would prevent a welfare guardian from acting in.
87 The ‘parens patriae’ power is contained in sections 16 and 17 of the Judicature Act 1908.
88 *Re X* [1991] 2 NZLR 365
Family Court

Since the PPPRA came into force, there have been regular uses of the courts’ powers to authorise medical treatment under section 10. As discussed at 6.2 above, the Family Court may only appoint a welfare guardian if someone is wholly incapable. However, according to section 6(1) for all purposes other than the appointment of a welfare guardian, the Family Court may make orders under section 10 where someone either wholly or partly lacks the capacity to make a decision about their personal care and welfare. Section 10(1) sets out a number orders which the Court can make:

- Orders relating to treatment at mental health institutions.
- Orders specifying the kind of medical treatment or advice that a person is to be provided with.
- Orders specifying the educational, rehabilitative or therapeutic services that the person is to be provided with.

5.4 CAPACITY OF MINORS TO CONSENT

The term ‘minors’ is used to refer to those who have not yet reached the age of majority, and are thus not adults in the eyes of the law. In New Zealand the age of majority is 20.

18 and 19 year olds

Minors who are either 18 or 19 years old have the same capacity as an adult to refuse or consent to medical treatment.

16 and 17 year olds

Section 36 of the Care of Children Act 2004 sets out a number of situations in which a child who is 16 years old or over may give or refuse consent. In these situations, the minor’s consent or refusal to consent will have the same effect as if they were of full age:

- Donation of blood; or
- Medical, surgical or dental treatment. However, this provision is only relevant if the treatment or procedure is carried out by a professional, for the benefit of the 16 or 17 year old.

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90 Age of Majority Act 1970, s4(1)
16 and 17 year olds can also give proxy consent if they are married (or living in a civil union) or in a de facto relationship.

Section 38 of the Care of Children Act 2004 must also be considered at this point, as it overrides the provisions in section 36. It states that if a female child consents or refuses to consent to an abortion procedure carried out by a professional, then that consent will have the same effect as if it were given by someone of full age.

As the common law capacity for minors to consent is more relevant to those under the age of 16, this will be discussed below.

**Under the age of 16**

Boys under the age of 16 have no statutory capacity to give or refuse consent to medical treatment. The situation is the same for girls, with one exception: they may give or refuse consent to an abortion.² While those under the age of 16 are still considered ‘consumers’ with regard to the Code, and are therefore presumed competent to give consent,³ this is only relevant to Code liability and does not confer a general capacity to consent upon minors under the age of 16.

The issue of whether minors can consent at common law is not an all or nothing matter, just as it was not for adults.⁴ It has been accepted by the House of Lords and the High Court of Australia that there is no requirement that a person has to be above a certain age in order for them to be able to give legally effective consent to a medical procedure (or indeed to the other touching that occurs in everyday life).⁵ However, New Zealand’s Care of Children Act does not preserve a common law capacity for children to consent, unlike similar legislation in the United Kingdom.⁶ Despite this, the general view in this country is that the legislation has not extinguished minors’ common law capacity to consent to medical treatment.⁷ This seems to be a common sense approach, with the level of consent required from a minor being proportionate to the gravity of the decision being made.

## 5.5 Capacity of Others to Consent to Treatment of Minors

There are a number of reasons why it is very unusual for 18 and 19 year olds to have anyone who can legally consent to their treatment. First, as discussed above, 18 and 19 year olds are treated as adults in the health care context, despite the fact that they have not

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² Care of Children Act 2004, s38
³ The Code, right 7(2)
⁵ Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL); Secretary, Department of Health and Community Services v JWB and SMB [Marion’s case] (1992) 175 CLR 218 (HCA)
reached the age of majority. Secondly, as 18 and 19 year olds no longer have guardians\textsuperscript{98}, the only other possibility for a valid proxy consent would have to come through a court appointed welfare guardian. Only a very small number of people will meet the requirements specified by the PPPRA 1988 for the appointment of such a guardian. In addition to this, 18 and 19 year olds are unable to make an enduring power of attorney.\textsuperscript{99}

All other minors (from 0 to 17) will generally have one or more guardians. This section will focus on the circumstances in which those guardians will be able to give legally effective consent to the treatment of minors.

The rights of guardians in relation to the giving of consent for the treatment of minors are contained in sections 36 and 15 of the Care of Children Act 2004. Section 36 gives guardians (and some others) the right to consent to any medical, surgical or dental treatment or procedure to be carried out on a child, if it is deemed that another person’s consent will be necessary or sufficient.\textsuperscript{100} While this appears to cover a wide range of treatments and procedures, section 15 of the Act could be used if the particular situation appeared to fall outside the ambit of section 36.\textsuperscript{101}

The question then becomes, when will the consent of a guardian be considered necessary or sufficient? This question has caused considerable debate, and is not yet resolved. Some believe that proxy consent should only be valid in law if the treatment being consented to is for the child’s benefit. Others feel that the test for sufficiency should be based on what the ‘reasonable parent’ would consent to. While there are both benefits and disadvantages to these approaches, there is no set legal approach to determining the question of necessity and sufficiency.\textsuperscript{102} There are, however, a handful of limits on a guardian’s ability to consent to treatment. First, a guardian cannot consent to the sterilisation of minor, if the minor is unable to give or refuse consent only by reason of his age.\textsuperscript{103} Secondly, a guardian may not override a minor’s consent or refusal to consent to an abortion.\textsuperscript{104} Thirdly, there have been a number of cases in Australia where the Family Court has ruled a guardian to be acting outside their capacities in providing proxy consent to treatment. For example, a guardian was held to be incapable of consenting to the harvesting of bone marrow from a ten year old boy (the marrow was intended to help treat the boy’s aunt).\textsuperscript{105}

It must also be considered in what circumstances a guardian will be able to override a minor’s consent or refusal of consent. This issue is particularly relevant to children under the age of 16, as they do not have any of the statutory rights to refuse consent that 16 and 17 year olds were provided with under the Care of Children Act 2004. Despite this, as discussed above it is widely accepted that older children (aged approximately 13 to 15) can consent to a number of medical procedures. There is debate over whether a guardian’s

\textsuperscript{98} See definition of “child” in the Guardianship Act 1968
\textsuperscript{100} Care of Children Act 2004, s36(3)
\textsuperscript{101} See Care of Children Act 2004, s15(c)
\textsuperscript{102} For a more in depth discussion on this point, see Skegg, PDG, Paterson, Ron, eds (2006) Medical Law in New Zealand, Wellington: Thomson Brookers, pp 197-199
\textsuperscript{103} Contraception, Sterilisation, and Abortion Act 1977, s7.
\textsuperscript{104} Care of Children Act 2004, s38.
\textsuperscript{105} Re W (1997) 21 Fam LR 612
ability to consent on behalf of such children should be reduced accordingly. Again, there is no set rule on this question, but it has been suggested that a guardian’s power should not be limited too much. For instance, it would be impractical for a guardian to be unable to consent on behalf of a 12 year old who had refused a tetanus injection. While New Zealand’s criminal law imposes a duty on parents and guardians to supply children with the necessaries of life (including appropriate medical treatment), this does not cover the majority of treatment provided on the basis of a guardian’s consent.

Note that when a guardian exercises his power, which includes the ability to determine the child’s medical treatment, he must act jointly with the child’s other guardians wherever possible. This means that he should consult with the other guardians wherever practicable with the aim of securing agreement on matters of medical treatment that are not routine in nature.

The Family Court and High Courts may make orders placing any minor under the age of 18 under the guardianship of the court. They may also appoint a person for either general or specific reasons. Thus the court may consent to a medical procedure or the court may appoint an agent to consent to the procedure.

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107 Crimes Act 1961, s152
108 Care of Children Act 2004, s16(2)(c)
109 Care of Children Act 2004, s16(5)
6. Justifications for Treatment without Consent

6.1 THE CODE OF RIGHTS

Central to the question of when treatment without consent can be justified is Right 7 of the Code. It provides that: “Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent...Except where any enactment, or the common law, or any other provision of this code provides otherwise.”

Right 7(4) then goes on to say: “Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where –

(a) It is in the best interests of the consumer; and
(b) Reasonable efforts have been taken to ascertain the views of the consumers; and
(c) Either –
   a. If the consumer’s views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the service is consistent with the informed choice the consumer would make if he or she, were competent; or
   b. If the consumer’s views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.”

While Right 7(4) is not intended to replace the common law, it is highly likely that a New Zealand Court would take it into account if it was called upon to consider the scope of a common law justification for treatment without consent. Right 7(4) would also be highly relevant if the Health Practitioners Disciplinary Tribunal had to decide whether a practitioner who had provided treatment without consent was guilty of an offence.

6.2 COMMON LAW JUSTIFICATIONS

There have been very few cases decided on this point. This stems from the fact that, while treatment without consent is common place, most people who are treated in this way are either grateful for the treatment that they received or are never in a position to complain. This, however, is not an indication that no common law justification for treatment without consent exists. In fact quite the opposite is true: there is a definite consensus amongst legal and health practitioners that such a justification does exist in a number of circumstances.

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111 The Code, Right 7(1)
Emergency Circumstances

Where there is no Proxy

This common law justification will not only apply when medical practitioners treat an unconscious accident victim, but also in a much broader set of circumstances. In *R v Harris* it was stated that:

“The common law allows a doctor to administer medical treatment without consent where the patient is incapable of consent, the treatment is reasonably thought necessary in the circumstances, and (in a case where incompetence is not due to some permanent disability) the treatment cannot safely be delayed until the patient is able to consent.”

Thus, if it was discovered part way through a surgery that an additional procedure needed to be performed on a patient, a surgeon might well be justified in carrying out the additional procedure without acquiring specific consent for it. It would, however, be appropriate for him to consider whether the risks and inconvenience of delaying the operation outweighed the benefits of proceedings immediately. It is not always necessary for there to be certainty about what the patient would have wanted had they been conscious, nor must the medical team be unanimous in their support of the procedure being carried out.

Where there is a Proxy

If possible, a proxy’s consent should be sought. However, a proxy’s refusal of consent for treatment does not have to be respected in emergency situations, a position which is confirmed by some legal policy. In an English case cited with approval in New Zealand, Lord Donaldson stated that a doctor might carry out a procedure that was vital to the survival or health of a child:

“...notwithstanding the opposition of a parent or the impossibility of alerting the parent before the treatment is carried out.”

Situations of Longer-Term Incompetence

The law surrounding situations of longer-term incompetence was set out in the English case of *Re F*, which involved a proposal to sterilise a mentally handicapped 36 year old woman.

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114 *R v Harris* 21/11/06, Miller J, HC Palmerston North CRI-2006-054-1008
116 See, for example, ss151-152 Crimes Act 1961
117 *Re J (An Infant)* [1996] 2 NZLR 134
118 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112
119 *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (HL)
The principle when deciding whether treatment can proceed without consent in such a situation is one of necessity, not emergency. There are three basic criteria that must be fulfilled:

1. There must be a necessity to act; and
2. The action must be such that a reasonable person in the circumstances would undertake it; and
3. The person undertaking the procedure must be acting in the best interests of the assisted person.

Lord Goff drew a clear distinction between situations of temporary incompetence and situations of permanent or semi-permanent incompetence. His basic rationale for this is that there is no point waiting for consent from a (semi) permanently incompetent person: they will never be able to give it. Thus, “...the doctor must then act in the best interests of his patient, just as if he had received his patient's consent so to do.”

**The Effect of New Zealand’s Legislation**

New Zealand legislation, including the Judicature Act 1908 and the Protection of Personal and Property Rights Act 1988, means that a court could hold that the common law justification to treat without consent in non-emergency situations no longer applies in this country. This means that major procedures, such as sterilising an incompetent adult, should not be carried out without the backing of New Zealand statute law. However, it is likely that the common law justification will continue to apply to the everyday care of incompetent patients (for example, bathing a mentally handicapped person).

### 6.3 STATUTORY JUSTIFICATIONS

The following are a selection of statute law in New Zealand that authorises medical treatment or detention (or both) without consent.

- The Mental Health (Compulsory Assessment and Treatment) Act 1992.
- The New Zealand Bill of Rights Act 1990, sections 6 and 11:
  
  **Section 6.** Wherever an enactment can be given a meaning that is consistent with the rights and freedoms contained in this Bill of Rights, that meaning shall be preferred to any other meaning.

  **Section 11.** Everyone has the right to refuse to undergo any medical treatment.

- The Tuberculosis Act 1948 and the Health Act 1956 (detention of people who could spread an infectious disease).

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120. Re F (Mental Patient: Sterilisation) [1990] 2 AC 1 (HL)
121. Medical Law in New Zealand, pp 249-250
• The Alcoholism and Drug Addiction Act 1966 (detention of “alcoholics” and “drugs addicts”).

• Section 126 of the Health Act 1956 (detention of aged, infirm, incurable, or destitute people).

• Section 41 of the Crimes Act 1961 (treatment of people attempting suicide).

• Section 4 of the Contraception, Sterilisation, and Abortion Act 1977 (prevention of conception or implantation in “mentally subnormal” females).
7. The Beginning and End of Life

7.1 THE LEGAL STATUS OF LIFE BEFORE BIRTH

In order to understand the legal status of life before birth, it is necessary to draw the distinction between a living organism before it is implanted in a woman’s body (the embryo) and a living organism inside a woman’s body (the foetus).

The Foetus

The Crimes Act 1961 distinguishes between:

- The time between conception and implantation;
- From the time of implantation until 20 weeks’ gestation;
- After more than 20 weeks’ gestation; and
- During birth.\(^{122}\)

The legal protection accorded to the foetus increases as it gets closer to full gestation, but it usually does not become a legally significant person until it is born alive.\(^{123}\) This is set out in section 159 of the Crimes Act:

“A child becomes a human being within the meaning of this Act when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, whether it has an independent circulation or not, and whether the navel string is severed or not.”

The New Zealand common law position is that a foetus is neither simply a part of the mother, nor an autonomous being. Instead, the court in *A-G’s Reference (No 3 of 1994)*\(^{124}\) described the unique relationship between mother and foetus. The result of this is that the foetus’ best interests are protected so long as to do so does not infringe on the mother’s rights. However, the New Zealand law on the status of the foetus has been complicated by various courts’ contrasting positions on the subject.\(^{125}\)

The Embryo

\(^{122}\) Crimes Act 1961, s187A

\(^{123}\) Crimes Act 1961, s187A


\(^{125}\) For more information on this complex subject, see Skegg, PDG, Paterson, Ron, eds (2006) *Medical Law in New Zealand*, Wellington: Thomson Brookers, Chapter 16.2.
The legal status of an embryo is controversial and legal opinion is divided over it. Their status is primarily governed by the HART Act 2004\(^{126}\), in which an embryo is defined as including “a zygote and a cell or a group of cells that has the capacity to develop into an individual; but does not include stem cells derived from an embryo.”

While the HART Act treats embryos as property, in that they can be stored, imported, exported, and destroyed when unnecessary\(^{127}\), some overseas courts have held that embryos should be treated at the very least as potential human beings\(^{128}\). While this view has been rejected in a number of cases\(^{129}\), it has been suggested that in New Zealand the legal status of embryos lies somewhere between property and person.\(^{130}\)

### 7.2 PREVENTING LIFE

#### Sterilisation

The aim of sterilisation is to permanently prevent a person from being able to produce a child. The sterilising procedure for men is generally a vasectomy, while for females it involves an operation on the fallopian tubes.

Sterilisation is governed by the Contraception, Sterilisation, and Abortion Act 1977. Because the consequences of a sterilisation operation are so significant, particularly stringent consent requirements have been imposed.\(^{131}\) This includes preventing parents and guardians from being able to consent to a sterilisation operation being performed on their minor children.\(^{132}\)

#### Contraception

Contraceptives are substances, devices or techniques intended to prevent conception or implantation.\(^{133}\) The Contraception, Sterilisation, and Abortion Act is the most important legislation in this area.

The administering of contraception to minors is subject to the same laws that govern the general treatment of minors.\(^{134}\) So-called “mentally subnormal females”\(^{135}\) are able to be...
administered with contraceptives by a number of people, if doing so is considered to be in her best interests.\textsuperscript{136}

7.3 TERMINATION OF LIFE BEFORE BIRTH

If a person terminates the life of a foetus or embryo it will be a criminal offence unless one of the grounds in section 187A of the Crimes Act 1961 is met. The Contraception, Sterilisation, and Abortion Act 1977 also makes it an offence for an abortion to be carried out without the appropriate certificate, in anywhere but a licensed institution.\textsuperscript{137}

\textbf{Attempting to procure a miscarriage}

Miscarriage is defined in section 182A Crimes Act 1961 as:

(a) The destruction or death of an embryo or foetus after implantation; or  
(b) The premature expulsion or removal of an embryo or foetus after implantation, otherwise than for the purpose of inducing the birth of a foetus believed to be viable or removing a foetus that has died.

Sections 183 and 186 of the Crimes Act 1961, and section 44 Contraception, Sterilisation, and Abortion Act 1977, make it an offence for someone to attempt to procure a miscarriage or supply the means for procuring a miscarriage, and for a woman to attempt to procure her own miscarriage. All of these offences involve three common elements:

- Intending to procure a miscarriage;  
- Unlawfulness\textsuperscript{138}; and  
- Using, administering or supplying drugs, poisons, noxious things, instruments or other means of procuring a miscarriage.

Section 187A Crimes Act 1961 sets out the grounds under which aborting a pregnancy of not more than 20 weeks’ duration is lawful:

- Continuing with the pregnancy would involve serious danger to the woman’s life or physical or mental health; or  
- Substantial risk of the child being born seriously handicapped; or  
- Pregnancy has resulted from intercourse between close family members; or  
- Pregnancy has resulted from intercourse that constitutes an offence under section 131(1) of the Crimes Act 1961; or  
- The woman or girl is severely subnormal according to section 138(2) Crimes Act 1961.

\textsuperscript{136} Contraception, Sterilisation, and Abortion Act, s4(1)  
\textsuperscript{137} Skegg, PDG, Paterson, Ron, eds (2006) \textit{Medical Law in New Zealand}, Wellington: Thomson Brookers, p480  
\textsuperscript{138} For a definition of ‘unlawfulness’ in this context, see s187A Crimes Act 1961
A pregnancy of more than 20 weeks’ duration can only be aborted if the person performing the operation believes that it is necessary to prevent either loss of the mother’s life or serious, permanent injury to her physical or mental health.\textsuperscript{139}

**The offence of causing the death of an unborn child**

In addition to the above provisions, section 182 Crimes Act 1961 sets out the offence of killing an unborn child. In order to be guilty of this offence, the accused must have both caused the death of an unborn child before it became a human being\textsuperscript{140} and had the mens rea for murder. While the offence was designed to deal with a killing that took place while the child was being born but before it became a full human being, its scope is now uncertain as the wording of the legislation means it applies to the killing of a child at any time before birth. This means that it has a problematic relationship with sections 183 and 187A Crimes Act 1961, and its scope is uncertain.\textsuperscript{141}

### 7.4 PASSIVE EUTHANASIA AND OMISSIONS TO PROLONG LIFE

Passive euthanasia occurs when the patient dies either because medical professionals don’t do something necessary to keep the patient alive, or when they stop doing something that is keeping the patient alive. It is important to note that there are thousands of cases of patients being “allowed to die” in New Zealand, but very few of these are ever involved in legal proceedings.

**Principles of the Law of Homicide**

There are three relevant questions concerning the law of homicide:

1. **Is it homicide?**

   - The Crimes Act 1961 states that “Homicide is the killing of a human being by another, directly or indirectly, by any means whatsoever."\textsuperscript{142}
   - It is clear from this that corporations such as DHBs can have secondary liability only.
   - Section 158 does not specify whether homicide may be committed by omission. However, later sections of the Crimes Act 1961 indicate that a human being may be killed, in terms of section 158, by an omission as well as by an act.\textsuperscript{143} However, the law only recognises omissions if there was a legal duty to act in the first place.

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\textsuperscript{139} Section 187A(3) Crimes Act 1961  
\textsuperscript{140} See 7.1 above for definition according to s159 Crimes Act 1961  
\textsuperscript{142} Crimes Act 1961, s158  
\textsuperscript{143} See Crimes Act 1961, ss164, 165.
Was there a legal duty?

Some of the relevant legal duties are listed here:

- Sections 151 and 152 Crimes Act 1961: Duties to provide the necessaries of life.
- Section 155 Crimes Act 1961: The duty for anyone who undertakes to administer surgical or medical treatment to have, and use, reasonable skill, knowledge and care.
- Section 156 Crimes Act 1961: If someone is in control of something which may endanger human life if it is not used with appropriate care, they have a duty to take reasonable care (and use reasonable precautions) to prevent such danger.
- Section 157 Crimes Act 1961: If a person undertakes to do an act, when the omission to do so is or could be dangerous to life, they are under a legal duty to do that act.
- Note also that common law duties are relevant to the question of whether homicide is culpable.\(^{144}\)

2. Is it culpable homicide?

- Section 160(2) of the Crimes Act provides that:
  “Homicide is culpable when it consists of the killing of any person...
  (2) By an omission without lawful excuse to perform or observe any legal duty
- Therefore, the questions that must be asked are:
  1. Was there a legal duty to act?
  2. Was there a lawful excuse for omitting to do so?
- It is also crucial to note that section 150A of the Crimes Act 1961 applies. This states that: “...a death-hastening ‘omission without lawful excuse to perform or observe any legal duty’ will not amount to culpable homicide unless there has been a major departure from the required standard of care.”\(^{145}\)

3. Is it murder?

- Crimes Act 1961, section 167: Culpable homicide is murder in each of the following cases:
  (a) If the offender means to cause the death of the person killed;
  (b) If the offender means to cause to the person killed any bodily injury that is known to the offender to be likely to cause death, and is reckless whether death ensues or not.
- Therefore, if it has been found that a person’s omission amounts to culpable homicide, this will normally be murder if the responsible person meant to cause the victim’s death.

\(^{144}\) R v Mwai [1995] NZLR 149 (CA)
The Question of ‘Lawful Excuse’

Omissions to provide life-prolonging treatment are very common, but the courts are hardly ever involved in them. However, during the 1990s there were a number of New Zealand cases on the matter of what will constitute a lawful excuse for omitting to provide a patient with life-prolonging treatment.

In *Auckland Area Health Board v A-G*[^146^], Mr L (who had a severe case of Guillian-Barré syndrome) was totally reliant on a ventilator, even though his brain function was normal. There was a shortage of ventilators in New Zealand and his wife wanted the treatment to be ceased. Thomas J did not specifically state what constitutes a ‘lawful excuse’, instead saying that the only appropriate criteria for determining the question would be one of ‘good medical practice’. He went on to say that:

> “A doctor acting responsibly and in accordance with good medical practice recognised and approved as such in the medical profession, would not...be liable, in my opinion, to any criminal sanction based upon the application of s151(1). He or she will have acted with lawful excuse.”[^147^]

While *Auckland Area Health Board v A-G* set out extensive criteria for determining ‘good medical practice’, the Court of Appeal in *Shortland v Northland Health Ltd*[^148^] simplified the position somewhat. The basic legal position in New Zealand is now that if a practitioner withdraws or withholds life-prolonging treatment in circumstances that are in keeping with ‘good medical practice’, he has a ‘lawful excuse’ for not complying with the duty to prolong life.^[149^]

[^146^]: *Auckland Area Health Board v A-G* [1993] 1 NZLR 235
[^147^]: Auckland Area Health Board v A-G [1993] NZLR 235; p653
[^148^]: *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 (CA)
8. Sources Used


Health and Disability Commissioner Online: http://www.hdc.org.nz


The Code of Health and Disability Services Consumers’ Rights

**Legislation**

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Alcoholism and Drug Addiction Act 1966

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Guardianship Act 1968

Health Act 1956

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