Medicine for the Soul:

Should the Code of Health and Disability Services Consumers' Rights Apply to Christian Healing Practices?

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Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise him up.

-- *James* 3:14-15

It is safe to say that every one of [my patients over the age of thirty-five] fell ill because [they] had lost that which the living religions of every age have given to their followers, and none of them has been really healed who did not gain a religious outlook.

-- Carl Jung, *Modern Man in Search of a Soul*[1]

[1] C. G. Jung, "Psychotherapists or the Clergy" (1932) in *The Collected Works of C.G. Jung,* translated form the German by G.F.C. Hull, Bollingen Series, Princeton University, 11:334.

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Introduction

Christian healing practices ('CHP') like prayer for healing, the laying on of hands, and pastoral counselling have tended to operate beneath the proverbial radar of mainstream media. However, recent months have witnessed a marked rise in media coverage of religious healing practices. In August 2009, five members of a Wainuiomata family were convicted of manslaughter after they drowned their niece while attempting to lift a makutu (Maori curse).[2] Each one received a non-custodial sentence, drawing the ire of some commentators who considered that the sentence would have been heavier had the offenders been of a different religious and cultural background.[3] In January and June 2009, two English nurses were censured by their employers for offering to pray for patients or advising patients to 'turn to God'.[4] In August 2009, Wisconsin man Dale Neumann was found guilty of second-degree reckless homicide of his 11 year old daughter who died of undiagnosed diabetes when Neumann and his wife refused to seek medical care for her, choosing instead to pray for her recovery.[5] The same month also witnessed the opening of a Christchurch-based Christian faith-healing clinic which purported to cure cancer, broken bones and mental illness through prayer. General practitioner Pippa McKay labelled the clinic's claims 'mischievous', saying the claims gave 'the wrong kind of hope' to the infirm.[6]

Issues like these draw attention to the fact that providers of CHP appear to be subject to little regulatory oversight. Criminal law intervenes only where Christian healing practices results in

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[2] "Curse spirit 'looked like a lion'," *Dominion Post*, 12 May 2009, http://www.stuff.co.nz/national/crime/2756065/Exorcism-sentencing-too-lenient, (accessed 1 June 2009). It is beyond the scope of this dissertation to consider the position of traditional Maori healing, and associated Treaty of Waitangi issues, in relation to the Code of Health and Disability Services Consumers' Rights.

[3] "Exorcism sentencing too lenient," *Dominion Post*, 12 August 2009, http://www.stuff.co.nz/national/crime/2756065/Exorcism-sentencing-too-lenient (accessed 17 August 2009).

[4] Andrew Alderson, "Nurse loses job after urging patients to find God during a training course," *The Telegraph,* 23 May 2009, http://www.telegraph.co.uk/news/newstopics/religion/5373122/Nurse-loses-job-after-urging-patients-to-find-God-during-a-training-course.html, (accessed 1 June 2009). Andrew Alderson, "Nurse suspended for offering to pray for elderly patient's recovery," *The Telegraph*, 31 January 2009, < http://www.telegraph.co.uk/health/healthnews/4409168/Nurse-suspended-for-offering-to-pray-for-patients-recovery.html> (accessed 27 March 2009).

[5] "Praying man let his daughter die," *BBC*, 2 August 2009, http://news.bbc.co.uk/nol/ukfs_news/mobile/newsid_8180000/newsid_8180100/8180116.stm (accessed 18 August 2009).

[6] Ian Steward, "Faith healers attack cancer with prayer," *The Press*, 13 August 2009 http://www.stuff.co.nz/the-press/news/christchurch/2746441/Faith-healers-attack-cancer-with-prayer (accessed 13 August 2009).

serious injury or death.[7] However, the majority of Christian healing practices appear unaffected by laws regulating the provision of health services, including the Code of Health and Disability Services Consumers' Rights ('the Code'). The Code plays a pivotal role in New Zealand medical law.[8] The consumer complaint mechanisms established by the Code have become the 'primary vehicle for dealing with complaints about the quality of health care and disability services in New Zealand'.[9] The Code confers certain rights on 'consumers' of health and disability services, and imposes corresponding duties on 'providers' of those services. The term 'provider' has been construed broadly. The Health and Disability Commissioners have found that primal healers,[10] colour therapists,[11] and a self-described 'Clairvoyant, Clairsentient Numerologist and Life-path Counsellor, facilitator of Healing and Teacher [sic]'[12] are as much 'providers' for Code purposes as nurses, physiotherapists or anaesthetists.

At the time of writing, the Code has not been applied to people who provide CHP exclusively.[13] This dissertation examines whether the Code could and should be applied to individuals who provide CHP. In asking those questions, it highlights the potential for conflict between two very vital and deeply personal areas of human experience – religion and health – and considers the role that the state ought to play in mediating those interests.

Chapter One provides an overview of the spectrum of practices collectively referred to as CHP. Chapter Two makes the case that people who provide CHP ('CHP practitioners') and people who receive CHP ('CHP users') do, in fact, come within the ambit of the Code.[14]

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[7] See the endangerment offences in ss 151(2) and 152(2) of the Crimes Act 1961, and also ss 145 (criminal nuisance) and 190 (injury by unlawful act).

[8] P.D.G. Skegg and Ron Paterson, "The Code of Patients' Rights," in *Medical Law in New Zealand*, eds. P.D.G. Skegg and Ron Paterson (Wellington, New Zealand: Brookers, 2006), 24. ('Skegg and Paterson, *MLNZ'*.)

[9] Office of the Health and Disability Commissioner, "*Background*," http://www.hdc.org.nz/aboutus (accessed 1 June 2009).

[10] *Opinion 97HDC5980* (Primal Healing Therapist) (Health and Disability Commissioner, 4/10/1998).

[11] *Opinion 08HDC00218* (Alternative Therapist) (Health and Disability Commissioner, 16/12/2008).

[12] See, for example, *Opinion 06HDC09882* (Health and Disability Commissioner, 25/1/2007), and *Director of Proceedings v Mogridge* 21/12/07, HRRT Decision No 27/07; HRRT27/07; HRRT28/07 ('*Mogridge'*).

[13] The Code has been applied to general practitioners who prayed for patients in the course of a consultation. See *Opinion 03HDC19027* (general practitioner) (Health and Disability Commissioner, 16/12/2007) and *Opinion 97HDC7400* (general practitioner) (Health and Disability Commissioner, 3/4/1998). However, in both situations it was non-contentious that the practitioners were 'health care providers' because they satisfed the definition in s 3(h) of the Health and Disability Commissioner Act 1994 ('health care provider means…any health practitioner').

[14] The phrases 'CHP practitioner' and 'CHP user' require some explanation. It is unlikely that a person providing CHP services would consider himself a 'practitioner' in the same way that a medical doctor might

Chapter Three considers the potential effect of Code rights and duties on CHP providers. It observes that the application of some rights and their corresponding duties may limit CHP practitioners' right to manifest religion, which is affirmed in s 15 of the New Zealand Bill of Rights Act 1990 ('BORA'). In Chapter Four it is argued that the Commissioner should be, and indeed, *is* bound by the BORA to exercise his statutory discretion to cease investigating complaints and his interpretive functions consistently with the BORA where possible to avoid the Code duties placing unjustifiable limits on the religious freedom of CHP practitioners.

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consider herself a 'medical practitioner'. A person receiving CHP is also unlikely to view herself as a 'user'… mirror the language of medical law without using Code/HDC Act terminology, which would imply they are subject to Code jurisdiction. The language of the Code (which refers to service 'providers' and 'consumers') will be adopted from chapter three when the paper proceeds on the basis that CHP practitioners and users may in fact be subject to the Code.

Chapter One: What are 'Christian Healing Practices'?

This Chapter introduces the concept of 'Christian healing practices' ('CHP'). For the purposes of this dissertation, CHP are defined as activities grounded in a biblical Christian worldview that aim to enhance human health; that is, spiritual, physical, mental, emotional and social well-being. It will suggest that there are several reasons why it may be desirable to regulate the provision of CHP using the Code. The Code confers a number of rights on consumers of health and disability services in New Zealand and places corresponding obligations on providers of those services.[15] Whether the obligations imposed on health service providers also extend to providers of CHP is the subject of Chapter Two.

A. Delimiting the scope of inquiry

This dissertation will focus on whether it is appropriate for the Code of Health and Disability Services Consumers' Rights to be used to regulate Christian healing practices ('CHP'). It will not consider the extent to which other forms of religious healing may be amenable to legal oversight through the Code. There are three reasons for restricting the focus of the dissertation to CHP.

First, limiting discussion to *Christian* healing practices ensures there are common characteristics in the types of healing practices that are under consideration. Countless religions and belief systems promote healing practices. However, the nature of the practices (and the beliefs underpinning them) may differ from the beliefs and practices expressed within the Christian faith.[16]

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[15] Health and Disability Commissioner website. See http://www.hdc.org.nz/theact/theact-thecode (last accessed 15/9/2009).

16 Christian Scientists regard the material world as a misperception of the true spiritual world. Prayer 'corrects' this misperception. Because medicine treats matter and prayer treats the immaterial (spirit), the two are often viewed as being incompatible. Conversely, most Christian denominations regard biomedicine and CHP as complementary, not mutually exclusive (see below n.42). Many Christian theologians do not consider the Church of Christ, Scientist to be a denomination of the Christian church because, inter alia, it rejects the deity of

Second, selecting healing practices with a Christian religious basis raises questions about religious freedom and the extent to which legal regulation of *religious* practices is desirable or appropriate. For example, Reiki healing therapy is a spiritual practice designed to facilitate a person's own healing response by enhancing their 'life force energy'.[17] Although Rekei is a *spiritual* practice it does not purport to be a *religion,* so it may not raise issues about the regulation of overtly religious practices.[18]

Finally, CHP have featured prominently in New Zealand news media in recent years, as noted in the introduction. The increasing visibility of the harms associated with CHP suggests it may only be a matter of time before a complaint is laid with the Health and Disability Commissioner alleging that a CHP practitioner has breached the Code.

1. A taxonomy of common Christian healing practices

CHP take a variety of forms. Different denominations, or groups within denominations, hold different views about the nature of healing and the nature of healing practices. The Catholic Church considers that some CHP should only be performed in a liturgical context and only by clergy.[19] Many denominations consider it appropriate for lay persons to perform healing ministrations in a non-liturgical context. Differences between CHP and they ways in which they are practised will become relevant when considering healing practices that may qualify as 'health services' under the Code. Common types of Christian healing practices include:

Jesus (typically viewed as a fundamental tenet of the Christian faith). Given the divergence between the Church of Christ, Scientist and other Christian denominations regarding attitudes towards biomedicine and theological positions, this dissertation will not consider healing practices of Christian Science. For core Christian Science teachings, see Mary Baker Eddy, *Science and Health: With Key to the Scriptures,* (Boston, Mass.: First Church of Christ, Scientist, 1994).

[17] See generally L. Nield-Anderson and A. Ameling, "Reiki: a complementary therapy for nursing practice," *Journal of Psychosocial Nursing and Mental Health Services* 4 (2001):42–49.

[18] The International Center for Reiki Training**,** "What is Rekei? A Brief Overview," http://www.reiki.org/faq/WhatIsReiki.html (accessed 25 August 2009).

[19] *Catechism of the Catholic Church*, (CEPAC ed., Dublin, Ireland: Libreria Editrice Vaticana, 1995), §1461**:** **"**Since Christ entrusted to his apostles the ministry of reconciliation, *bishops* who are their successors, and *priests*, the bishops' collaborators, continue to exercise this ministry." (Emphasis added.)

- **Prayer for healing** – petitioning God for healing and health for oneself or for another person.

- **'Laying on of hands'** – physical touch accompanying prayer for healing to convey support and strength, and a sense of the presence of God. Viewed as a symbolic act, not a medical treatment.[20]

- **Anointing with oil / anointing of the sick** – applying oil to a person seeking healing. As with laying on of hands, the application of the oil is not regarded as a medical treatment but as a reminder of the healing presence of God.[21]

- **Exorcism** – the action of exorcizing or expelling an evil spirit by adjuration or the performance of certain rites.[22]

- **Deliverance** – prayer for a person considered oppressed by evil spirits.[23]

- **Pastoral counselling** – there is no commonly accepted definition of 'pastoral counselling'.[24] In its most expansive form, Christian pastoral counselling may be provided by persons without formal counselling qualifications within a Christian church or Christian-based clinic. Pastoral counselling may include, inter alia, grief, marriage, inner healing and 'salvation' counselling.[25]

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[20] Committee on the Relation of Christian Faith to Health, *The Relation of Christian Faith of Health*, (Philadelphia, United States of America: The United Presbyterian Church in the United States of America, 1960), 50. See also Luke 4:40 and Matthew 9:18.

[21] James K. Wagner, *Healing Services* (Nashville, Tennessee: Abingdon Press, 2007), 5 ('Wagner, *Healing Services'*) See also *James* 5:14-15.

[22] "Exorcism", *The Oxford English Dictionary 2nd ed.* (Oxford, Oxford University Press: 1989)

[23] Francis McNutt, *Healing* (Notre Dame, Indiana: Ave Maria Press, 1974), 208 ('MacNutt, *Healing'*). Although 'exorcism' and 'deliverance' are sometimes used interchangeably, MacNutt notes that exorcism is performed with reference to persons *possessed* by demons, whereas deliverance is performed for people *oppressed* by demonic activity.

[24] See generally J. Foskett ., and G. Lynch, "Pastoral counselling in Britain: An introduction", *British Journal of Guidance and Counselling*, 29 (2001) 373 - 379. The authors suggest that the reason for the absence of one universally accepted definition of 'pastoral counselling' is the presence of "fundamental questions about the suitability of a professional counselling model for pastoral counsellors, the role of pastoral counselling in a society in which orthodox Christian faith is a minority view, and the nature of an appropriate integration of religion, spirituality and therapeutic practice." (376).

[25] Salvation counselling is here used to refer to the process of guiding a person through their decision to become a Christian.

- **Eucharist / Holy Communion** – ritual commemoration of Jesus' last supper with his disciples.

It should be noted that healing is not attributed solely to the performance of these CHPs. Rather, Christians view CHPs as a means of connecting a person with God who alone has the power to heal.[26]

2. Theological bases of Christian healing practices

Healing is an integral aspect of Christian faith. Pope Benedict XVI observed that "Healing is an essential element of the apostolic mission and of Christian faith in general". He went on to say that, when properly understood, Christian healing "expresses the entire content of redemption."[27] In the context of many Christian traditions, 'healing' is not purely 'spiritual'; it also pertains to physical, psychological and emotional wellbeing. Healings are attributed to power of God which is outworked through the ministrations of Christian believers, especially prayer.

The origins of CHP can be traced to the public ministry of Jesus of Nazareth in the New Testament.[28] The canonical Gospels record 32 instances of individual and group healings by Jesus while the apostles are credited with 16 individual and group healings.[29] Many healing encounters were dramatic instances of physical healing. Men and women were reportedly raised from the dead,[30] sight was restored to blind men[31] and a woman with a chronic

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[26] Wagner, *Healing Services*, above n.21, 3.
[27] Joseph Ratzinger (Pope Benedict XVI), *Jesus of Nazareth* (London, England: Bloomsbury Publishing PLC, 2007), 177-178.
[28] Doctrinal Commission of the International Catholic Charismatic Renewal Services, *Guidelines on Prayers for Healing* (Palazzo della Cancelleria, Vatican City: International Catholic Charismatic Renewal Services, 2007), 23. Healings are also recorded in the Old Testament (see, for example, the healing of Namaan from a skin condition in *2 Kings* 5:1-14) but feature more prominently in the activity of Jesus in the New Testament. See, for example, *Matthew* 4:23: "Jesus went throughout Galilee…healing every disease and sickness among the people." See also *Matthew* 9:35 and *Luke* 9:11.
[29] Where a healing is recorded in more than one Gospel, it has only been counted as one instance of healing. For a comprehensive list of healings performed by Jesus and the apostles, see the appendix to Wagner, *Healing Services*, above n.21, 81.
[30] See, for example, the raising of Dorcas (*Acts* 9:36-42) and Lazarus (*John* 11:1-44).

haemorrhage was healed when she touched the hem of Jesus' garments.[32] Jesus not only performed healings himself; he gave his disciples "authority to drive out evil spirits and to heal every disease and sickness",[33] commanding them to "heal the sick, raise the dead, cleanse those who have leprosy, [and] drive out demons".[34] In a passage often cited as the scriptural authority for performance of CHP today, Jesus appears to extend healing authority to *all* believers saying they "will place their hands on sick people, and they will get well".[35] The apostle Paul writes that Christians may receive the spiritual 'gift' of healing.[36] Christian scripture has been interpreted as a setting a precedent for Christians to continue healing ministries today.

While restoring of physical health is important in Christian teaching, many Christians shy away from viewing physical healing as an end itself. Rather, physical healing is viewed as "an act that portrays what salvation does".[37] In other words, healing of bodily and mental restoration signifies restoration of right relationship with God, which is the primary concern of Christian faith.[38]

3. CHP use in New Zealand

There is scant data about what motivates people to use CHP. As complementary and alternative medicine ('CAM') and CHP are healing modalities outside 'mainstream' medicine, studies investigating the reasons consumers use complementary and alternative

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[31] See, for example, *Matthew* 9:27-31.
[32] See *Matthew* 9:20-22, *Mark* 5:25-34 and *Luke* 8:43-48.
[33] *Matthew* 10:1.
[34] *Matthew* 10:8.
[35] *Mark* 16:18.
[36] *1 Corinthians* 12:8-9. "To one there is given through the Spirit the message of wisdom… to another gifts of healing by that one Spirit…"
[37] Darrell L. Bock, *Acts* (Michigan, USA: Baker Academic, 2007), 158.
[38] The link between health and salvation is not only conceptual but etymological - the Greek term *sōzein*, used in Luke 8:36 to refer to the healing of a demon-possessed man, means 'to save' and 'to heal'. See John Donahue and Daniel Harrington, *The Gospel of Mark: Volume 2 of Sacra Pagina Series* (Collegeville, Minnesota: Liturgical Press, 2005), 318.

medicine ('CAM') may throw some light on why people seek CHP.[39] These studies suggest that the majority of people use CAM because it appears "to be more congruent with their own values, beliefs, and philosophical orientations toward health and life", not because of dissatisfaction with conventional medical treatment.[40] For many Christians, CHP are not merely congruent with their worldview, they are a core aspect of it.[41] The view that CHP should complement rather than supplant biomedical treatment is advocated by many Christian theologians.[42]

There is also a dearth of information about the extent of CHP use in New Zealand. The United States National Centre for Complementary and Alternative Medicine ('NCCAM') found that prayer for self (43 per cent) and prayer for others (24.4 per cent) were the two most utilised alternative treatments adopted by the 62 per cent of Americans who use complementary and alternative medicine in 2002.[43] There is no comparable New Zealand data. However, a recent study found that thirty-nine per cent of New Zealanders believe that some 'faith healers' have God-given powers.[44] Although neither study asked respondents to specify whether they believed in the Christian God, or whether faith healers received healing power from the God of the Christian Bible, the findings suggest that a significant number of people in New Zealand and the United States believe in the efficacy of religious healing practices, even if they do not practice them.

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[39] Opinion is divided about whether prayer for healing is a form of CAM. A few studies treat prayer or "spiritual healing" as CAM modalities; see, for example, E. Ernst, "The Role of Complementary and Alternative Medicine", British Medical Journal, 321 (2000) 1133-1135, while most do not. There does not appear to be any discussion about why prayer is or is not included as a CAM modality.

[40] J.A. Astin**, "**Why patients use alternative medicine: results of a national study," *Journal of the American Medical Association*, 279(1998):1548-1553, 1548.

[41] Some Christians believe that divine healing, along with other charismatic gifts of the Holy Spirit, ceased to be practised in the early church. This view is known as 'cessationism'.

[42] See, for example, Wayne Grudem, *Systematic Theology: An Introduction to Biblical Doctrine* (Leicester, England: Inter-Varsity Press; Grand Rapids, Michigan: Zondervan Publishing House, 1994) 1064-1065 and MacNutt, *Healing*, above n.23, 263.

[43] P. Barnes, E. Powell-Griner, K. McFann, & R. Nahin, (2002) "CDC Advance Data Report #343: Complementary and Alternative Medicine Use Among Adults: United States, 2002" Washington DC: *National Centre for Complementary and Alternative Medicine*.

[44] Department Of Communication, Journalism & Marketing, Massey University, "Religion in New Zealand: International Social Survey Programme, Massey University" Survey, March 2009, *publicaddress.net/assets/files/ISSPReligioninNZ09.pdf* (last accessed 17 August 2009). Unsurprisingly, perhaps, the report comments that belief in the power of faith healers is a "superstitious belief" (2).

4. Potential harm associated with CHPs

Like any kind of healing intervention, CHPs may cause harm to the people receiving them. This harm may be physical, especially where the CHP involves forceful physical touching. Exorcism is an obvious example,[45] but less invasive CHPs may also result in injury. For instance, a person may be 'slain in the spirit'[46] while receiving healing prayer. If the person is not caught by a 'catcher' (people positioned to catch persons at risk of falling), the consumer may sustain injury.

CHP may also cause emotional or mental distress. Examples include the distress may result where a person has been assured of healing through a CHP and their expectations are disappointed,[47] where a person is blamed for the apparent inefficacy of the CHP (because they 'lacked faith' to be healed, for example), or where a CHP practitioner releases personal information about a consumer's medical condition to church members.

Third, CHP practitioners may inhibit consumers from seeking and using biomedical treatments for themselves or other persons, whether by active dissuasion or by failing to present the option of biomedical treatment where it would be appropriate to do so.[48] For instance, a person may be counselled by their minister to cease taking prescribed medication as a sign of their faith that God will cure their illness, resulting in relapse of illness.[49]

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[45] See, for example, *R v Lee* [2006] 3 NZLR 42; discussed below n.137.

[46] A term used within Pentecostal and Charismatic Christianity to describe a person falling to the ground during an event they perceive as a personal encounter with the Holy Spirit. See, for example, Bill Subritzky, "Guidelines for Counsellors", http://www.doveministries.com/usa/pamphlets/guidelines_counsellors.htm (last accessed 15/8/2009).

[47] For an example of inappropriately elevated expectations in the context of colour therapy treatments, see *Opinion 08HDC00218* (alternative therapist) (Health and Disability Commissioner, 16/12/2008).

[48] See *Opinion 08HDC00218* (alternative therapist) (Health and Disability Commissioner, 16/12/2008) for an example of where a CAM practitioner may be under a duty to present the option of conventional biomedical treatment in order.

[49] For discussion of the theological and ethical implications of a CHP practitioner advising a consumer to cease taking medication, see MacNutt, *Healing*, above n.23, 262-263.

5. Extent of regulation of Christian healing practices

(a) New Zealand

New Zealand practitioners of CHP are not subject to any direct professional regulation, though facets of criminal, privacy and tort law regulate all CHP practitioners.

General provisions of the criminal law regulate conduct of CHP practitioners.[50] The statutory bar on recovery of compensatory damages for personal injury[51] diminishes the import of tort law in all but the most 'outrageous' circumstances.[52] The Privacy Act 1993 will apply to CHP practitioners to prevent the unauthorized distribution of personal information given to the practitioner.[53] Whether CHP practitioners are subject to the Health Information Privacy Code 1994 ('HIPC') depends on whether CHP constitute 'personal health services' as per the definition in the HIPC, which is essentially the same as the definition of 'health services' in the Code (of Health and Disability Services Consumers' Rights).[54] Even if the HIPC does not apply, the Privacy Act principles will still operate to regulate CHP practitioners.

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[50] See the Crimes Act 1961, especially duties incumbent on persons performing dangerous acts and on persons required to provide the necessaries of life for another (see ss 150A-152, 155-156, and ss 61, 61A and 145). In *R v Moorhead*, (HC, Auckland, 2002, T 011974, Harrison J) ('*Moorhead'*)the parents of an infant were found guilty of the manslaughter of their son Caleb by omitting to perform a legal duty to provide him with medical treatment under s 152, relying instead on prayer and cayenne and garlic poultices. In *R v Laufau*, (HC, Auckland, 2000, T 000759, Potter J) ('*Laufau'*) the defendants were acquitted of manslaughter but convicted of failing to observe the legal duty of parents to provide the necessaries of life for their son who had been diagnosed with a form of bone cancer. The defendants refused to take him to hospital to receive medical treatment that may have given him a 60-70 per cent chance of recovery, choosing to rely on "God's healing power" instead. See also the law of assault (s 196 and definition of 'assault' in s 2, but see also the partial defence of consent expounded in *R v Lee* [2006] 3 NZLR 42).

[51] Injury Prevention, Rehabilitation, and Compensation Act 2001, s 317.

[52] The majority of the Privy Council in *Bottrill v A* [2003] 2 NZLR 721 held that judicial discretion to award exemplary damages in personal injury cases should only be exercised where the defendant's conduct in committing a tort is "so outrageous that an order for payment of compensation is not an adequate response" (para [20]).

[53] See the Privacy Act 1993, s 66.

[54] The HIPC applies to 'health practitioners' and 'health agencies' who have (a) information about an identifiable individual relating to the individual's *health* or disability, or the health and disability services they receive, and (b) provide *health* or disability-related services. 'Health services' are defined as including 'personal health services'. The definition of 'personal health services' in clause 1 of the HIPC is almost identical to the definition of 'health services' in the Code. Therefore, if CHP constitute 'health services' under the Code, they will also constitute 'personal health services' under the HIPC, and CHP practitioners will be subject to the HIPC. Whether CHP are 'health services' for the purpose of the Code (of Rights) will be discussed in Chapter Two.

Enactments governing other health professions (including some CAM modalities) are unlikely to apply to CHP practitioners. The Consumer Guarantees Act 1993 and Fair Trading Act 1986 regulate the quality of services and representations made about those services. They apply only to 'services' provided a 'trade' context, whereas CHP are usually offered free of charge.[55] The Health Practitioners Competence Assurance Act 2003 does not apply to CHP as it is not one of the regulated 'health professions' listed in the Act, though there is scope for CHP to be registered (and consequently regulated) as a 'health profession'.[56] The Health and Disability Services (Safety) Act 2001 is also inapplicable to CHP, because CHP are unlikely to fall within the definition of 'specified health and disability services of any kind'[57] and it is improbable that CHP practitioners will seek certification from the Director-General of Health as required by the Act.[58]

(b) Overseas

There do not appear to be any statutes or cases from common law jurisdictions specifically regulating provision of CHP. Like New Zealand, the criminal law of Australia,[59] Canada,[60] the United Kingdom ('UK') and the United States of America ('US') prohibits *any* action or omission that causes serious harm to another person. However, the claim that none of those jurisdictions regulate the provision of CHP specifically requires to qualifications.

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[55] Section 13 of the Fair Trading Act 1986 prohibits false or misleading representations in relation to persons "*in trade*, in connection with the supply or possible supply of goods or services" [emphasis added]. The definition of 'services' in s 2 of the Consumer Guarantees Act 1993 requires that they are provided by a supplier, who is a person 'in trade'.

[56] Health Practitioners Competence Assurance Act 2003, s 114. The Act may be extended to regulate new professions (which may include CHP) where the Minister of Health is satisfied that the provision of certain health services "poses a risk or harm to the public" or where regulation of services is "otherwise in the public interest", subject to provider agreement regarding necessary qualifications and standards. (See ss 115-116.)

[57] Health and Disability Services (Safety) Act 2001, ss 4(1) and 5(1).

[58] Health and Disability Services (Safety) Act 2001, s 9.

[59] See, for example, *R v Mika and Sagato* [2000] NSWSC 852 and *R v Vollmer & Ors* [1996] 1 VR 95 (both manslaughter cases where the victims died while being exorcised.)

[60] For example, Canadian law has consistently held that "it is not a lawful excuse for a parent who, knowing that a child is in need of medical assistance or any other necessity of life, refuses to obtain such assistance because to do so would be contrary to his/her belief, religious or otherwise." (*R. v. Atikian* (1990), 62 C.C.C. (3d) 357 per O'Driscoll J. See also *R v Tutton* [1989] 1 S.C.R. 1392 and *R v Lewis* (1903), 7 C.C.C. 261.)

First, voluntary self-regulation ('VSR') of 'spiritual healers' is becoming well-established in the United Kingdom.[61] The increase in the number of VSR bodies for spiritual healing followed a recommendation from the House of Lords that CAM should be subject to greater regulatory control.[62]

Secondly, US state legislatures have attempted to prevent the medical statutory licensing regime from impinging on the practice or core beliefs of religion in two ways. One is by providing that the licensing regime is not intended to interfere with the practice or core beliefs of a religion. The other is by exempting treatment by religious or spiritual means from licensing requirements. However, these provisions have been construed narrowly to include treatment by prayer or 'spiritual means' alone. The courts have been swift to prosecute providers of religious or spiritual healing services who step outside these exemptions.[63]

In short, several common law jurisdictions avoid direct statutory regulation of religious healing. However, some jurisdictions increase the potential for regulatory oversight by encouraging VSR (UK) or interpreting statutory protections for religious and spiritual healers narrowly (US).

Summary

As with conventional medicine, CHP can have positive and adverse consequences for users. Whether users and practitioners alike would be well-served by having the Code apply to persons providing CHP to minimize the incidence of potentially negative effects associated with it will be discussed in chapter two.

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[61] See, for example, For examples of voluntary self-regulation in the area of 'spiritual healing', see a template ode of conduct at UK Healers Regulatory Body, "UK Healers Code of Conduct", (http://www.ukhealers.info/code.htm, November 2007) (last accessed 18/8/2009); British Complementary Therapies Council, "Introduction to Standards of Practice for Complementary Therapists", (http://www.bctcvsr.org.uk/Documents%20page.html) (last accessed 18/8/2009) and the Guild of Professional Healers (http://www.guildofprofessionalhealers.org.uk/), which was created for the purpose of establishing standards for Rekei, spiritual and energy therapists.

[62] House of Lords Select Committee on Science and Technology, *Complementary and Alternative Medicine* hl 123 (6th Report 2000), ch. 5. For a copy of the full report, see http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12308.htm (last accessed 14/9/2009).

[63] See Barry Nobel, "Religious Healing in the Courts: The Liberties and Liabilities of Patients, Parents and Healers", University of Puget Sound Law Review 16 (1992-1993), 393-394.

Chapter Two: Does the Code of Health and Disability Services Consumers' Rights Apply to Providers and Users of CHP?

Chapter one described the spectrum of practices collectively referred to as 'Christian healing practices' ('CHP'). This chapter will make the case that people who provide CHP ('CHP practitioners') and people who receive CHP ('CHP users') come within the ambit of the Code.

A. An Overview of the Code

1. The Cartwright Inquiry 1988

The Code has its genesis in the Cartwright Inquiry 1988. The Inquiry investigated the conduct of health practitioners researching cervical cancer at National Women's Hospital.[64] In the report of the Committee of Inquiry, Judge Cartwright (as she then was) recommended that New Zealand law provide for a statement of patients' rights and the appointment of a "Health Commissioner". Although Judge Cartwright's recommendations addressed patients' rights - particularly the right to be informed and give informed consent to health services[65] - in a public hospital context, subsequent legislation had a much wider ambit.[66]

2. The Health and Disability Commissioner Act 1994

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[64] Judge Cartwright, *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (1988). Minister of Health, Michael Basset, commissioned the inquiry to investigate allegations of malpractice about Dr Herbert Green's carcinoma-in-situ treatment and research that occurred at the hospital during the 1950s until the early 1980s. The Report found that some trials were performed without patient consent and that treatment was withheld from some patients.

[65] See especially pp. 69, 171, 174-176 of the Report.

[66] Ron Paterson, "Medicine for today - Professional Responsibility and Complementary Medicine," *Office of the Health and Disability Commissioner*, 1 June 2000, http://www.hdc.org.nz/publications/presentations?Medicine%20for%20today%20-%20Professional%20Responsibility%20and%20Complementary%20Medicine (last visited 10 August 2009).

In response to the Judge Cartwright's recommendations, Parliament enacted the Health and Disability Commissioner Act 1994.[67] The primary purpose of the Act is to "promote and protect the rights of health consumers and disability consumers"[68]. The Act has several mechanisms for achieving this objective. It provides for the establishment of the office of the Health and Disability Commissioner ('the Commissioner') to investigate complaints against providers of health care or disability services. The Act also provides for the formation of a consumer advocacy service, as well as the promulgation of a Code of Health and Disability Services Consumers' Rights.[69]

3. The Code of Health and Disability Services Consumers' Rights

The Code is set out in the Schedule to the two primary clauses of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. The Schedule contains six clauses. Clause 1 states that consumers have rights set out in the Code, and providers have corresponding duties. Clause 2 sets out various rights, the headings of which are as follows: [70]

1. Right to be treated with respect;
2. Right to freedom from discrimination;
3. Right to dignity and independence;
4. Right to services of an appropriate standard;
5. Right to effective communication;
6. Right to be fully informed;
7. Right to make an informed choice and give informed consent;
8. Right to support;
9. Rights in respect of teaching or research; and

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[67] The Bill was originally introduced as the Health Commissioner Bill 1990. The Act entered into force on 20 October 1994 (see Health and Disability Commissioner Act 1994, s 1(2)).
[68] Health and Disability Commissioner Act 1994, Long title.
[69] *Ibid*.
[70] The full text of the Code of Rights can be found in the Appendix.

10. Right to complain.

Clause 3 is the 'provider compliance' provision, whereby a provider will not be found in breach of the Code if the provider has taken "reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in [the] Code."[71] The "circumstances" are defined as "all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints."[72] The onus is on the provider to prove that it took reasonable actions.[73] Definitions of key terms are contained in Clause 4. Clause 5 affirms that providers are not required to violate any other enactment in order to discharge their Code obligations,[74] while Clause 6 provides that consumer rights are not confined to rights listed in the Code.

4. The Health and Disability Commissioner

The Office of the Health and Disability Commissioner is specially tasked with promoting and protecting the rights of consumers who use health and disability services, and to help resolve problems between consumers and providers of health and disability services.[75] The importance of the complaint assessment and investigation aspect of the Commissioner's role is magnified by the statutory bar on civil actions for personal injury, includes injury caused by providers of health and disability services.[76]

The Commissioner[77] has several options when responding to complaints. At the preliminary

[71] Health and Disability Commissioner (Code of Health and Disability Consumers' Rights) Regulations 1996, cl 3(1). ('Code of Rights')
[72]Code of Rights, cl 3(2)
[73] Code of Rights, cl 3(3).
[74] 'Enactments' include primary and secondary legislation. (see Interpretation Act 1999, s 29.)
[75] See generally the Health and Disability Commissioner Act 1994, s 14(1) and the Health and Disability Commissioner website (http://www.hdc.org.nz/aboutus/aboutus-faq).
[76] Ron Paterson, "Assessment and Investigation of Complaints" in Skegg and Paterson, *MLNZ*, above n.8, 594.
[77] The Commissioner is appointed for a five-year term, and may be eligible for reappointment from time to time; see s 12 of the HDC Act. Robyn Stent was the first Commissioner (1994-2000), followed by Ron Paterson (2000-present).

assessment stage, the Commissioner must decide whether to take further action or whether to take no action on the complaint.[78] If the Commissioner elects to take further action, he may refer the complaint to a person or agency involved in the health and disability sector,[79] refer the complaint to an advocate,[80] call a conference of the parties concerned,[81] or to investigate the complaint himself.[82] The Commissioner can cease taking action on a complaint at any stage after the preliminary assessment where the Commissioner considers that, having regard to all the circumstances of the case, any action or further action is unnecessary or inappropriate.[83]

If the Commissioner elects to investigate the complaint and subsequently forms the view that a provider has breached the Code, he may make recommendations to the provider,[84] and to any other authority, professional body, or other person, including the ACC.[85] He may also refer providers to the Director of Proceedings ('DP'). The DP will decide whether to initiate disciplinary proceedings, bring an action in the Human Rights Review Tribunal ('HRRT') or bring other proceedings.

The Commissioner's power to enforce recommendations made to providers is limited.[86] However, the Commissioner's opinions and reports can affect a provider's reputation, policies and procedures. In this sense, the Commissioner's 'word' (in the form of a provisional opinion about whether the Code has been contravened) is 'law' to the providers and consumers involved.[87]

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[78] Health and Disability Commissioner Act 1994, s 33(1). ('HDC Act')
[79] HDC Act, s 34.
[80] HDC Act, s 37.
[81] HDC Act, s 33.
[82] HDC Act, s 33(1)(b).
[83] HDC Act, s 38(1). The significance of the discretion to take no action on a complaint the Code as a means of protecting providers' right to manifest religion and avoiding close scrutiny of the 'reasonableness' of CHP will be discussed in detail in chapters three and four.
[84] HDC Act, s 45(2)(a). Typical recommendations include a written apology to the consumer, a fees refund and process changes.
[85] HDC Act, s 45(2)(b).
[86] See HDC Act, s 45.
[87] The potency of the Commissioner's opinions is reflected in the 98.5 per cent compliance rate with the Commissioner's recommendations of change in a provider's practice for the year ending 30 June 2009. See

B. Does the Commissioner's jurisdiction extend to CHP practitioners and users?

The Health and Disability Commissioner has jurisdiction to consider a complaint where each of the following four elements are present:

1. A health or disability service provider; and
2. A health or disability service consumer; and
3. A health or disability service; and
4. An apparent breach of the Code.[88]

All four elements must be made out before the Commissioner's jurisdiction is established. Thus, even if the first three elements are satisfied, the question of jurisdiction will not arise until triggered by the fourth element – an apparent breach of the rights contained within the Code. The two vignettes below are hypothetical examples of situations that may give rise to an apparent breach of the Code that may in turn trigger a complaint to the Commissioner.

1. Two vignettes

(a) Earnest's anger

Earnest is diagnosed with acute hypertension (high blood pressure) and is prescribed anti-hypertensive medication by his doctor. One month later, Earnest sees a billboard for "The Christian Healing Centre – helping you find wholeness through physical and emotional healing". Earnest calls the Centre and arranges an appointment with Reverend Theophilus, reasoning that anything that might stop the dizziness, blurred vision, headaches and occasional chest pain is worth trying. At the appointment, Earnest tells Reverend Theophilus about his medical condition and medication. Reverend Theophilus lays hands on Earnest and prays for Earnest's healing.

Health and Disability Commissioner, *Annual Report for the Year Ended 30 June 2009* (Auckland, New Zealand: Health and Disability Commissioner) 1.

[88] Personal correspondence with Cordelia Thomas, HDC senior legal advisor, 11 September 2009 (on record with author).

As soon as the prayer is ended, Earnest feels as though his symptoms – by now largely kept in check by the medication - have vanished altogether. Reverend Theophilus says to Earnest, "God only heals people who believe that He can heal. If you want to keep your healing, stop taking any medication you have been prescribed as a sign of your faith in God's healing power."[89] Eager to retain his 'healing', Earnest follows Reverend Theophilus' advice and discards his medication as soon as he gets home. Two weeks later, Earnest suddenly realises that he can no longer see from his right eye. His optometrist tells him that blood vessels in his retina have burst, unable to withstand the strain caused by his elevated blood pressure. The visual impairment is irreversible.

(b) Sheeba's dilemma

Sheeba has been attending Abundant Life Church for several weeks. After fifteen years of marriage, she feels as though her relationship with her husband is falling apart. Flicking through the church newsletter one Sunday, Sheeba sees a notice:

> Pastor John David, leader of pastoral care and visitation ministries. Available for spiritual guidance and direction. Phone the church office to arrange an appointment.

Sheeba makes a time to meet with Pastor David to discuss her marital concerns. They meet in his office at the church on a fortnightly and then, at Pastor David's suggestion, weekly basis. Pastor David begins telephoning Sheeba at home during the day while her husband is at work. Initially surprised by the frequency of his calls, Sheeba supposes that he is simply concerned for her well-being. She is surprised when Pastor David arrives unannounced one Saturday evening while her husband and children are away camping. As they talk, Pastor David begins to make sexual advances towards Sheeba. Pastor David tells Sheeba that her husband is away and will "never know about anything". Confused and upset, Sheeba tells Pastor David to leave. She feels uncomfortable about the prospect of raising the incident with

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[89] Mark 11:22-24 intimates that faith is essential to healing:

> "Have faith in God", Jesus answered. "I tell you the truth, if anyone says to this mountain, 'Go, throw yourself into the sea,' and *does not doubt in his heart but believes* that what he says will happen, it will be done for him. Therefore I tell you, *whatever you ask for in prayer, believe that you have received it, and it will be yours*."

[Emphasis added.]

the senior pastor at Abundant Life (who is good friends with Pastor David), but doesn't know who else to turn to.

Earnest and Sheeba's situations are examples of the kinds of grievances that may arise from the provision of CHP and could form the basis of a complaint to the Commissioner. Earnest and Sheeba received services that were intended to promote their physical or emotional health. The manner in which those services were provided seems to violate the rights that attach to consumers of health care services. Arguably, Reverend Theophilus failed to take reasonable care and skill when furnishing Earnest with advice about 'keeping' his healing by discarding his medication. Pastor David disregarded Sheeba's right to be free from sexual exploitation. The importance of the complaint resolution process facilitated by the Office of the Health and Disability Commissioner via the Act and the Code is magnified by the absence of alternative dispute resolution mechanisms. For example, Earnest could attempt to lay a complaint with the police, alleging that Reverend Theophilus' conduct constituted a major departure from the standard of care expected of a reasonable person performing a lawful act (exorcism) that may be dangerous to human life.[90] However, he would face major difficulties proving *beyond reasonable doubt* that his visual impairment was *caused* by Reverend Theophilus' admonition to cease taking medication, not his pre-existing medical condition. Like Earnest, Sheeba may also be reluctant to raise her grievance with anyone at her church, especially because she is new to the congregation.

Earnest and Sheeba's situations show that CHP consumers may be able to demonstrate apparent breaches of the Code, thus satisfying the fourth element of the jurisdiction test. Whether the remainder of the jurisdiction test can be satisfied hinges on whether practitioners of CHP fulfil the definition of "health care provider".

2. Practitioners of CHP as "health care providers" under the Code

[90] See ss 150A and 155 of the Crimes Act 1961. Sections 150A and 155 are not themselves offences, but would come into play if the prosecution was based on s 190 (injuring by unlawful act).

The next stage of the jurisdiction enquiry is to ascertain whether a CHP practitioner is a 'health care provider'. Clause 4 of the Code states that 'provider' means a 'health care provider' or 'disability services provider'.[91] Neither 'health care provider' nor "disability services provider" is defined in the Code. Many of the key terms in the Code are defined in the Health and Disability Commissioner Act 1994 ('HDC Act'). These definitions apply when the same terms are used in the Code by virtue of s 34 of the Interpretation Act 1999, which provides that:

> 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.

Section 3 of the HDC Act defines 'health care provider' expansively.[92] It includes, inter alia, health practitioners, ambulance officers[93] and, at paragraph (k):[94]

> Any other 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.

According to this definition, a practitioner of CHP will be a 'health service provider' if she or he:

1. Provides *health services*; and
2. Is a natural or legal person who provides, or who holds himself or herself or itself out as providing health services *to the public or any section of the public.*

(a) "Health services"

[91] Code of Rights, cl 4.
[92] HDC Act, s 3.
[93] 'Health practitioner' means a person who is, or is deemed to be, registered with an authority as a practitioner of a particular health profession recognised by the Act; see s 5 Health Practitioners Competence Assurance Act 2003. See ss 169-179 for a list of registered 'health professions' recognised by the Health Practitioners Competence Assurance Act 2003.
[94] HDC Act, s 3(k).

The Act defines 'health services' as services to promote or protect health, or to prevent disease or ill-health; treatment, nursing, rehabilitative or diagnostic services; and psychotherapy, counselling, contraception, fertility and sterilisation services.[95]At a glance, it is clear that one form of CHP – counselling – will qualify as a 'health service'. Although not mentioned specifically, all other forms of CHP would be captured by the definition because their core purpose is the promotion and protection of 'health'. The Act defines 'health' simply as 'human health'.[96] The generality of this definition suggests Parliament intended 'health' to be interpreted broadly, including physical, emotional, mental and spiritual health.[97] CHP targets all of these.

One possible objection to the argument that CHP practitioners offer 'health services' is that CHP practitioners may not see themselves as providers of 'health services'. After all, Reverend Theophilus and Pastor David provided 'merely' *spiritual* ministrations in their capacity as *spiritual* advisors. The Human Rights Review Tribunal ('HRRT') rejected a similar objection in *Director of Health and Disability Proceedings v K B M.*[98] The HRRT held that a social worker who provided social work services to members of a family fell within paragraph (k) of the definition of 'health care provider'. The HRRT disregarded the label used to describe the person's job and the person's subjective perception of the nature of the services they were providing. It focussed instead on what the person did as part of the job.[99]

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[95] HDC Act, s 2(a)(i)-(vii).
[96] HDC Act, s 2.
[97] A wide interpretation of 'health' is supported by the World Health Organisation ('WHO') definition of 'health', which provides that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." See the Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948; http://www.who.int/suggestions/faq/en/index.html (last accessed 11/7/2009).
[98] [2005] NZHRRT 27 (29/8/05).
[99] The HRRT noted that: "[u]ltimately the question of what the defendant did, or was held out as doing, is one of fact. If the evidence shows in due course that the defendant was providing or purporting to provide health or disability services…then we cannot see that the description 'social worker' (rather than 'health care provider' or 'disability services provider') makes any difference." (para [22]).

Following the reasoning in *K B M,* it seems clear that Pastor David provided Sheeba with a health service when he counselled her. It will not matter that Pastor David viewed himself as a 'pastor' rather than a 'counsellor'. Nor will it matter that the church newsletter described his area of expertise as 'spiritual guidance and direction' rather than 'counselling'. Pastor David's claim that it is not him but *God* who provides the 'health services' is also immaterial, because Pastor David in fact performed an action (counselling) intended to improve Sheeba's health.[100]

It could be argued, however, that 'counselling' should be given a narrow meaning, referring only to individuals who are trained as counsellors or have received some formal instruction in counselling practices. 'Counselling' and 'psychotherapy' constitute a sub-paragraph in the definition of 'health service' in s 2 of the HDC Act. 'Psychotherapy' refers to psychological (as opposed to physical) methods for the treatment of mental disorders and psychological problems.[101] It can be inferred that some level of training is required before a person becomes a psychotherapist. Thus, 'counselling' is coloured by the meaning of 'psychotherapy', and should refer only to counselling services provided by adequately trained persons who are skilled in the art of psychological treatment. Even on this narrow interpretation of 'counselling', some CHP providers may still satisfy definition having received pastoral care and counselling instruction during their vocational training, and will therefore possess the requisite level of skill and knowledge. However, a narrow interpretation may defeat the consumer-protection focus of the Code.[102] Excluding individuals from the obligations the Code imposes on 'providers', even where an individual holds herself out as providing a 'counselling' service, simply because she her level of counselling expertise is not as advanced as a trained psychotherapist may leave the people she advises without adequate consumer protection. Therefore, it is unlikely that the Commissioner would adopt a narrow view of 'counselling' so as to exclude pastoral counselling performed by clergy.

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[100] In that sense, he is no different from the crystal healer or reiki therapist who claims that healing power is not located in her or the actions she performs, but comes from a transcendent force or energy.

[101] 'Psychotherapy', *The Oxford Concise Medical Dictionary 7th ed.* (Oxford, Oxford University Press: 2007).

[102] As expressed in the Long Title of the HDC Act.

A third potential objection to the claim that CHP practitioners are providing 'health services' is that there is scant evidence to support claims that CHP do, in fact, 'promote health'. Leaving to one side the recent studies investigating the health benefits associated with religious healing practices,[103] the context of the definition does not support this interpretation. The phrase 'services *to* promote health' implies that health services do not need to produce a quantifiable improvement in health. Rather, the inclusion of the word 'to' (as in, 'services *to* promote health') suggests that it is sufficient if the *purpose* of the service is to promote health.[104] The Commissioners have implicitly rejected the notion of an efficacy threshold, opining repeatedly that services lacking endorsement from randomised medical trials *do* come within the Commissioner's jurisdiction.[105] Further, treating services of uncertain efficacy as 'health services' promotes the consumer-protection focus of the Code: consumers should have access to an effective complaints mechanism regardless of the efficacy of the services in question.

An opinion from Commissioner Stent offers further support for the proposition that CHP practitioners do offer "health services". The complaint concerned a GP who suggested prayer as a form of treatment to the consumer. The GP then proceeded to pray for the consumer despite the consumer's protestations.[106] The Commissioner was of the opinion that the doctor had breached Right 7(1) of the Code, which provides that "*services* may be provided to a

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[103] Many studies have investigated the efficacy of CHP, and particularly distant intercessory prayer for healing ('DIP'). The results of these studies are mixed; some suggest that DIP can have positive health outcomes, even if only through non-specific effects (see, for example, Randolph C. Byrd, "Positive Therapeutic Effects of Intercessory Prayer in a Coronary Care Unit Population", *Southern Medical Journal* 81(1988) 826-829) and others suggest DIP has no discernable effect on health (see, for example, Kevin Masters & Glen Spielman, "Prayer and Health: Review, Meta-Analysis, and Research Agenda" 30 (2007): 329–338). Some studies suggest that DIP can have adverse health outcomes, especially where the person receiving prayer is informed that they are being prayed for (see, for example, Herbert Benson, et al "Study of the Therapeutic Effects of Intercessory Prayer (STEP) in cardiac bypass patients: A multicenter randomized trial of uncertainty and certainty of receiving intercessory prayer" *American Heart Journal* 151 (April 2006): 934-942).

[104] Reuven Young, *Alternative Medicine and the Code of Health and Disability Consumers' Rights: The Right to Services of an Appropriate Standard and the Affect of 'Informed Consent,* LLB Dissertation, University of Otago, 2001, 27. ('*Alternative Medicine and the Code')*

[105] See, for example, *Opinion 02HDC18117* (Health and Disability Commissioner, 4/2/2004) which found that a shiatsu massage therapist was a 'health care provider' within the meaning given to it in the HDC Act and *Opinion 08HDC00218* (Alternative Therapist) (Health and Disability Commissioner, 16/12/2008), where a colour therapist was held to be a 'health care provider', even though there was no evidence colour therapy had any positive health benefits to the consumer in question or any consumer generally.

[106] See *Opinion 97HDC7400* (Health and Disability Commissioner, 3/4/1998) (general practitioner).

consumer only if that consumer makes an informed choice and gives informed consent…"[107] This finding suggests the Commissioner viewed prayer as a "health *service*" within the purview of the Code.

To summarise: pastoral counselling is certain to fall within the expansive definition of "health services", and other forms of CHP are likely to be included as well.

(b) "To the public or any section of the public"

The meaning and scope of the terms 'public' and especially 'section of the public' are not self-evident. In some cases it will be non-contentious that a CHP practitioner is providing services to the public. Where information about the CHP is disseminated in a public forum like the internet, print media or the radio, the person or organisation offering the CHP is clearly holding themselves out as providing a 'health service' to 'the public'. CHP advertising on the internet, for example, is available for anyone to view. Christian healing retreat centres,[108] healing rooms,[109] providers of intercessory prayer for healing,[110] healing meetings,[111] and an association of Christian community nurses[112] are but a few of the CHP services offered online.

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[107] The Code defines 'services' as: 'health services, or disability services, or both; and includes health care procedures' (see clause 4).
[108] See, for example, http://www.titoki.org.nz/ and http://www.tewaiora.com/ (last accessed 17 September 2009).
[109] 'Healing rooms' are set up like a doctor's clinic where people receive prayer and are anointed with oil by a group of Christians. See http://www.healingrooms.co.nz/index.html (last accessed 17 September 2009).
[110] See the Order of Saint Luke (http://www.oslnz.org/index.htm), Christian Healing Ministries http://www.christianhealingmin.org/index.php (based in the United States but receives requests for intercessory prayer from around the globe), and Christian Prayer Ministries http://www.christianprayermin.org.nz/ (the New Zealand-based branch of christianhealingmin.org) (all accessed 17 September 2009).
[111] See, for example, http://www.doveministries.com/usa/frame.htm?URL=http://www.doveministries.com/usa/free.htm for details of upcoming healing meetings held by healer and evangelist Bill Subritzky (last accessed 17 September 2009)
[112] See http://www.faithnursing.co.nz/index.html (last accessed 17 September 2009).

In many situations, however, it will be less obvious whether a CHP practitioner is holding themselves out to the public or a section of it. Consider the Abundant Life Church newsletter in Sheeba's story. Should notification of Pastor David's availability to provide CHP in a publication intended for church members constitute a 'holding out' about health services to a 'section of the public'? Or should it fall outside the Code's ambit?

To give meaning to the phrase 'section of the public' in the context of CHP, it is helpful to consider when a 'health care provider' may be providing services to a 'section of the public'. Take, for example, a nurse employed in a local general practice.[113] She provides nursing services to those who attend that practice. In that sense, she provides nursing services to the 'section of the public' that visit her clinic. Similarly, if that same nurse worked part-time as a parish nurse, the people within her parish who wished to avail themselves of her assistance would also constitute a 'section of the public'. These two situations can be distinguished from times where the nurse cares for her three-year-old child at home or her eighty-three-year-old mother who lives with her. In the latter two situations, the nurse does not appear to be providing services to a 'section of the public'. Rather, she is offering assistance in a private context.

A similar distinction may be drawn regarding the provision of CHP (granted that CHP are 'health services' within the meaning of the HDC Act). For example, church members who seek prayer from the 'healing prayer team' that assembles after a church service every Sunday are, arguably, a 'section of the public'. Likewise, people who respond to church newsletter advertisement informing them that their pastor is available to pray for healing with them in their homes during the week will also constitute a 'section of the public'. These two situations may be contrasted with a parent laying hands on an ill child at home, or a group of friends meeting informally during a lunch break for healing prayer. In the latter two situations, the CHP are not held out to a 'section of the public'. Instead, they are provided privately.

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[113] Section 3(h) of the HDC Act provides that 'health practitioners' are 'health care providers'. Registered nurses are 'health practitioners' within the meaning of s 5(1) of the Health Practitioners Competence Assurance Act 2003 (see also s 184 of the Health Practitioners Competence Assurance Act 2003).

Comparing the provision of 'health services' by nurses and CHP practitioners suggests that CHP are provided to a 'section of the public' where they are available to a range of people, even though provision of the service may not be widely publicised. This conclusion is fortified by case law from New Zealand and overseas jurisdictions.

In *K B M*, the HRRT did not specifically address whether rendering services to a family in the family home constitutes services provided 'to the public or any section of the public'.[114] However, embedded in its conclusion (that a social worker providing services to a family in their own home could be a 'health care provider') is an acceptance that a family in its own home constitutes a 'section of the public' for the purposes of the HDC Act.[115] This situation is comparable to the parish nurse providing in-home nursing services to parishioners. Though the services are provided in residential dwellings, they not provided in 'private' because they are made available to a wide range of people: that is, the whole parish. Thus, Pastor David's notice in the church newsletter is likely to constitute the 'holding out' of services to a 'section of the public' (the Abundant Life church fellowship).

In England, Canada and New Zealand, the phrase occurs in human rights legislation proscribing prohibited forms of discrimination in the provision of goods and services offered 'to the public or a section of the public'.[116] Cases that interpret the meaning of that phrase agree that the words comprising it are 'words of limitation'. [117] In other words, the state has confined itself to regulating discriminatory conduct within the *public* sphere only;

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[114] *K B M*, above, n.98. The HRRT confined its discussion of 'health care provider' to the 'health services' limb of the s 3 definition. It noted at [22]: "If the evidence shows in due course that the defendant was providing or purporting to provide health or disability services (having regard to the definitions of those things in the Health and Disability Commissioner Act) then we cannot see that the description 'social worker' (rather than 'health care provider' or 'disability services provider') makes any difference."

[115] The phrase "to the public or any section of the public" also appears in legislation regulating *commercial dealings* (see s 3 of the Securities Act 1978 and s 2 of the Fair Trading Act 1987). Thus, judicial consideration of that phrase in those enactments offers little interpretive assistance in the context of health law.

[116] See, for example, the Human Rights Act 1993, s 44 (N.Z.), Race Relations Act 1968, s 2(1) (Eng.) and Human Rights Act, R.S.Y. 1986 (Supp.), c. 11 (Can.).

[117] *Dockers' Labour Club and Institute v Race Relations Board* [1976] A.C. 285, 291 (HL) per Lord Reid. ('*Dockers''*)

discrimination the private sphere is beyond its reach.[118] Thus, in interpreting the phrase 'to the public or [any] section of the public', the courts (or, in this case, the Commissioner) are tasked with drawing a line between the public and the private sphere. In light of the array of situations in which 'traditional' health services are provided to the 'public' or a section of it, it seems likely that CHP offered to church congregations will count as services offered to a 'section of the public'.

Summary

Many CHP practitioners are likely to fall within the ambit of the Code given the expansive definitions of 'health services' and the phrase 'to the public or any section of the public.' The wide capture of the Code aligns with the current Commissioner's conviction that:[119]

> …every tohunga, every iridologist, every primal therapist and every *faith healer* who holds herself out as providing services to promote health is subject to providers' duties under the Code.

Parliament has opened the proverbial gate of Code liability wide, allowing passage to many services not commonly regarded as 'health services' in situations not always considered 'public'. Even if Code jurisdiction is established, Parliament has provided a second 'gate' that can be shut where the Commissioner considers that it would be unwise to proceed with Code-related dispute resolution processes. The second 'gate' is the discretion afforded to the Commissioner under s 38 of the HDC Act to discontinue acting on a complaint.[120] The following two chapters will argue that religious freedom and practicality issues associated with applying the Code to CHP should encourage the Commissioner to exercise that discretion when faced with a complaint regarding CHP.

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[118] Commenting on the need for discrimination within the private sphere and the absurdity of inviting state regulation of it, Lord Diplock commented "No one has room to invite everyone to dinner. The law cannot dictate one's choice of friends." (*Dockers'* at 296 per Lord Diplock).

[119] Ron Paterson, 'Medicine for Today – Professional Responsibility and Complementary Medicine', Presentation at the University of Otago, Dunedin, 1 June 2000. http://www.hdc.org.nz/publications/presentations?Medicine%20for%20today%20-%20Professional%20Responsibility%20and%20Complementary%20Medicine

[120] From June 2008 to June 2009, the Health and Disability Commissioner received 132 complaints beyond its jurisdiction. See Health and Disability Commissioner, *Annual Report for the Year Ended 30 June 2009* (Auckland, New Zealand: Health and Disability Commissioner) 3.

Chapter Three: How Might the Code Apply to CHP Providers?

Chapter two established that CHP providers are likely to come within the ambit of the Code. Chapter three considers the potential effect of Code rights and duties on CHP providers. It will show that some rights may be applied with minimal difficulty, while other rights – most notably the right to receive services of an appropriate standard – may require the Commissioner to address complex issues of religious freedom raised by s 15 of the New Zealand Bill of Rights Act 1990 ('BORA'). Whether the application of a right (and corresponding duty) constitutes an unjustified limitation on the right to manifest religion will be discussed in detail in chapter four.

A. Right One: Treated with Respect

Right 1(1) and (2) provide that a consumer has the right to be treated with respect, and to have the consumer's privacy respected. Right 1(3) provides that: [121]

> Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.

Right 1(3) is framed broadly; rights 2 to 6 may be viewed as specific formulations of the general principle to be treated with respect. Right 1 has been applied sparingly, suggesting that the Commissioner prefers to apply specific formulations of the principle. Take, for example, a consumer who complained to the Commissioner that they were barred from bringing a family member with them for a pastoral counselling session, a common practice in the complainant's culture. In that situation, the Commissioner might frame the complaint as a violation of the right to receive services of an appropriate standard[122] rather than characterise the issue as one of ethnic or cultural respect. However, the practical difficulties associated

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[121] See *Opinion 98HDC15904* (Health and Disability Commissioner, 31/5/2001) (general practitioner). The Commissioner found that the GP failed to treat the consumer with respect. He interrupted the consumer, rushed through the consultation, admonished her for losing attention on the procedures being performed and commanded the consumer to 'thank the Lord' following a prayer for healing.

[122] Code of Rights, right 4.

with applying right 4, and particularly right 4(1), may encourage the Commissioner to channel complaints regarding CHP through right 1(3).

B. Right Two: Freedom from Discrimination, Coercion, Harassment, and Exploitation

Right 2 provides that:

> Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial, or other exploitation.

'Exploitation' is defined as any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence.[123] Right 2 is typically engaged in instances of financial and sexual exploitation. It may arise in pastoral counseling contexts where the counsellor abuses the trust vested in him or her by the consumer (arguably the case in Sheeba's situation).[124] Financial exploitation may occur where a CHP provider intimates that God will only heal the consumer if they make a donation to the provider.

C. Right Four: Services of an Appropriate Standard

Right 4 deals with the standard of care that must be exercised when providing health and disability services.[125] The absence of professional regulation or voluntary self-regulation [126] of CHP providers enhances the importance of right 4 as a 'quality control' mechanism. However, while consumer protection is an important focus of the Code, it ought to be held in tension with another of the Code's objectives – consumer protection fostering and promoting consumer choice in health services.[127] It is important that the standard of services is fixed at an appropriate level to ensure providers *can* meet the standard of care. Setting the standard of

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[123] Code of Rights, cl 4.
[124] See Chapter Two.
[125] Right 4 is concerned with the *quality* of services. It does not create a right of *access* to services. See P.D.G. Skegg and Ron Paterson, "The Code of Patients' Rights," in Skegg and Paterson, *MLNZ*, 37.
[126] For examples of voluntary self-regulation in the area of 'spiritual healing', see n.61 above.
[127] Young, '*Alternative Medicine and the Code'*, above n.52 34-35.

services impossibly high may impose onerous burdens on CHP providers, and may cause some providers to cease providing CHP, restricting consumer choice in the health services arena.[128] Thus, in deciding how to apply right 4 to CHP, the Commissioner must strike a balance between consumer protection and consumer choice.

1. Right 4 (1) Every consumer has the right to have services provided with reasonable care and skill

Right 4(1) restates the common law requirement that providers of health services exercise reasonable care and skill in the practice of their healing modality.[129] The standard of care and skill required is that of the reasonably careful practitioner of the profession in question and is formulated with reference to accepted practice. Therefore, physiotherapists are entitled to be measured against physiotherapists, crystal healers against crystal healers, and so on.[130] (In the words of Commissioner Paterson, "Quantum booster operators are not held to the standard of paediatric oncologists." [131]) It follows that the Commissioner should measure the care and skill of CHP providers against other CHP providers when applying right 4(1).[132]

The Commissioner may find that a CHP provider has failed to meet the requisite standard of care in two ways. First, expert evidence may prove that the CHP provider failed to exercise reasonable care and skill while providing CHP. Take Earnest's story as an example. Imagine two CHP providers give evidence that providers should *always* encourage 'healed' CHP users

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[128] Ibid., 13.
[129] See *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 ('*Bolam*').
[130] It is standard practice for the Commissioner to consult experts when investigating potential breaches of right 4(1) to ascertain what the reasonably careful and skilled provider would have done in the circumstances. See Ron Paterson, "Assessment and Investigation of Complaints" in Skegg and Paterson, *MLNZ*, 605. The right to manifest religion is affirmed in s 15 of the BORA.
[131] Ron Paterson, "Children and Quackery", *New Zealand GP* June 2001. Available at http://www.hdc.org.nz/publications/articles?Children%20and%20quackery (last accessed 24 September 2009).
[132] There are two justifications for the principle that health services providers ought to be measured against providers of the same health services when assessing reasonable care and skill. One is that the patient is presumed to have consented to treatment provided with the standard of care and skill exercised by a particular practitioner. If she or he desired services of a different standard, they could have selected a different health service provider. The other justification is that it seems unfair to permit a provider of one service to assess the care and skill of a provider of a different service. See Joanna Manning, "The Required Standard of Care for Treatment", in Skegg and Paterson, *MLNZ*, 88, fn. 183.

to seek clinical verification of their healing before discontinuing their medication.[133] Their evidence could well ground a finding that Reverend Theophilus failed to satisfy right 4(1).

Now imagine that the CHP providers testified that authentication of healings encourages consumers to put their faith in someone or something other than God's healing power (namely, a medical practitioner). Therefore, they say, it is *never* appropriate for CHP providers to advise people who have been 'healed' to seek verification of their healings. In this situation, the Commissioner may find not only that Reverend Theophilus' conduct is contrary to right 4(1), but that the standard of care itself is 'unreasonable'.[134] Therefore, Reverend Theophilus failed to take reasonable care when providing a health service to Earnest even though he was acting in accordance with accepted practice.

The difficulty for the Commissioner is that he appears to be assessing the reasonableness of *religious* conduct. If the Commissioner finds that one way of performing a religious practice is 'unreasonable', he may be limiting CHP providers' statutorily-affirmed rights to freedom to manifest religion.[135]

The Court of Appeal addressed this concern in *R v Lee*.[136] Mr Lee, pastor of Lord of All's [sic] Church in Auckland, was indicted on two alternative counts for the murder of church

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[133] This seems to be the approach followed by most CHP providers. See, for example, Doctrinal Commission of International Catholic Charismatic Renewal Services, "Guidelines on Prayers for Healing", (Vatican City, Italy; ICCRS, 2007), 45: "When perceptible healings do occur, it is appropriate to exercise prudent caution in verifying them…" See also Francis MacNutt, *Healing*, (Notre Dame, Indiana: Ave Maria Press, 1974), 263. "To say that God inspires some people to stop taking their medicine, and even to disregard their symptoms, is according to my experience, true. But to say that is the way he always works leads some people… to make a false choice: between faith (not taking the medicine, and not accepting the appearance of disease symptoms) and science (the doctor's judgment according to what he sees before him)."

[134] At common law, decision-makers are empowered to reject evidence of accepted practice they regard as "unreasonable". See *Bolitho v City and Hackney HA* [1997] 4 All ER 771; *Shakoor v Situ* [2001] 1 WLR 410, 416.

[135] For this reason, it could be argued that CHP providers would have little to gain from invoking clause 3 of the Code (the so-called 'provider compliance' clause) because – again – it would require an assessment of the 'reasonableness' of the provider's actions. Clause 3 provides:

(1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.
(2) The onus is on the provider to prove that it took reasonable actions.
(3) For the purposes of this clause, **the circumstances** means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints. [Emphasis original.]

[136] [2006] 3 NZLR 42 (*'Lee'*). The judgment of the Court was delivered by Glazebrook J.

member, Joanna Lee, during an exorcism.[137] The second count alleged that having undertaken to administer a religious procedure (exorcism), Lee caused Joanna's death by omitting without lawful excuse to have and to use reasonable care in performing the exorcism.[138] The Crown submitted there had been a major departure from the required standard of care because Mr Lee's methods of exorcism – which included sitting on Joanna, bouncing up and down on her, and 'exerting considerable pressure on her neck'[139] - deviated from the 'proper', hands-off method described by two expert witnesses.[140] The Court rejected this submission. In light of s 15 of the BORA, the Court noted that the test for what constituted a 'major departure' "must accommodate those who believe that demons have a more corporeal form than do [the expert witnesses]."[141]

The fact that the Court of Appeal declined to pronounce on what constituted a 'proper' mode of exorcism does not mean the Commissioner ought to refrain from assessing the 'reasonableness' of CHP altogether; no human right – including the right to manifest religion – is absolute.[142] The facts of *Lee* may be distinguished from the 'run of the mill' CHP cases that may require the Commissioner's consideration. Lee involved exorcism – an overtly religious practice that clearly engaged the right to manifest religion. In contrast, though the counselling provided by Pastor David may have involved some distinctively 'religious' elements (prayer at the conclusion of a counselling session, for example), other elements of his practice may be indistinguishable from other 'secular' or non-religious counselling practices.[143] Therefore, s 15 may not be implicated in all CHP contexts.

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[137] Lee was convicted on the first count; namely, that he caused Joanna's death by an unlawful act: namely, assault. (See s 160(2)(a) of the Crimes Act 1961.) Therefore, comments pertaining to the second count are obiter dicta.
[138] See s 160(2)(b) of the Crimes Act 1961.
[139] *Lee*, para [71].
[140] *Lee,* para [345]. Mr Subritzky and Mr Dowie gave evidence about the practice of exorcism within the denomination that Mr. Lee belonged to (Assemblies of God).
[141] *Lee*, para [345]. The Court also refused to limit the availability of the partial defence of consent to 'mainstream' exorcisms. Defining what constituted a 'mainstream' exorcism, it observed, would "pose difficult lines of demarcation" (para [325]).
[142] See BORA, s 5 which provides: "Subject to section 4 of this Bill of Rights, the rights and freedoms contained in this Bill of Rights may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."
[143] The scope of s 15 of the BORA and situations that may be engage the right to manifest religion will be discussed in more detail in Chapter Four.

Moreover, Lee's liberty depended, inter alia, on whether consent was available as a partial defence to all or only 'mainstream' exorcisms. If the Court had limited the availability of consent to 'mainstream' exorcisms – implicitly limiting Joanna's right to manifest religion by engaging in any kind of exorcism – Lee would have faced certain imprisonment (provided the Court found that Lee's exorcism was not 'mainstream'). In most complaints that come before the Commissioner, the consequences of limiting a person's right to manifest religion are unlikely to be as severe; that is, it is improbable that incarceration would result. Where the consequences associated with limiting a person's right to religious freedom are less 'serious', in the sense that a person will not be deprived of their liberty, and modification of CHP practice may benefit other consumers of the CHP, the Commissioner may be more willing to assess the reasonableness of a CHP.

To avoid engaging right 4(1) and its attendant challenges, the Commissioner may endeavour to recast complaints about CHP services as breaches of other rights contained in the Code. For example, Pastor David's sexual advances arguably breach of right 4(1) and right 2 (the right to be free from sexual exploitation). Breach of right 2, not right 4(1), would be likely to form the basis of the Commissioner's opinion. This is because there is no need for recourse to accepted practice and it does not raise any questions about the efficacy of the CHP.[144]

To summarise: where the Commissioner is forced to apply right 4(1) to CHP providers its application will not be a straight-forward matter, because it implicates the right to manifest religion. CHP providers will not be able to rely on s 15 of the BORA as a shield from Code liability.[145] For example, failure to investigate Sheeba's complaint simply because the counselling was provided in a 'Christian' context, even if there was ample evidence from the

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[144] Joanna Manning "The Required Standard of Care for Treatment", in Skegg and Paterson, *MLNZ*, above n.8 90-91.

[145] In addition to *Lee* (above n.136), there are three other New Zealand cases involving exorcism (*R v Gibson* (citation could not be located),('*Gibson'*), *R v Martin* 23/3/98, Morris J, HC Auckland T 191/97 ('*Martin'*) and *R v Rawiri* 14/8/09, Simon France J, HC Wellington CRI-2007-032-5294 ('*Rawiri'*)). Only one of the three cases*, R v Gibson*, involved exorcism in a 'Christian' context, as opposed to exorcisms involving syncretism or other blends of Maori and Christian spirituality (*Martin*) or no recognisable religious or cultural foundation at all (*Rawiri*. At para [93] Simon France J observed that "[the exorcism] was not the acting out of any cultural or religious practice.") None of the cases touched on the issue of religious freedom. The absence of discussion about religious freedom where the exorcism *was* religiously motivated (c.f. *Rawiri*) is perhaps explicable by virtue of the fact that the defendants were either found not guilty by virtue of insanity (*Gibson*), received a suspended sentence because the defendant appeared to be labouring under a mental illness bordering on insanity at the time of the exorcism (*Martin*). Given the 'impaired' condition of the defendants, genuine exercise of religious freedom was not at issue.

Christian community that Pastor David's conduct was unconscionable, [146] would itself be unreasonable and a failure to uphold the consumer-protection focus of the Code. The scope of the right to manifest religion and strategies for limiting that right will be discussed in chapter four.

2. Right 4(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards

There are three kinds of 'standards' that CHP could be measured against for the purposes of right 4(2).

The first are ethical standards regulating the provision of pastoral counselling in particular and ethical conduct in general. These standards are embedded in Codes of Ethics (or equivalent documents) promulgated by church denominations for application to their employees and volunteers.[147]

The second group of standards are those established by the Catholic Church for the performance of CHP. The Catechism of the Catholic Church outlines occasions when it may be appropriate to perform a CHP, who is authorised to perform the specific CHP and the ritual formulae associated with some CHP.[148]

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[146] Christian counselling literature is replete with strongly-worded prohibitions against sexual exploitation. See, for example, Sharyl B. Peterson, *The Indispensable Guide to Pastoral Care* (Cleveland; Ohio: The Pilgrim Press, 2008), 18: "As a minister, it is *never* ethical to engage in any form of sexual relationship with a person in your care." [Emphasis in original]; Joe E. Trull & James E. Carter, *Ministerial Ethics: Moral Formation for Church Leaders* (2nd ed.) (Baker Academic; Grand Rapids, Michigan, 2004), ch. 7; Gaylord Noyce, *Pastoral Ethics: Professional Responsibilities of the Clergy*, (Abingdon Press; Nashville, Tennessee, 1988), 98-106.

[147] Ethical codes may regulate forms of CHP other than pastoral counselling indirectly, by providing a baseline of acceptable ethical conduct applicable across all fields of activity.

[148] *Catechism of the Catholic Church*, (CEPAC ed., Dublin, Ireland: Libreria Editrice Vaticana, 1995) at §1511-1519, for example, which describes how the sacrament of the sick (akin to anointing with oil) is to be received and celebrated.

The third set of standards offer practical guidance to people providing prayer, laying on of hands, counselling and deliverance. They are produced by Dove Ministries, an organisation that promotes Christian evangelism and healing.

The Commissioner is unlikely to use any of these 'standards' to assess CHP provider conduct, primarily because these 'standards' are more akin to internal guidelines than standards that have previously been enforced by the Commissioner. Clearly the three kinds of guidelines described above are not 'legal' standards underpinned by statute. Nor are they 'professional' standards issued by a professional body of CHP providers. 'Ethical' standards usually refer to standards set down by registration authorities.[149] It is uncertain whether the national leadership bodies of 'mainstream' Christian denominations or by evangelistic groups are analogous to registration authorities to enable the standards they have promulgated to qualify as "ethical" standards.

However, the Commissioner is also empowered to consider 'other relevant standards' that are not professional, legal or ethical standards. The High Court in *Culverden Group Ltd v Health and Disability Commissioner*[150] affirmed the Commissioner's finding that *Standards of Care for Old People's Homes* promulgated by the Ministry of Health were 'other relevant standards' for the purposes of the Code.[151] In that case, the standards were applied by the Ministry when licensing rest homes under the Old Peoples' Homes Regulations.[152] None of the 'standards' pertaining to CHP provision are legally enforceable in the same way; that is, they are not integrated into a CHP licensing regime (there is no such regime at present). Moreover, the 'standards' developed by Dove Ministries do not make any claim to be uniformly enforceable to all providers of CHP. Rather, they appear to be guidelines or suggestions.

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[149] P. D. G. Skegg and Ron Paterson, "The Code of Patients' Rights", in Skegg and Paterson, MLNZ, above n.8, 38.

150 25/6/01, Glazebrook J, HC Auckland M1143-SD00 [85].

151 *Opinion 97HDC09172* (Health and Disability Commissioner, 11/7/2002).

152 Note that the placement of the apostrophes in the *Standards of Care for Old People's Homes* and the Old Peoples' Homes Regulations is consistent with their placement in the original documents.

Absent any legal, professional and ethical codes specifically regulating CHP providers, the Commissioner may be required to draw on 'other relevant standards' to help ascertain whether right 4(1) has been breached. However, the imprecise (in the case of Dove Ministries) or highly particularised (the standards of the Catholic Church) nature of the 'standards' may mean they are not amenable to being applied to CHP providers generally.

3. Right 4(3) Every consumer has the right to have services provided in a manner consistent with his or her needs

Right 4(3) promotes a consumer-focussed approach to the Code, requiring providers to consider specific needs (as distinct from 'wants') of individual consumers. Commissioner Stent had speculated that right 4(3) would require providers to consider "not only clinical but also consumers' personal, social and spiritual needs".[153] She acknowledged that this expansive interpretation would overlap with right 1(3).[154] In practice, Commissioner Paterson appears to have construed right 4(3) narrowly, reserving consideration of social and spiritual needs for right 1(3).[155]

4. Right 4(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer

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[153] Robyn Stent, *Proposed Draft Code of Rights for Consumers of Health and Disability Services : a Resource for Public Consultation on the Proposed Draft Code* (Wellington, New Zealand: Health and Disability Commissioner, 1995), 25 ('Stent, *Proposed Draft Code'*) For example, Commissioner Stent applied right 4(3) in the 'Rau Williams case'. Mr Williams died from renal failure on 10 October 1997 following the refusal of Northland Health to admit Mr Williams to the End Stage Renal Failure ('ESRF') programme and dialysis treatment. Commissioner Stent found that the provider's decision to refuse dialysis did not amount to a breach of right 4(3). However, she considered that breaches of ESRF guidelines (which mandated provision of spiritual and cultural services that "best meets individual needs and needs of their family/whanau") had been breached, thereby breaching right 4(2). See *Opinion 97HDC8872* (Health and Disability Commissioner, 18/6/1999).

[154] See Stent, *Proposed Draft Code,* above n.153, 35.

[155] P. D. G. Skegg and Ron Paterson, "The Code of Patients' Rights", in Skegg and Paterson, *MLNZ*, above n.8, 39.

Right 4(4) may be engaged where a health care provider has exposed a consumer to 'an unnecessary degree of risk' or has failed to exercise the degree of care required by the level of risk associated with the health service.[156] It difficult to envisage instances of CHP provision that might engage this right. CHP services like exorcism may cause physical harm to consumers. However, right 4(4) does not prohibit harm resulting from a health service; it only requires that the harm be minimised. The Dove Ministries guidelines mentioned above instruct individuals providing prayer, laying on of hands and exorcism to apply light touching only, and only where the provider considers it necessary. They also suggest that 'catchers' be positioned behind people receiving prayer in case they are 'slain in the spirit' and fall over.[157] These guidelines suggest that some CHP providers do attempt to minimise any harm associated with the CHP they provide.

5. Right 4(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services

Right 4(5) imposes a duty on providers to take positive steps to ensure the services they provide are coordinated with other providers.[158] It targets situations where 'quality of care continuation' is at issue.[159] (For example, at a shift hand-over meeting when new nurse, caregivers and doctors are beginning a shift, or when a patient is moved from a rest home to a hospital.)[160] An important aspect of care continuation is taking accurate and comprehensive patient records that can be transferred to subsequent providers.[161] It does not seem to require constant communication between every provider serving a consumer, including CHP providers.

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[156] Ibid.
[157] See Bill Subritzky, "Guidelines to Healing" (http://www.doveministries.com/usa/pamphlets/healing.htm, last accessed 18/7/2009) and Bill Subritzky, "Guidelines for Counsellors" (http://www.doveministries.com/usa/pamphlets/guidelines_counsellors.htm, last accessed 18/7/2009).
[158] Stent, *Proposed Draft Code*, above n. 135, 25.
[159] P.D.G. Skegg and Ron Paterson, "The Code of Patients' Rights" in Skegg and Paterson, *MLNZ*, above n.8, 39.
[160] See, for example, *Opinion 07HDC14286* (Health and Disability Commissioner, 27/2/2009). The Commissioner found that Southland District Health Board was in breach of right 4(5) for failing to share patient information with Otago District Health Board and other providers.
[161] Stent, Proposed Draft Code, above n. 135, 25.

In short, 'cooperation' requires providers to communicate with one another regarding transfer of patient care or change of provider to ensure that a provider is supplied with all relevant patient information.

Earnest's situation may have triggered right 4(5) because it involved a change in health care providers (from Earnest's doctor to Reverend Theophilus). However, viewing 'cooperation' as a positive duty described above is unlikely to have promoted Earnest's health. For example, it is unlikely that Earnest's doctor would have disclosed his client's details to Reverend Theophilus.[162] Furthermore, it is likely Reverend Theophilus would have remained impervious the recommendations of Earnest's doctor even if the two had been in direct communication. Reverend Theophilus's comment: "If you want to keep your healing, stop taking any medication you have been prescribed" demonstrates he had countenanced the possibility that Earnest had been prescribed medication for his condition, yet he counselled Earnest against the advice of Earnest's doctor. In sum, even if Earnest's situation did trigger right 4(3), the imposition of a duty on CHP providers to take positive steps towards communicating with other providers seems unlikely to assist CHP consumers.

A 'negative' duty of cooperation – that is, a duty on CHP providers to accede to medical opinion – may be a better way of securing continuity of care for consumers of both CHP and medical health services. For example, the UK '*Code of Conduct and Guidance to Practitioners* [of CAM]' orders that CAM practitioners "must not countermand instructions or prescriptions given by a doctor."[163] A negative duty would impose only a minimal burden on CHP providers (to acquiesce). It may also provide better protection of consumer health in instances where a CHP provider proffers advice contrary to that given by a consumer's doctor (or other health professional).

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[162] See HIPC, cl 3-5, especially health information privacy rule 11 and the Privacy Act 1993, information disclosure principles 9 and 10.

[163] British Complementary Medicine Association, "Code of Conduct and Guidance to Practitioners", (http://www.collegeofhealing.org/code_of_conduct.html, last visited 23 September 2009),para [1.12.] See especially para. [1.8], [1.11] and [1.13]. For general discussion of the inter-relationship between medical practitioners and CHP providers and faith healing generally, see David Aldridge, "Spirituality, Healing and Medicine" *British Journal of General Practice* 41[1991] 425-427.

D. Right 6: Right to be Fully Informed

Contrary to the heading, the "right to be fully informed" will not compel CHP providers to provide all information available to consumers. Rather, the information must be sufficient to enable to the consumer to make and give informed consent. "Right 6(1) provides that "[e]very consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive…" Information can include, inter alia, an explanation of the consumer's condition,[164] advice about the estimated time within which the services will be provided,[165] and – most importantly for CHP providers and consumers - an explanation of the options available (including an assessment of the expected risks, side effects, benefits, and costs of each option).[166] "Options available" has been interpreted to extend beyond different treatments and procedures provided by a provider, encompassing services the provider does not offer[167] or recommend.[168] Yet the duty to disclose options is unlikely to require CHP providers to canvas options other than CHP they or other CHP providers may offer. It would be absurd to construe the right as requiring CHP providers, or any provider to disclose other options they know nothing about.

Summary

The application of right 4 raises a number of issues, foremost among them being the extent to which the Commissioner should be assessing the standard of religious practices. However, because the Code (arguably) does apply to providers of CHP and because there are no other

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[164] Code of Rights, Right 6(1)(a).
[165] Code of Rights , Right 6(1)(c).
[166] Code of Rights , Right 6(1)(b).
[167] See, for example, *Opinion 02HDC18414* (Health and Disability Commissioner, 6/4/2004) where a neurosurgeon failed to disclose the option of major surgery for a brain tumour.
[168] See *Opinion 04HDC00031* (Health and Disability Commissioner, 24/2/05). An orthopedic surgeon's omission to disclose or discuss a surgical option with a patient because it was not feasible was not an excuse for failing to canvas options available.

regimes specifically regulating CHP conduct, the Commissioner is unlikely to be able to avoid these issues.

A. Does the BORA apply to the Commissioner?

Section 15 of the BORA affirms the right to manifest religion and belief. It provides:

> Every person has the right to manifest that person's religion or belief in worship, observance, practice, or teaching, either individually or in community with others, and either in public or in private.

Section 6 of the BORA provides that wherever an enactment (which includes delegated legislation like the Code[169]) can be given a meaning that is consistent with the rights and freedoms contained in the BORA, that meaning shall be preferred to any other meaning.[170] Therefore, section 6 requires the Commissioner to interpret rights and duties contained in the Code consistently with the right to manifest religion, wherever possible.

The BORA also impacts the exercise of the Commissioner's discretionary power not to investigate or to cease investigating a complaint, a power conferred on him by s 38 of the HDC Act.[171] Section 38 of the HDC Act allows the Commissioner to decide to take no further action on a complaint if "having regard to all the circumstances of the case, any action or further action is unnecessary or inappropriate." Arguably, it would be inappropriate to investigate or to continue investigating a complaint that would result in an unjustifiable limitation on the CHP provider's right to manifest religion. In this way, s 38 can function as an exemption-granting mechanism. The exercise this discretionary power of action and decision is not an 'interpretation' of an enactment,[172] meaning that s 6 does not apply. However, the discretion must be exercised consistently with the BORA if the exercise of discretion satisfies one of the two limbs of s 3 of the BORA, which provides:

> This Bill of Rights applies only to acts done—
>
> (a) By the legislative, executive, or judicial branches of the government of New Zealand; or

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[169] Interpretation Act 1999, s29 provides that 'enactment' means the whole or a portion of an Act *or regulations*. [Emphasis added.]

[170] BORA, s 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."

[171] Section 38(2) provides matters that the Commissioner *may* have regard to when considering whether to exercise his discretion, which may also affect his decision to exercise the discretion.

[172] P. Rishworth, 'When the Bill of Rights Applies' in P. Rishworth (ed.), *The New Zealand Bill of Rights* (Oxford, UK; New York, US: Oxford University Press, 2003) 158 ('Rishworth, *Bill of Rights*').

(b) 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 law.

The Commissioner performs a 'public function' (that is, the exercise of his power is of an essentially 'governmental' rather than private character[173]) in pursuance of the powers and duties conferred on him by the HDC Act, satisfying the s 3(b) test.[174] Therefore, the Commissioner's discretion must not be exercised to perpetrate an impairment of a right that is not capable of justification under s 5 of the BORA.[175]

B. If the BORA does apply to the Commissioner, how should s 15 of the BORA be interpreted?

Given the relevance of s 15 of the BORA to the interpretation of the Code and the exercise of the discretion to discontinue investigating complaints, it matters a great deal how s 15 is interpreted. There are two principal and competing interpretations of s 15.

The *special protection* interpretation views the right as 'protecting religious persons from any state burden on their ability to manifest their religion, regardless of whether the burden is imposed by a religiously neutral law of general application.'[176] In other words, the special protection approach allows the decision-maker (in our case, the Commissioner) to grant religious exemptions (exercise his statutory discretion) to protect religious individuals (CHP

[173] See *Ransfield v The Radio Network Ltd.* [2005] 1 NZLR 233: "In a broad sense, the issue [of whether an act is a 'public function' as per s 3 of the BORA] is how closely the particular function, power, or duty is connected to or identified with the exercise of the powers and responsibilities of the State. Is it 'governmental' in nature or is it essentially of a private character?" per Randerson J, para [69].
[174] The Commissioner may also satisfy the s 3(a) test. The Commissioner is a Crown entity (see s 8(2) HDC Act). Crown entities are subject to varying degrees of ministerial control. Because of the varying degrees of control the minister may exercise over the entity, it is not always clear whether a crown entity can properly be described as part of the executive branch of government. See Paul Rishworth, "When the Bill of Rights Applies" in Rishworth, *Bill of Rights*, above n.172, 82-83.
[175] P. Rishworth, "Interpreting Enactments: Sections 4, 5 and 6" in Rishworth, *Bill of Rights,* above n.172, 158.
[176] James Little, *Religious Exemptions and the New Zealand Bill of Rights,* LLB Dissertation, University of Auckland, 2008, iii ('Little, *Religious Exemptions'*).

providers) from a law that does not specifically discriminate against religious people (the Code).[177]

The second interpretation - the equality or '*anti-discrimination*' reading - interprets s 15 as protecting religious persons only from those laws that impose a 'discriminatory' burden on their ability to practice their religion, whether by design or neglect. Construed in this fashion, religiously neutral and generally applicable laws like the Code do not engage the right, and so exemptions from laws like the Code are never legally required.[178]

Thus, the interpretation selected by the Commissioner matters greatly for CHP providers, as it will determine whether they can be shielded from Code liability.[179]

I contend that the special protection interpretation of s 15 should be preferred primarily because it recognises the unique nature of religious obligations. As a consequence, it does not create 'injustices' by treating religious individuals differently from other groups in society. Rather, the special protection interpretation promotes justice by recognising the special nature

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[177] It does not follow from this interpretation that the right will be upheld and an exemption will be granted in every case; see s 5 BORA. Exemptions will only follow where the burden on the religious person (in this case, a CHP provider) outweighs the state's interest in imposing that burden. This approach construes the right widely so that the balancing inquiry, triggering the need for the balancing enquiry in a potentially wide array of circumstances.

[178] In the United States (US), the equality or anti-discrimination approach has been adopted in relation to the Free Exercise Clause of the First Amendment of the US Constitution: see, for example, *Employment Division v Smith*, 494 US 872 (1990); *Church of the Lukumi Babalu Aye, Inc. v City of Hialeah*, 508 US 520 (1993). In Strasbourg jurisprudence, there is conflicting authority: see, for example, *C v United Kingdom*, App. No. 10358/83 (1983) 37 D&R 142, 147 ("Article 9 [of the European Convention for the Protection of Human Rights and Fundamental Freedoms] does not confer on [an] applicant the right to refuse, on the basis of his convictions, to abide by legislation…which applies neutrally and generally in the public sphere"); but compare *Chappell v United Kingdom* No. 12587/86, Dec. 14.7.87, D.R. 53, 241 (the Court found that a generally applicable decision to close Stonehenge during midsummer solstice interfered with the freedom of Druids to manifest religion). In the United Kingdom (UK), the question has not been directly addressed, though one recent decision suggests the special protection approach has been adopted: see *R v Secretary of State for Education and Employment, ex parte Williamson* [2005] UKHL 15 ('*Williamson*') (involving a neutral and generally applicable law prohibiting corporal punishment that was nonetheless assessed under the "justification" provision, implying that a neutral and generally applicable *could* in theory be inconsistent with the relevant manifestation of religion provision).

[179] Of course, the effect of s 15 of the BORA is not the only factor the Commissioner ought to consider when deciding whether to exercise his discretion under s 38 of the HDC Act. (See s 38(2) for the list of factors the Commissioner may consider when deciding whether to exercise the discretion.) However, the Commissioner ought to give specific consideration to the interpretation of s 15 because it is a significant human rights issue with significant implications for CHP providers, and because it may add weight to his reasons for choosing to exercise the discretion (which must be disclosed to the complainant and the health care provider that was the subject of complaint; see HDC Act, s 38(4)).

of the harm that conflict between religious and state laws imposes on religious individuals. Finally, I suggest that the problems associated with the balancing approach (a rights-limiting strategy that accompanies the special protection interpretation) are also inherent in the anti-discrimination interpretation, and will be inevitable in any right-limiting strategy.

C. The case for the 'special protection' interpretation

1. Religion is normatively and morally unique from other forms of thought and belief

The Commissioner should be guided by the 'special protection' interpretation of s 15 when considering whether to exercise his discretion to discontinue complaints because religious belief and practice is normatively and morally different from other forms of thought. However, not all the reasons advanced supporting normatively 'unique' nature of religion have been advanced, not all of them compelling.

One reason is that the state should treasure religious diversity rather than employing regulation so as to homogenise all forms of religious conduct.[180] In other words, religion and religious differences should be treasured because diversity is desirable as an end in itself. The inadequacy of this approach is plain. We do not 'treasure' every form of religious diversity.[181] When a child contracts a life-threatening illness, we do not celebrate the fact that some parents refuse to seek medical attention[182] or treatment[183] for their patently ill child, choosing instead to rely on prayer and non-medical interventions. Diversity for diversity's sake is not compelling reason for the claim that religion is worthy of special protection.

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[180] See, for example, *Kokkinakis v Greece* (1994) 17 EHHR 397, 418 (ECtHR): "Freedom of thought, conscience, religion and belief guarantee the 'pluralism indissociable from a democratic society.'"

[181] Jeremy Waldron "One Law for All? The Logic of Cultural Accommodation" (2002) 59 Washington & Lee Law Review, 12 ('Waldron, *One Law*').

[182] See *Moorhead*, above n.50.

[183] See *Laufau*, above n.50.

A second reason for adopting an expansive interpretation of s 15 would be that it promotes 'equality of treatment'. At first, this argument seems counter-intuitive. Equality of treatment entails that people should be treated 'equally'.[184] This principle is reflected in the concept of the rule of law.[185] As Jeremy Waldron notes, "[o]ur belief in the rule of law commits us to the principle that the law should be the same for everyone: one law for all and no exceptions."[186] Religious exemptions treat people differently, appearing to thumb their nose at the rule of law and equality of treatment. While equality of treatment is desirable, we shrink from the notion that Parliament (and, to some extent, the courts) can trample on religious freedom by treating everyone the same, refusing to acknowledge the special burden that a law may impose on religious people.[187]

Martha Nussbaum attempts to diffuse this tension between equality and fairness – between treating everyone the same and accommodating differences. Nussbaum claims that equality of treatment requires that people be treated equally in a *substantive* rather than a formal sense.[188] In other words, because of the unequal burden laws can impose on religious persons, we do not contravene the equality of treatment principle when we grant special exemptions because we are not dealing with like cases: rather, we are simply treating different cases differently.[189] She also asserts that 'religion'[190] should be treated with "special protection and

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[184] Ronald Dworkin, *Law's Empire* (Cambridge, Mass.: Harvard University Press, 1986) 296-301; Will Kymlicka, *Contemporary Political Philosophy* (2nd ed., Oxford, England: Oxford University Press, 2002) 3-5. The concept is also expressed as the principle that like cases should be treated alike.

[185] A.V. Dicey, *Introduction to the Study of the Law of the Constitution* (8th ed., London, Macmillan: 1927) 114 ([W]e mean…when we speak of the 'rule of law'…not only that with us no man is above the law, but…that here every man, whatever be his rank or condition, is subject to the ordinary law of the realm.").

[186] Waldron, *One Law*, above n.181, 3. See also A.V. Dicey, *Introduction to the Study of the Law of the Constitution* (8th ed., Macmillan, London, 1927) 114 ([W]e mean…when we speak of the 'rule of law'…not only that with us no man is above the law, but…that here every man, whatever be his rank or condition, is subject to the ordinary law of the realm.").

[187] A 'zero-tolerance' approach towards legal exemptions can lead to absurd consequences. Waldron (above n.181, 37) playfully cites the instance of an eight-year-old-boy who was suspended from school for three days after he pointed a breaded chicken finger at a teacher and said "Pow, pow, pow". The school was in a district in Arkansas where four students and a teacher were killed and ten students were injured when they were shot by two students in 1998. The school district had a 'zero-tolerance' policy against any kind of weapons. (See 'Boy Suspended for Pointing Breaded Chicken Finger Like Gun', *Atlanta Constitution,* February 5 2001, 6D.)

[188] Nussbaum claims that a correct view of religious liberty may "involve not formally similar treatment but, rather, the removal or prevention of hierarchies. Sometimes, making minorities fully equal requires treating them differently, giving them dispensations from laws and customs set up by the majority." See Martha C. Nussbaum, *Liberty of Conscience: In Defense of America's Tradition of Religious Equality,* (New York, Basic Books, 2008), 20 ('Nussbaum, *Religious Equality'*).

[189] Little, *Religious Exemptions*, above n.176, 6.

delicacy" because we "ought to respect the space required by any activity that has the general shape of searching for the ultimate meaning of life."[191]

Nussbaum fails to provide a satisfactory justification for adopting the special protection approach for two reasons.

First, she fails to distinguish what makes religion distinctive from other belief systems and non-religious worldviews. Chris Eisgruber and Lawrence Sager, key proponents of the anti-discrimination interpretation, note that "religion does not exhaust the commitments and passions that move human beings in deep and valuable ways".[192] Moreover, to: [193]

> single out one of the ways that persons come to understand what is important in life, and grant those who choose that way a license to disregard legal norms that the rest of us are obliged to obey, is to defeat rather than fulfil our commitment to toleration.

In short, religious people feel strongly, non-religious people feel strongly – why should one be granted an exemption and not the other?[194]

Secondly, Nussbaum fails to acknowledge that *all* law imposes unequal, discriminatory burdens.[195] For example, a law forbidding drunk driving will affect an alcoholic with a vehicle license more than a 'tee-totaller' who does not own a car. It is precisely *because* the legislature disapproves of certain kinds of conduct that it legislates against them. Just because that law may impose a heavier burden on the alcoholic does not mean that he or she should be

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[190] Nussbaum defines 'religion' as including theistic, non-theistic, idiosyncratic and highly-individualised religions. See Nussbaum, *Religious Equality,* above n.188, 170.
[191] Nussbaum, above n.188, 169-170.
[192] Christopher L. Eisgruber and Lawrence G. Sager, "The Vulnerability of Conscience: The Constitutional Basis for Protecting Religious Conduct" 61 (1994) *University of Chicago Law Review* 1245, 1262-1263 ('Eisgruber and Sager, Vulnerability of Conscience').
[193] Eisgruber and Sager, above n.192, 1315.
[194] Waldron, One Law, above n.181, 23.
[195] Abner Greene, "Three Theories of Religious Equality…and of Exemptions", 87 [2008-2009] *Texas Law Review*, 963-1007, 993 ('Greene, Three Theories').

granted an exemption. Something more is needed to show why laws that discriminate against religion – albeit inadvertently, as with the Code – are worthy of special protection.

Jeremy Waldron suggests that the 'something more' is the special hardship faced by religious people when torn between state and religious laws. Advocates of the anti-discrimination interpretation reject the hypothesis that religious people suffer a unique kind of pain – "a sort of external, extra-temporal compulsion quite unlike other forms of compulsion"[196] – when compelled to choose between their religious and legal obligations.[197] Waldron concedes that the threat of eternal condemnation is not common to all religions and that even where it is present, it might not be the primary motivator of a religious conduct.[198] In essence, he concurs with critics who state that the case for exemption should not be based on the vehemence of one's opposition to a law.[199]

Waldron proffers an alternative account of the special hardship faced by believers. He suggests it is the believer's grounding in a community that is a source of norms for its members – norms that are enforceable and viewed as establishing an objectively correct way to live – that makes the choice between obeying state and religious law so painful. [200] In Waldron's own words:[201]

> [I]t is not just a matter of how strongly [a religious person] feels, nor is it a matter of his own strong or conscientious belief that he – or we all – ought to be under a different obligation. His being pulled in the direction of the…religious practice (contrary to state law) has *social* reality; it is not just a matter of subjective conviction. Because of the positive existence of a scheme of regulation rivalling the state, the person we are considering is already under a

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[196] Rex Ahdar and Ian Leigh, *Religious Freedom and the Liberal State* (Oxford, England: Oxford University Press, 2005) 34. See also Jesse H. Choper, *Securing Religious Liberty: Principles for the Judicial Interpretation of the Religion Clauses* (Chicago, US: University of Chicago Press, 1995) 74-75.
[197] Little, Religious Exemptions, above n.176 8.
[198] Eisgruber and Sager, Vulnerability of Conscience, above n.192, 1262-1263.
[199] Waldron, One Law, above n.181, 24.
[200] "Religious obligations are obligations to submit the norms of what Robert Cover called a nomic community – a community that is a source of norms for its members." (See Michael Dorf, 'God and Man in the Yale Dormitories', 84 [1998] *Valley Law Review* 843, 852.)
[201] Waldron, One Law, above n.181, 24.

> socially-enforced burden, established as part of an actual way of life, a burden grounded in the actually-existing and well-established regulation and coordination of social affairs.…

Waldron's account of the tension between two systems of regulation explains that Dicey's 'rule of law' refers to one law only – state law. It does not account for competing sources of perceived obligation. Therefore, the rule of law cannot function as 'neutral' arbiter to resolve disputes between state law and religious law.[202]

Waldron's approach does not make any pretence of conforming to the equality of treatment principle. Rather, Waldron appears to distinguish 'inequality' from 'injustice', implying that the two do not necessarily coinhere. In other words, affording religious people (like CHP providers) special protection *will* violate the formal 'equality of treatment' principle (that all health providers ought to be subject to the same regulatory regime), but will not always create an injustice because of the state's special interest in protecting religious liberty.

Of the three explanations about why religion is deserving of special protection, Waldron's is the most convincing because it recognises that an impugned law may impose special hardship on religious people who are torn between existing state and religious or cultural laws.

2. Difficulties inherent in the special interpretation balancing approach are also inherent in the anti-discrimination approach to right-limiting

Religious convictions touch every aspect of a believer's life; there is no division between the 'sacred' and the 'secular', the 'numinous' and the 'natural'.[203] In the words of a contemporary Christian pastor and author, "everything is spiritual".[204] On the other hand, the modern state has expanded into almost all areas of life.[205] Therefore, a right to be free from

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[202] Ibid., 17.
[203] A.M. Wolters, *Creation Regained: Biblical Basics for a Reformational Worldview* (2nd ed.) (Wm. B. Eerdmans Publishing, Grand Rapids, Michigan; Cambridge, UK: 2005), 12. See also *R v Secretary of State for Education and Employment, ex parte Williamson* [2005] UKHL 15, [17] per Lord Nicholls of Birkenhead: "the tenets of a religion may affect the entirety of a believer's way of life."
[204] See Rob Bell, *Everything is Spiritual* (DVD), Zondervan. See product details at http://store.flannel.org/eis.html (last accessed 10/9/2009).
[205] Rex Ahdar, "Slow Train Coming: Religious Liberty in the Last Days" [2009] 12 *Otago Law Review* 37, 40.

state-imposed burdens – including those contained in neutral and generally applicable laws like the Code – must be limited if it is to be effective.[206]

There are two principal right-limiting strategies. The 'balancing' approaches attend the special protection interpretation.[207] They require a decision-maker to balance the burden a law imposes on an individual's religious practice against the state's interest in imposing that burden. If the burden on the individual's right to manifest religion outweighs state interest in imposing the burden, an exemption may be required.[208]

The second limiting strategy attaches to the 'anti-discrimination' interpretation (the "equal regard" approach). The anti-discrimination approach requires the decision-maker to ask whether "the government treated mainstream interests more favourably than vulnerable minority interests…"[209] An oft-cited example of how the approach could be applied is a law requires a police officers to be clean-shaven. The law exempts police officers who cannot shave due to irritating skin conditions, but does not exempt Sunni Muslims whose religious convictions require them to wear beards.[210] In this situation, the anti-discrimination approach suggests the court should grant an exemption because the legislature has not regarded the interests of the mainstream and minorities equally.

The limiting strategy associated with the special protection interpretation has been critiqued for being fraught with indeterminacy, 'ad-hockery' and concerns about ease of

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[206] Little, *Religious Exemptions*, above n.176, 17.
[207] Balancing approaches may be divided into threshold balancing and ad hoc balancing. Ad hoc balancing requires the decision-maker to balance the nature and weight of the burden imposed on religious practice against the interest advanced by the state in every case. Threshold balancing is described below at n.218. Both kinds of balancing approaches are compatible with the preferred method of applying the BORA to other enactments affirmed by the majority of the Supreme Court in *Hansen v R* [2007] 3 NZLR 1.
[208] See, for example, *Prince v President of the Law Society of Good Hope* 2002 (2) SA 794 (CC); *Williamson*; *Sherbert v Verner*, 374 US 398 (1963). While there are other possible strategies that could also be employed to limit such a right, balancing is a necessary part of the process.
[209] Greene, above n.195, 1002.
[210] Christopher L. Eisgruber and Lawrence G. Sager, *Religious Freedom and the Constitution* (Cambridge, Mass.: Harvard University Press, 2007), 90-91.

administration.[211] These critiques should not dissuade the Commissioner from adopting the special protection approach because those same issues are latent in the anti-discrimination limiting strategy.

The most common critique of the balancing approaches associated with the special protection interpretation is that such an inquiry is beyond the competence of courts. If theologians find it difficult to determine what God requires of man, it seems even less likely judges are capable of doing so. The US Supreme Court considered this issue in *Employment Division v Smith.*[212] Delivering the lead majority judgment, Justice Scalia stated:[213]

> It is no more appropriate for judges to determine the "centrality" of religious beliefs before applying a "compelling interest" test in the free exercise field than it would be for them to determine the "importance" of ideas before applying the "compelling interest" test in the free speech field. What principle of law or logic can be brought to bear to contradict a believer's assertion that a particular act is "central" to his personal faith?

There are also concerns that, where a decision-maker does attempt to balance competing interests, it may treat unfamiliar and obscure religious sects less favourably than individuals from familiar and mainstream sects.[214]

These concerns are, to an extent, valid. Balancing fundamental human rights is a challenging area of the law for any decision-making body, and requires the court to weigh and measure values that seem to defy quantification. However, critics of the balancing approach have tended to overlook the fact that the anti-discrimination approach entails similar problems.

The claim that the 'equal regard' approach is easier to administer because it does not force decision-makers to assess theological claims is unlikely to be borne out in practice. This is because the 'equal regard' approach also necessitates a balancing exercise. Both approaches require the decision-maker to determine the weight of the state interest, and both require

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[211] See generally Greene above n.195 and Kent Greenawalt "Moral and Religious Convictions as Categories for Special Treatment: The Exemption Strategy" 48 [2007] 48 *William and Mary Law Review* 1605.
[212] 494 US 872 (1990).
[213] Ibid. 886-887 (internal citations omitted).
[214] Little, *Religious Exemptions*, above n.176, 23.

some preliminary determination about whether the claimant or the claimant's group are vulnerable to disfavour as a minority group.[215] Moreover, although a decision-maker applying the 'equal regard' test may not regard herself as making a theological assessment about a claim, she is in fact making a theological claim or worldview assessment in deciding to regard secular and religious interests as commensurable concerns.

D. How could the 'special protection' approach be applied to consumer complaints about CHP?

To illustrate how the special protection interpretation of s 15 might assist the Commissioner to exercise his discretion under s 38 of the HDC Act, we return to Reverend Theophilus and Earnest, and Pastor David and Sheeba.

We begin with the presumption that it may be necessary to exempt religious individuals like Theophilus and David from the Code, even though the Code is religiously neutral and (otherwise) generally applicable. Assume for the sake of discussion that the Commissioner applies the threshold balancing approach.[216] The next step is for the CHP provider to demonstrate their sincere belief that they are required to do the action that is burdened by the law because of their religion.[217] Once this initial threshold is met, s 15 is implicated. The state must then show that its interest in imposing that burden (or in denying the claimed exemption) meets a certain level of importance to warrant imposing the burden.[218] If the state's interest does not meet that level, the right has been unjustifiably infringed and an exemption is prima facie required. The test would need to be applied on a case-by-case basis.

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[215] Greene, Three Exemptions, above n.195, 1005.
[216] It matters little whether the threshold or ad hoc balancing enquiries are used as *both* require balancing of the individual's and the state's interests, albeit at different stages in the limiting process. (The ad hoc approach implicates s 15 where there is any burden on religious conduct, and immediately require the courts to balance the interests under s 5 of the BORA.)
[217] The decision-maker is only concerned with the sincerity of a person's belief. The decision-maker is not required to judge whether the religion *actually requires* a person to do or to omit to do an action. See, for example, *Police v Razamjoo* [2005] DCR 408.
[218] See *R v Hansen* [2007] 3 NZLR 1, 42 para [108] per Tipping J.

Pastor David

It is unlikely that Pastor David could demonstrate that he sincerely believed his Christian convictions required him to make sexual advances towards Sheeba while he counselled her.[219] Therefore, it is unlikely Pastor David would be able to meet the initial threshold of the balancing test because his conduct was not religiously motivated. If Sheeba complained to the Commissioner about Pastor David's conduct, it would be incumbent on the Commissioner to investigate. It is likely that the Commissioner would find Pastor David breached right 2 of the Code.[220]

Reverend Theophilus

How the Commissioner ought to respond to a complaint about Reverend Theophilus is less obvious. Reverend Theophilus' advice to Earnest to cease taking medication may well have been dictated by his religious convictions (as a sign that Earnest was to put his trust wholly in God, for example). A necessary corollary of that conviction may have been the fact that Reverend Theophilus did not perceive a need to provide Earnest with a disclaimer about the risks entailed with forfeiting his medication. If the Code were applied, it may burden Reverend Theophilus' right to manifest religion by praying for and laying hands on Earnest. For instance, the Commissioner may find a breach of right 4 if a 'reasonable' CHP provider would have required a signed disclaimer from CHP consumers at the end of the consultation.[221]

In sum, it seems the Code would impede Reverend Theophilus' ability to perform religious practices. Thus, the initial 'threshold' would be met and s 15 would be engaged.

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[219] See the injunctions against sexual involvement with persons receiving counseling above n.146.
[220] Right 2 affirms the right to be free from sexual exploitation. See the Appendix.
[221] The same omission may also indicate a breach of rights 6(1)(b), 6(2) and 7(1). See below n.225.

The Commissioner would then need to determine whether there the state's interest in upholding the Code justified the limitation on Reverend Theophilus' right to manifest religion. Several New Zealand cases have held that, while not absolute, the right to manifest religion without state interference is important and should only be limited where there are strong countervailing concerns. These concerns include danger to public order and environmental or public health.[222] The Code is exists precisely to promote and protect public health.[223] Thus, the state appears to have a strong interest in limiting freedom of religion where its exercise might compromise public health. Yet this interest is circumscribed by s 11 of the BORA, which provides that "[e]veryone has the right to refuse to undergo any medical treatment." In light of s 11, Earnest seems perfectly entitled to cease taking his medication; the state has no proper interest in interfering with his decision. The question then becomes what level of information Earnest must be given so that he is in a position to exercise the right to refuse.[224]

Rights 6 (right to be fully informed)[225] and 7 (right to make an informed choice and give informed consent) of the Code address the issue of informed consent. Right 7(1) affirms that services may only be provided to a consumer only if that consumer makes an informed choice and gives informed consent. The relevant provisions of right 6 include:

> (1) Every consumer has the right to the information that a *reasonable consumer*, in that *consumer's circumstances*, would expect to receive, including—
>
> (b) An explanation of the options available, including an assessment of the *expected risks, side effects, benefits, and costs* of each option; and
>
> (2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make

[222] See, for example, *Mendelssohn v Attorney-General* [1999] 2 NZLR 268 ("The very nature of these rights and freedoms means that they are freedoms from state interference"); *Police v Razamjoo* [2005] DCR 408, 496 para [96] ("Whilst the rights of thought, conscience, religious and other belief affirmed by s 13 can be regarded as absolute, rights of manifestation such as those affirmed by…s 20 must necessarily be subject to constraints of many types. Obvious examples of contexts far removed from the subject matter of the present case include public health and hygiene, environmental health, workplace health and safety.") and *Lee* above n.136 ("a person's right to manifest his or her religious beliefs by consenting to a religious practice cannot be overridden by s 8 of BORA, except where the public interest demands it.") at para [330].

[223] The Long Title of the HDC Act states that its purpose, inter alia, to: "promote and protect the rights of health consumers and disability services consumers…."

[224] Paul Rishworth, "Rights Against Medical and Scientific Experimentation" in Rishworth, *Bill of Rights*, above n.172, 256.

[225] See above n.164.

an informed choice or give informed consent.

Earnest may contend that Reverend Theophilus should have informed him about the expected risks of ceasing his medication, as per right 6(1)(b). Failure to be properly informed vitiates his exercise of s 11 of the BORA, meaning that the state has a compelling interest in requiring CHP providers to disclose the information a reasonable consumer in the consumer's circumstances would expect to receive.

However, the right to have an assessment of the risks associated with ceasing medication is tempered by the 'reasonableness' requirements in right 6(1). A 'reasonable' consumer is likely to know that deleterious consequences may result when he or she stops taking prescribed medication. Moreover, it may be assumed that a consumer in Earnest's circumstances would have been informed of the risks associated with taking or not taking antihypertensives by his doctor during the consultation where they were prescribed. Finally, the state's interest in protecting health does not include a guarantee of successful medical outcomes. If Earnest's hypertension was symptomatic of acute heart disease, his injury may have occurred *even if* he was provided information about the risk of harm and consequently rejected Reverend Theophilus' advice. If medical science cannot guarantee successful medical outcomes, why should religion?[226] Hence, it seems likely that the Commissioner would find that the state's interest in imposing the Code does not offset Reverend Theophilus' right to manifest religion. The Commissioner may decide to exercise his discretion under s 38 of the HDC Act and decline to investigate (or continue investigating) Earnest's complaint.

Alternatively, if the Commissioner is satisfied that the state's interest in protecting consumer health does outweigh Reverend Theophilus' right to manifest religion, s 6 of the BORA mandates that he must interpret the rights and duties in the Code consistently with the BORA, where possible.[227] Compelling CHP providers to refrain from advising consumers to stop taking medication would be a clear infringement of the provider's right to manifest religion. Instead, providers could be required to inform consumers to remain in regular contact with their health practitioner in the event of any adverse effects of ceasing their medication.

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[226] I am grateful to Selene Mize for suggesting this idea.
[227] See above n.163 onwards.

Summary

The Commissioner is bound by the BORA when deciding whether to exercise his discretion to not to pursue a complaint, and when interpreting the rights and duties contained in the Code. Whether the application of the BORA impels the Commissioner to exercise his discretion or to interpret Code rights and duties in a manner that causes minimal impairment to CHP providers' rights will depend on the facts of the case.

Concluding Comments

Locating providers and consumers of CHP within the ambit of the Code presents the Commissioner with a difficult task. When faced with a complaint – and it may only be a matter of time before a complaint is made – the Commissioner will be required to assess two sets of competing interests: a CHP consumer with an ostensibly legitimate grievance seeking to hold a CHP provider to account, and a CHP provider seeking to avail him or herself of the special protection granted to persons manifesting their religion by s 15 of the BORA.

The tension the Commissioner will encounter when confronted with a complaint against a CHP provider is, in fact, a microcosm of a much larger conflict. The tension represents a contest about the place of religion and religious values in public life.[228] This contest is intensifying as an increasing array of matters formerly cosseted within the private sphere become subject to regulatory oversight. The inexorable expansion of state law is set on a collision course with people who profess allegiance to law of another kind – religious law – and for whom there is no such thing as conduct that is not 'religiously-motivated'. As this dissertation illustrates, the terrain on which the contest is waged is moving from the floor of the parliamentary debating chamber and the courts, and into church halls, Christian healing rooms and almost anywhere else practitioners of religious healing practices care to tread.

Complaints against CHP providers also symbolises the tension between the notion that all health providers should be treated equally regardless of their religious convictions, and the goal of freedom to pursue one's own conception of the good, unencumbered by the state. If CHP are (as the title of this paper suggests) 'medicine for the soul', it begs the question: who ought to be able to prescribe this kind of medicine and to what extent, if any, should they be subject to state oversight. The Commissioner will need the wisdom of Solomon if he is to chart a course between the interests of consumers and providers in a way that respects the

[228] Paul Rishworth, "The Religion Clauses of the New Zealand Bill of Rights" [2007] *New Zealand Law Review*, 638.

seriousness of the harm suffered by the consumer and the unique importance of the providers' right manifest religion.

Appendix:

Code of Health and Disability Services Consumers' Rights

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