

Incapacity and Consent to Medical Treatment:

Inconsistencies and Uncertainties in the Application of the
Objectives of the Protection of Personal and Property Rights Act
1988.

Ruth Jeffery

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Chapter one:

Protection of Personal and Property Rights Act 1988.

1. Introduction

The Protection of Personal and Property Rights Act 1988 (PPPRA) provides a mechanism for the giving of consent or the authorisation for medical treatment on persons incapable of consenting for themselves. In the twenty years since its enactment issues have arisen around the application of the express and implied objectives of the Act. In particular, it seems possible to interpret or apply the provisions within the Act seemingly in contradiction of the express objectives of the PPPRA. What effect (or potential effect) have these issues had on the provision and authorisation of health care to the partly or wholly incapacitated adult in New Zealand?

Recent common law decisions discussing capacity¹ have influenced the interpretation of capacity under the PPPRA. This is important as the interpretation of the jurisdictional criteria of incapacity differs between the appointment of a welfare guardian and the making of personal orders. As the express objective in the PPPRA is to enable the person to exercise such capacity as they have,² lowering the threshold for incapacity for the appointment of a welfare guardian potentially conflicts with the objectives of the PPPRA.

The main issues involve possible application of the objectives of the Act. There is an inherent tension in the Act between the expressly stated objective to make the least restrictive intervention in the life of the subject,³ and the implied objective of acting for the welfare and best interests of the person. The two concepts, on occasion, may be antipathic. Additionally, in Part 2 of the PPPRA, which deals with the appointment of welfare guardians, and in Part 9 dealing with the granting of an enduring power of attorney (EPOA), there is an express requirement for working of the welfare and best interests of the subject, but no express requirement for making least restrictive intervention in the life of the subject. Does the objective of least restrictive intervention apply to welfare guardian and attorneys, and what is the potential effect of this on the provision of healthcare for the incapacitated?

¹ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95; *Re MB* [1997] 2 FLR 426.

² PPPRA s8(b)

³ PPPRA s8(a)

Secondly, the express objective of the PPPRA is to enable and encourage incapacitated persons to exercise as much capacity as she or he has.⁴ However, it may be possible under the PPPRA that a welfare guardian could be appointed for someone who still retains some level of competence. Therefore in certain situations a welfare guardian could potentially override competent refusal of consent, which runs counter to the objectives of the Act, as well as the common law principles of autonomy and the right to refuse treatment.

The remainder of this Chapter will give a brief discussion the role and function of the PPPRA, why it was required and the impact of the New Zealand Bill of Rights Act 1990 (NZBORA); the Mental Health (Compulsory Treatment and Assessment) Act 1992(MH(CAT)A); and the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (Code of Patients' Rights) on the interpretation or application of the PPPRA.

In this work 'Court' refers to a New Zealand Family Court unless otherwise specified.

1.2 Background:

1.2.1. The position before the PPPRA

Despite a longstanding and widespread belief that next of kin or a spouse could consent on behalf of an incapacitated person,⁵ there was no legal basis for this view.⁶ The PPPRA was enacted as a response to the realisation that the common law did not provide adequate provision for substitute decision making for adults lacking in capacity.⁷ In the United Kingdom, it was confirmed in *Re F*⁸ and in *Re T*⁹ that, other than in the case of a child, no one was legally entitled to refuse or consent to medical treatment on behalf of an incapacitated adult.

However in New Zealand the High Court had retained, by virtue of the Judicature Act 1908, its inherent jurisdiction over all 'mentally disordered persons and

⁴ PPPRA ss8(b),18(3).

⁵ Eccles J, 'Mental Capacity and Medical Decisions' (2001) 30 *Age and Aging* 5.

⁶ Skegg P, 'Capacity to Consent to Treatment' in Skegg P, Paterson R (eds), *Medical Law in New Zealand* (2006) 180.

⁷ Bray A, Dawson J, van Winden J, *Who Benefits from Welfare Guardianship?* (2000).

⁸ *Re F (Mental Patient: Sterilisation)*[1990] 2 AC 1.

⁹ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95

persons of unsound mind'.¹⁰ Although most medical treatment was administered without the High Court's protective guardianship being utilised, the High Court could, exercising its *parens patriae* jurisdiction, authorise, refuse or withdraw medical treatment to the incompetent patient. This jurisdiction has been retained with the enactment of the PPPRA.¹¹

1.2.2 The requirement for informed consent or authorisation to treat:

In New Zealand the right of the competent person to refuse, or consent to, medical or surgical treatment is a basic premise in modern medical ethics and law. It is codified in both the NZBORA and in the Code of Patients' Rights.¹² It is founded on the underlying respect for a person's right to autonomy and bodily inviolability.¹³ Judge Cardozo said in 1913:

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault . . .”¹⁴

Consent must be “real” and not vitiated by lack of information of material risks and alternatives.¹⁵ Juxtaposed with the concept of giving informed consent for treatment is the presumption of capacity to do so.¹⁶ But what is the requisite level of capacity?

With patient autonomy being a guiding principle in health care law, it is important that the test that sets the limit for capacity is at a level that allows most people to make their own decisions about treatment.¹⁷ However, the principle of

¹⁰ Judicature Act 1908, ss16,17. Although in *Re H* [1993] NZFLR 225, Judge Inglis expressed doubt that the *parens patriae* jurisdiction still existed, this was overruled in the High Court decision of *Re W* [1994] 3 NZLR 600 where Neazor J held the High Court still retained the jurisdiction which was expressly affirmed under the PPPRA and it had not been extinguished by the 1992 MH(CAT)A.

¹¹ PPPRA s114.

¹² Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

¹³ Somerville M, “Changes in mental health legislation as indicators of changing values and policies.” *Psychiatry, Human Rights and the Law*. Roth M, Bluglass R (eds), (1985)167.

¹⁴ *Schloendorff v Society of New York Hospital* 211 NY 125 (1914).

¹⁵ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. Rights 6 and 7 set out the right to information and requirement of informed consent.

¹⁶ Gunn M, 'Decision Making Capacity' (1999) *Med Law Review* 269.

¹⁷ Gunn M, 'The Meaning of Incompetence' (1994) 2 *Med Law Review* 8.

informed consent emphasizes patients be given enough information to enable them to evaluate the risks and benefits of potential treatment regimes to make an informed decision. The dilemma then is between giving a detailed explanation which the patient may not understand and the simplistic explanation that may not be sufficient or exact enough to be informed consent.¹⁸ This dilemma is magnified in the presence of diminished capacity.

In the absence of sufficient capacity to consent, the health professional must look elsewhere for authority to treat. The main avenues available in New Zealand are: treatment under the doctrine of necessity; proxy consent by a welfare guardian or attorney; via High Court in exercise of its *parens patriae* jurisdiction; or via a Family Court by personal order under the PPPRA. There are additional statutory regimes which may also authorise treatment without consent in certain circumstances.¹⁹

Aside from the ethical reasons for obtaining consent or authorisation to treat patients, there is also legal liability associated with failure to do so. Unjustified failure to obtain any type of consent leaves the practitioner open to claims of criminal assault,²⁰ or the tort of battery;²¹ and the failure to obtain informed consent opens up liability in negligence,²² and liability under the Code of Patients' Rights.

Although the Code of Patients' Rights protects the clinician from liability under the Health and Disability Commissioner Act²³ when treating an incapacitated patient without consent (if it is in their best interests and reasonable steps have been taken to ascertain if the patient would have consented to the treatment if competent),²⁴ it does not absolve them from other forms of liability. Additionally there is potential criminal liability for failure to provide the necessities of life for

¹⁸ Jones M, 'Informed Consent and Other Fairy Stories' (1999) 7 *Med Law Review* 103.

¹⁹ For example: Criminal Procedure (Mentally Impaired Persons) Act 2003, s43; Intellectual Disability (Compulsory Care & Rehabilitation) Act 2003, s62; Health Act 1956 s79; Alcoholism and Drug Addiction Act 1966, s9; Mental Health (Compulsory Assessment and Treatment) Act 1992, s59.

²⁰ Crimes Act 1961 ss 188-90, 196.

²¹ Although damages for personal injury cannot be claimed under the ACC legislation.

²² *Rogers V Whittaker* (1992) 175 CLR 479, adopted into New Zealand in *B v Medical Council* [1995] 3 NZLR 810. Although damages for personal injury will not be actionable, exemplary damages may be awarded if the conduct was "so outrageous" *Bottrill v A* [2003] NZLR 721 (PC).

²³ Health and Disability Commissioner Act 1994.

²⁴ Right 7(4) of the Code in the Schedule to the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (Code of Patients' Rights).

a patient under care,²⁵ which creates a duty to treat. However, there is protection against criminal liability for appropriately performed surgical operations, even in the absence of consent.²⁶

1.3 Overview of the role and function of the PPPRA

The PPPRA is designed to provide for protection and guardianship of the partly or wholly incapacitated adult. Any interested person is able to make an application in respect of a person who they believe requires guardianship or protection.²⁷

The primary objectives of the Act are to make the least restrictive intervention possible in the life of the person in respect of whom the application is made, having regard to the degree of the person's incapacity²⁸ and to encourage that person to exercise and develop such capacity as he or she has, to the greatest extent possible.²⁹ Protecting the welfare and best interests of the person are not *expressly* included as objectives of the Act. This will be discussed more fully in Chapter Three.

Before a Court can entertain³⁰ any application under the PPPRA, the subject person must meet the criteria of residency³¹ and age.³² A Family Court's jurisdiction is established if the person meets the requirement for incapacity.³³ If the presumption for capacity has been rebutted the Court will decide if it should exercise jurisdiction,³⁴ taking into account the objectives of the Act. Lastly, the Court will consider what type of order needs to be made: personal or property orders, or the appointment of a welfare guardian.³⁵

The Act also provides for the making of an enduring power of attorney (EPOA).³⁶ The attorney can act in relation to the donor's personal care and welfare when

²⁵Crimes Act 1961 s151.

²⁶Crimes Act 1961 s61 protects against criminal responsibility persons performing surgical operations with reasonable skill and care that were reasonable under the circumstances.

²⁷ PPPRA s7.

²⁸ PPPRA s8(a).

²⁹ PPPRA s8(b).

³⁰ Inglis B, *New Zealand Family Law in the 21st Century* (2007).

³¹ PPPRA s6.

³² PPPRA s6(2).

³³ PPPRA s6.

³⁴ PPPRA s9(2)

³⁵ PPPRA ss10-12.

³⁶ PPPRA s 105

they become mentally incapable,³⁷ subject to the same restrictions as a welfare guardian under section 18 of the PPPRA.

1.3.1 When is it necessary to invoke the PPPRA?

The PPPRA was enacted, in part, in recognition that there was no provision for substituted decision-making for an incapacitated adult under the common law.³⁸ But does it always need to be invoked?

In the United Kingdom, in the decision of *Re F (Mental Patient: Sterilisation)*,³⁹ the House of Lords explicated the doctrine of necessity as authority for the provision of treatment to those incapable of consenting, if their treatment was necessary and in the best interests of the patient. The doctrine of necessity has been held to authorise in English law treatments as extreme as sterilisation,⁴⁰ and the withdrawal of hydration and nutrition in patient in persistent vegetative states.⁴¹

Whilst only of persuasive authority in New Zealand, the decision of the House of Lords in *Re F*⁴² gives more credence to the long accepted conviction that the doctrine of necessity allows for routine medical treatment of incapacitated patients.⁴³ However, it is not clear where the boundary of this doctrine lies, particularly in the New Zealand context where there are other avenues for authorisation of treatment such as PPPRA or the *parens patriae* jurisdiction. Even in the England, in both *Re F*⁴⁴ and in *Airedale NHS Trust v Bland*⁴⁵ the Court held it is advisable for the medical professionals to seek authorisation from the court for treatments that are fundamentally irreversible in nature.⁴⁶

Following the English reasoning, irreversible procedures such as sterilisation or abortion should not be performed under the auspices of necessity in NZ, but

³⁷ PPPRA s98.

³⁸ Bray A, Dawson J, van Winden J, *Who Benefits from Welfare Guardianship?* (2000).

³⁹ *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

⁴⁰ *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

⁴¹ *Airedale NHS Trust v Bland* [1993] AC 789.

⁴² *Re F (Mental Patient: Sterilisation)*[1990] 2 AC 1.

⁴³ Skegg P, 'Justifications for Treatment without Consent.' in Skegg P, Paterson R (eds), *Medical Law in New Zealand* (2006) 250, 250.

⁴⁴ *Re F (Mental Patient: Sterilisation)*[1990] 2 AC 1.

⁴⁵ *Airedale NHS Trust v Bland* [1993] AC 789.

⁴⁶ *Airedale NHS Trust v Bland* [1993] AC 789, 859,873,874,885; *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 42, 56, 61, 70.

under the authority of either *parens patriae* jurisdiction or the PPPRA. Cessation of treatment, where controversial, may also require Court authorisation.⁴⁷

The *parens patriae* jurisdiction has been utilized since the enactment of the PPPRA to authorise withdrawal of nutrition and hydration of a patient in minimally conscious state.⁴⁸ Although not discussed, it would be unlikely the PPPRA could be invoked for an order to withdraw treatment, as personal orders may only be made for the *provision* of medical treatment.⁴⁹ It would be difficult to include the *withdrawal* of therapy as providing ‘medical advice or treatment’. Additionally, it is doubtful that a welfare guardian could be given authorisation to permit the withdrawal of treatment, as a Court held in *Re H*⁵⁰ it could not grant to the welfare guardian an authority it does not have itself.⁵¹

However, Inglis (writing extra-judicially) argued that the Court could make a personal order “that no medical treatment of the type proposed be offered”,⁵² to prevent needlessly prolonging the life of the patient. This however, is different from the active withdrawal of current treatment, particularly if the current treatment is life sustaining nutrition and hydration on a person who is not “brain dead”. Nevertheless Inglis⁵³ cogently argued a Family Court has a residual protective power, emanating from the principles underlying the *parens patriae* jurisdiction,⁵⁴ which would allow a Court to make such decisions that are in the welfare and best interests of the subject person:

“In general terms it is therefore probably correct to speak of an implicit “residual” protective jurisdiction in cases not precisely or adequately covered by statute either expressly or by necessary implication”⁵⁵

⁴⁷ *Re G* [1997] NZFLR 362; However, in *Auckland Area Health Board v Attorney-General* [1993] 1 NZLR 235, Thomas J discouraged recourse to Court for essentially medical decisions.

⁴⁸ *Re G* [1997] NZFLR 362.

⁴⁹ PPPRA s10(1)(f).

⁵⁰ *Re H* [1993] NZFLR 225.

⁵¹ *Re H* [1993] NZFLR 225. “...there seems little sense in an interpretation of ss 10(1)(f) and 18(2) which would enable the Court to empower the welfare guardian to consent to sterilisation when the Court itself has no power to make a personal order to that effect.” Also PPPRA s18(1)(c) does not allow a welfare guardian to refuse standard medical treatment aimed at saving persons life.

⁵² Inglis B, *New Zealand Family Law in the 21st Century* (2007) (footnote 127, page 750).

⁵³ Inglis B, *New Zealand Family Law in the 21st Century* (2007), 11.3.

⁵⁴ Inglis B, *New Zealand Family Law in the 21st Century* (2007), 11.3

⁵⁵ Inglis B, *New Zealand Family Law in the 21st Century* (2007), 11.5

Nevertheless, it may well be crossing the line using a 'protective' jurisdiction to authorise the withdrawal of treatment, which would be the antithesis to the general concept of 'protection'.

1.3.2 Conclusions:

When there is controversy over a decision regarding medical treatment, or when the decision has serious irreversible consequences, the most appropriate method of authorisation for treatment would be via the PPPRA and not to rely on the doctrine of necessity. This was confirmed in *Re H*.⁵⁶

“There is nothing in this case to suggest that it could be wise for anyone concerned to rely on *In re F* [sic] in offering H the medical procedures contemplated here without express authorisation from the Court or from H's welfare guardian.”

However there may be a dichotomy between what the clinicians should do, and what happens in reality. The limited number of cases about sterilisation and abortion suggest that either these procedures are not carried out or, more likely, that they are carried out without Court sanction, in reliance of the common law doctrine of necessity.

When decisions involve a controversial or contested withdrawal of life supporting treatment, the *parens patriae* jurisdiction should be sought as it could well be ultra vires if the Family Court made such a decision. Seeking authority under the *parens patriae* jurisdiction, rather than a declaratory judgment, also centres the question on the best interests of the patient, rather than the culpability of the medical staff,⁵⁷ which is a more appropriate approach to making life and death decisions.

However, routine medical care should still be provided under the doctrine of necessity, when it is in the best interests of the patient. However, if the patient is actively refusing, or there is doubt as to the level of incapacity, it would be wise for the clinician to seek Court approval before providing anything above basic provision of health care.

⁵⁶ *Re H* [1993] NZFLR 225.

⁵⁷ Peart N, Gillett G, 'Re G: A Life Worth Living?' (1998) 5 *Journal of Law and Medicine* 239, 240

1.4 The Effect of More Recently Enacted Legislation on the PPPRA.

What has the effect of NZBORA, MH(CAT)A and the Code of Patients' Rights been on the application of the objectives of the PPPRA?

1.4.1 New Zealand Bill of Rights Act 1990

NZBORA confirms that patients have the right to refuse treatment.⁵⁸ As this has been interpreted to mean all *competent* patients,⁵⁹ there has been little effect on the interpretation and application of the PPPRA.

The NZBORA applies to acts done by a person or body in the performance of a public function, power or duty conferred or imposed on that person or body by or pursuant to law.⁶⁰ Individual medical professionals would not therefore be liable for a breach of NZBORA, although it is possible that DHB's⁶¹ would be, if competent patients were treated when they have refused consent. Treatment without consent would not be a breach of the NZBORA when legislatively permitted,⁶² as NZBORA does not make other enactments ineffective.⁶³ Additionally NZBORA is subject to the justified limits prescribed by law as can be justified in a free and democratic society.⁶⁴

1.4.2 The Code of Patients' Rights

The Code of Patients' Rights specifies the requirement to give informed consent as well as the right to refuse treatment or withdraw from treatment.⁶⁵ Where the person is not competent to consent and no person is available to consent on their behalf, services may be provided if it is the best interest of the patient, and after taking reasonable steps in ascertaining the views of the patient or if this is not possible, taking into account the views of other "suitable persons".⁶⁶ The provider

⁵⁸ NZBORA ss10,11.

⁵⁹ *Re S* [1992] NZLR 363, 364.

⁶⁰ NZBORA s3(b).

⁶¹ District Hospital Boards.

⁶² For example: Criminal Procedure (Mentally Impaired Persons) Act 2003, s43; Intellectual Disability (Compulsory Care & Rehabilitation) Act 2003, s62; Health Act 1956 s79; Alcoholism and Drug Addiction Act 1966, s9; Mental Health (Compulsory Assessment and Treatment) Act 1992, s59.

⁶³ NZBORA s4.

⁶⁴ NZBORA s5.

⁶⁵ Right 7(9).

⁶⁶ Right 7(1).

is not in breach of the Code if they take all reasonable steps in the circumstances to comply.⁶⁷

How has this impacted on the PPPRA? Two issues arise. In non urgent situation, when there is no ‘person’ able to consent on behalf of the patient, the provider must take into account the views of “suitable persons” before proceeding with the proposed treatment. Could the Court be considered a person in either of these categories? If so, then in most circumstances application would need to be made under the PPPRA for authorisation to treat. Although the Code is about the promotion of Rights, it would be an ironic situation that treatment would be delayed to get a Court order for every procedure. Certainly the decisions of the Commissioner do not appear to suggest this.

However, to hold otherwise may almost give the health professionals a carte blanche to treat without incurring Code liability. There are no limits to what treatment can be performed without consent under the Code of Rights, with the possible exception of those procedures where consent must be in writing.⁶⁸ Regardless, this would not exempt the health professionals from other forms of liability such as assault.⁶⁹

Additionally there is no definition of competence. Therefore it is conceivable that where the Court may find competence under the PPPRA, the medical profession may find incompetence under the Code or vice versa. There have been a number of instances where the Court and the Medical professionals have been at odds in assessments of capacity when using the PPPRA criteria.⁷⁰ Without criteria for competence the possibility for divergence of opinion is greater. Conceivably then, treatment could progress under the presumption of competence, when the Court under the PPPRA may have held other wise.

It almost seems as if the Code of Rights undermines the conceptual basis of the PPPRA for providing a means of treatment without consent (albeit protecting against only one form of liability). However, as both the Code of Rights and the Act are for the protection of the rights of individuals, it would be improper to interpret it this way. It would be more in keeping with objectives of both Acts to

⁶⁷ Code of Patients’ Rights, s3.

⁶⁸ Right 7(6).

⁶⁹ Or the other forms of liability discussed in chapter one.

⁷⁰ *HLS v BDI* [2005] NZFLR 795; *B v B* unreported, 13 March 2007, Judge Smith, Family Court Dunedin 2007-012-28; *Re H and H* (PPPR 1(1999) 18 FRNZ 297

accept that the exemption from consent or authorisation applies only to situations of emergency, urgency or for minor necessary treatments on the incompetent.⁷¹

1.4.3 The Mental Health (Compulsory Assessment and Treatment) Act

Possibly the legislation which had the greatest impact on the provision of health care under the PPPRA was the MH(CAT)A. The major change from the previous mental health legislation was that those with intellectual disability could not be detained or compulsorily treated under the MH(CAT)A unless they had a concurrent mental disorder.⁷² Even then, compulsory treatment is limited to treating the mental disorder⁷³ and not the co-morbidities. As a result, institutions who looked after the intellectually disabled realised they needed to have authorisation or proxy consent for treatment of their residents.⁷⁴ Therefore applications were made under the PPPRA to appoint welfare guardians. They in turn could allow the institution to provide basic provision of care and treatment.

How did this impact upon the provision of healthcare? The powers the Court can grant to the welfare guardian are limited in scope, and welfare guardians are expected to approach the Court for further personal orders or to grant authorisation for procedures such as sterilisation and abortion.⁷⁵ However, as the PPPRA is for adult guardianship,⁷⁶ parents can still consent to such procedures for those under 16.⁷⁷ In at least one instance, the *parens patriae* jurisdiction of the High Court was used to authorise sterilisation of a minor.⁷⁸ It is unknown how many others proceeded without judicial consent. Overseas studies have shown that there is a higher prevalence of sterilisation among the intellectually disabled living in care.⁷⁹ If the same statistics are representative in NZ, this would suggest that the number of cases proceeding to Court is possibly not a true reflection of the number of surgeries taking place.

⁷¹ And there is no one else authorised to consent on their behalf (Right 7(4)).

⁷² MH(CAT)A s4(e).

⁷³ MH(CAT)A s59.

⁷⁴ Bray A, Dawson J, van Winden J, *Who Benefits from Welfare Guardianship?* (2000).

⁷⁵ *Re H* [1993] NZFLR 225; *Re X [PPPR]*(1993) 10 FRNZ 104.

⁷⁶ PPPRA s5(2).

⁷⁷ However, section 7 of The Contraception, Sterilisation, and Abortion Act 1977, states that no one can consent to the sterilisation of another person who lacks capacity through age alone.

⁷⁸ *Re X* [1990] 2NZLR 365.

⁷⁹ Servais L, Leach R, Jacques D, Rosussaux JP, 'Sterilisation of Intellectually Disabled Women.' (2004) 10 *European Psychiatry* 428

Chapter Two

Capacity and the Objectives of PPPRA.

2.1. Decision-making Capacity at common law.

At common law the Courts have followed a functional approach in assessing capacity to consent to medical treatment. Decision making capacity is assessed at the time of the decision⁸⁰ and is task specific.⁸¹ This enables the court to make findings that capacity is only diminished, or absent, in certain areas relating to the person, or for certain types of decisions.⁸²

There have been several English decisions discussing capacity since the enactment of the PPPRA. The test for decision making-capacity was discussed at length in *Re C*.⁸³ It was held that to have capacity to make genuine decisions the person needed to be able to:

1. Comprehend and retain the relevant treatment information
2. Believe the information
3. Weigh the information balancing the risks and needs.

Therefore the more information a person must retain, and the more complex the nature of the information, the more impact it has on the persons ability to consent.⁸⁴ Mental disorder and intellectual disability do not automatically obliterate capacity to consent.⁸⁵ Incapacity may also be temporary. In *Re T*⁸⁶:

“Others who would normally have that capacity may be deprived of it or have it reduced by reason of temporary factors, such as unconsciousness or confusion or other effects of shock, severe fatigue, pain or drugs being used in their treatment.”

⁸⁰ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.

⁸¹ Gunn M, 'The Meaning of Incapacity' (1994) 2 *Med Law Review* 8.

⁸² *Re CMC* (1995) FRNZ 112.

⁸³ *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

⁸⁴ Gunn M, Wong J, Clare I, Holland A, 'Decision-making Capacity' (1999) 7 *Med Law Review* 269.

⁸⁵ *Re C* [1994] 1 All ER 819. In *Re C* the patient, a delusional schizophrenic detained under the UK Mental Health Act, was held to have the capacity to refuse medical treatment for a non-psychiatric condition (amputation of a gangrenous foot) even though his condition was life-threatening.

⁸⁶ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95. [1993] EWCA Civ 18 para 22

In conjunction with this, a person of limited capacity may be influenced by outside factors, including undue influence of another person, negating that consent.⁸⁷

Incapacity can also be as to a limited aspect of an otherwise competent person's decision making ability. In *Re MB*⁸⁸ a needle phobic woman was found incompetent to refuse consent to analgesia, as her fear of needles so overwhelmed her that, during the moment of panic, she was unable to consider anything else, leaving her incompetent. Although it was acknowledged that there is a fine line between competence and incompetence when caused by phobia or fear:

“Although it might be thought that irrationality sits uneasily with competence to decide, panic, indecisiveness and irrationality in themselves do not as such amount to incompetence, but they may be symptoms or evidence of incompetence.”

And later:

“Another such influence may be panic induced by fear. Again careful scrutiny of the evidence is necessary because fear of an operation may be a rational reason for refusal to undergo it. Fear may be also, however, paralyse the will and thus destroy the capacity to make a decision.”⁸⁹

Capacity may also be fluctuating, and in elderly patients with senile dementia there may be periods of relative lucidity between bouts of confusion. The impact of this on the objective of exercising such capacity as the patient has will be discussed in Chapter Four.

2.2 The Effect of Common law decisions on the PPPRA.

Under the PPPRA ‘competence’ or ‘capacity’ has been construed in the same way as the common law, and has evolved in response to recent common law decisions.

⁸⁷ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.

⁸⁸ *Re MB* [1997] 2 FLR 426.

⁸⁹ *Re MB* [1997] 2 FLR 426. Butler-Sloss LJ

There is a dearth of New Zealand cases before the PPPRA discussing consent to treatment, probably as there were extensive powers to treat mentally disordered persons under the Mental Health Act 1969.⁹⁰ The definition of mental disorder was broad,⁹¹ with no specific test for capacity, merely the person “requires care and treatment” or suffers from “subnormality of intelligence” and has a condition that “substantially impairs mental health”⁹² and therefore included the intellectually disabled. There was no requirement for patients to consent to treatment under the 1969 Act and unlike the current MH(CAT)A⁹³ treatment was not limited to that for mental disorder.

Cases arising,⁹⁴ under the 1969 Mental Health Act, the Aged and Infirm Persons Act 1912 or other legislation,⁹⁵ did not particularly evaluate the capacity of the person in detail, but tended to use a status⁹⁶ approach to define jurisdiction.⁹⁷ However, even then the courts were careful to establish if the protected person had any level of decision making capacity. For example, in one case there was a decision to order “service on the protected person himself as the evidence revealed that he might be capable of forming some opinion on the matter”, even though he was described as “...a congenital mental defective of about feeble minded level whose mental condition is unlikely to improve”.⁹⁸

The PPPRA shifts away from using a status approach in assessing capacity. In *Re Tony*⁹⁹ (one of the early cases discussing capacity under the PPPRA) Judge Inglis stated:

“It is therefore wrong to allow the concepts of “capacity” or “competence” as used in the Act to be limited by any narrow

⁹⁰ Mental Health Act 1969 ss15,25,43.

⁹¹ Mental Health Act 1969 s2.

⁹² Mental Health Act 1969 s2.

⁹³ MH(CAT)A s59.

⁹⁴ *Re W. (A Protected Person)* [1966] NZLR 380; *J v J* [1974] 2 NZLR 498; *Miller v Wellington Hospital Board* (1988) unreported, Court of Appeal, Richardson J, 14 Oct 1988, CA 15/86.

⁹⁵ Limitation Act 1950; Matrimonial Proceedings Act 1963, s 7(1)(a)(ii).

⁹⁶ Gunn M, 'Decision Making Capacity' (1999) *Med Law Review* 269, 229.

⁹⁷ The Mental Health Act 1911 worked very much on a status approach to define ‘mentally defective’. These concepts may well have influenced the interpretation of ‘mental health’ in the 1969 Act.

⁹⁸ *Re W. (A Protected Person)* [1966] NZLR 380.

⁹⁹ *Re “Tony”* (1990) 5 NZLR 600

interpretation or, in particular, to be limited by similar common law concepts from which the Act has provided a radical departure.”¹⁰⁰

However, as Bray¹⁰¹ has pointed out, there is a long history in the law of assessing capacity, and the use of the same terminology in the Act made it difficult to move away from former common law 'status' notions of incapacity.

The earlier cases did seem to approach capacity on a global prospective and not functional for the particular decision to be made. Even in *Re Tony*¹⁰² (1990), Judge Inglis held that when evaluating capacity, the Court should evaluate the degree of capacity required, for the types of decisions needing to be made, in the situation the person was in. This was reminiscent of the common law approach that the PPPRA was supposed to move away from. In the supported environment where “Tony”, was situated he was not required to make complex decisions, and given that, his lack of competence was not such that he required any personal orders. However, later cases rejected this composite analysis and focused on a two step process, establishing jurisdiction via incapacity; and secondly, once established, whether the exercise of jurisdiction was required (i.e. the making of personal order).¹⁰³

In the early cases there was less analysis of the actual decision making process, when looking at the ability to understand the nature and foresee the consequences of the decision. However, the effect of the two English cases of *Re T (Adult: Refusal of Treatment)*¹⁰⁴ and *Re C (Adult: Refusal of Medical Treatment)*¹⁰⁵ seem to have an (unacknowledged) impact on how the discussions of capacity were framed. *Re C*¹⁰⁶ defined the decision-making process by which capacity could be assessed and *Re T*¹⁰⁷ acknowledged that incapacity could be both temporary and caused by situational events.

¹⁰⁰ *Re “Tony”* (1990) 5 NZFLR 609, 614.

¹⁰¹ Bray A, 'The Protection of Personal and Property Rights Act 1988: Progress for people with disabilities?' (1996) 2(3) *BFLJ* 64.

¹⁰² *Re “Tony”* (1990) 5 NZFLR 609.

¹⁰³ *R v C* [1992] NZFLR 162; *Re Rosemary* (1990) 6 FRNZ 479.

¹⁰⁴ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.

¹⁰⁵ *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

¹⁰⁶ *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

¹⁰⁷ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95

*Re G*¹⁰⁸ (March 1994, Judge Inglis), which was decided shortly after *Re C*, (October 1993) but without reference to it, decision-making capacity was discussed in the following terms:

“The capacity to make a decision must therefore include the capacity to receive and digest the information on which the selection is to be based and in particular the capacity to know that options are available to be selected and the nature and character of those options. The capacity to know the nature and character of those options must necessarily include that capacity to foresee and understand the likely consequences of the selection that is to be made between the available options”¹⁰⁹

The common law test, as expressed in *Re C*,¹¹⁰ was more comprehensive, discussing the ability to comprehend and *retain* the relevant treatment information, *believe* the information and *weigh* the information balancing the risks and needs.

In *Re FT*¹¹¹ (1995, Judge Boshier) the Court adopted a similar approach to that of the English common law. Judge Boshier referred to the person’s ability to communicate choices; their understanding of the relevant information; their appreciation of the situation and its consequences; and their manipulation of the relevant information (the ability to follow a logical consequence of thought through in order to reach a decision). This has been cited with approval in subsequent decisions.¹¹²

It has been suggested that the court must consider the person’s general capacity to understand personal decisions, even when the decision relates only to one aspect of their care.¹¹³ This is contrary to the current common law position that the competence for consent is based on the level of capacity for a particular decision.¹¹⁴

¹⁰⁸ *Re G*[PPPR: Jurisdiction](1994)11 FRNZ 643.

¹⁰⁹ *Re G*[PPPR: Jurisdiction](1994)11 FRNZ 643, 648.

¹¹⁰ *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819.

¹¹¹ *Re FT* unreported, 11 January 1995, Judge Boshier, District Court, Auckland PPPR 68/94.

¹¹² *Greer v PGK* unreported, 6 August 2006, Judge Grace, DC Nelson, PPPR 20/95; *Re CMC* (1995) FRNZ 112; *KR v MR* [2004] 2 NZLR 847.

¹¹³ 'Protection of Personal and Property Rights' in Geraghty P (ed), *Family Law in New Zealand* (11th ed, 2003) vol 2, 7.813.

¹¹⁴ *Re F (Mental Patient: Sterilisation)*[1990] 2 AC 1

This was discussed in *In the Matter of F (No 3)*¹¹⁵ (1992), Judge Inglis questioned if they should look to global competence:

“That leads to the question whether, in respect of personal orders, the Act requires the Court in determining whether the subject person has ‘capacity’ to assess that issue on a global view of that person’s capacity or whether it is permissible to isolate and assess specific aspects of that persons decision- making ability.”

Judge Inglis held it was only capacity relating to the particular aspect of personal care or welfare that needed to be addressed, as recognised the legislation.¹¹⁶ This has been confirmed in subsequent decisions such as *Re CMC*¹¹⁷ (1995) where Judge MacCormick assessed CMC’s capacity in relation to her decision to refuse nasogastric feeding and not by her global decision-making competence. There was no suggestion she lacked capacity in other areas of her own care and welfare, and the treatment order would lapse after twelve months by which time it was hoped she may have regained capacity.¹¹⁸ This decision reflects the acceptance that the incapacity may only be temporary and not global, as reflected in the decision of *Re T*.¹¹⁹ The Courts have also acknowledged they cannot make a “snap shot” at a point in time view to determine the degree of capacity.¹²⁰

2.3 The requirement for Incapacity under the PPPRA.

Unlike previous legislation dealing with the incapacitated,¹²¹ the PPPRA is premised on a presumption of capacity¹²² which must be rebutted before jurisdiction is established.¹²³ The onus of proof lies with the applicant to establish jurisdiction.¹²⁴

¹¹⁵ *In the Matter of F (No 3)* unreported, 1 Jan 1992, Judge Inglis, DC Levin, PPPR 031 020 91.

¹¹⁶ PPPRA s12(1).

¹¹⁷ *Re CMC* [1995] NZFLR 538.

¹¹⁸ PPPRA s17(1)(b) – when no time limit is specified, the order expires 12 months from date of order.

¹¹⁹ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.

¹²⁰ *Re L* [2001] NZFLR 310.

¹²¹ Mental Health Act 1969; Aged and Infirm Persons Protection Act 1912.

¹²² PPPRA s5.

¹²³ PPPRA s6.

¹²⁴ Atkin B Webb P, Caldwell J, Adams J, Henaghan M, Clarkson D, 'Protection of Personal and Property Rights' in Geraghty P (ed), *Family Law in New Zealand* (11th ed, 2002) vol 2, 7-812.

The interpretation of incapacity can possibly lead to an application of the provisions of the PPPRA that are in contravention of the objectives of the PPPRA.

2.4 Incapacity for personal orders

Section 6 (1) defines the initial incapacity requirements: this is that the person in respect of whom the application is made:

- “(a) Lacks, wholly or partly, the capacity to understand the nature, and foresee the consequences, of decisions in respect of matters relating to his or her personal care or welfare; or
- (b) Has the capacity to understand the nature, and foresee the consequences, of decisions in respect of matters relating to his or her personal care or welfare, but wholly lacks the capacity to communicate decisions in respect of such matters”¹²⁵

2.4.1 Interpreting “wholly lacks the capacity to communicate decisions in respect of such matters”

If a bed bound patient who is only able to communicate with a caregiver who refuses to carry out the patient’s decisions, they (arguably) are unable exercise their capacity. Despite the objectives of the PPPRA being to enable the person to exercise such capacity as they have, a physical inability to implement decisions has not been found to be grounds for the appointment of a welfare guardian to achieve this.¹²⁶ Inglis¹²⁷ has argued that this could be the type of narrow, legalistic approach to the Act which was eschewed by the High Court in *In the Matter of A*.¹²⁸ Potentially, if the subject person could not communicate his or her wishes to the outside world, this could be considered lack of capacity to communicate as per the Act,¹²⁹ even if due to a lack of facilitation by the caregiver rather than physical impediment of expressing her wishes.

Bray also argues that:

“ the "capacity to communicate decisions" does not relate to "*mental* capacity", but to the more general dictionary meaning of "*capability*" ie

¹²⁵ PPPRA s6(1). Jurisdictional requirements also mandate the person to be ordinarily resident in New Zealand and over the age of 18 (subject to the exceptions in section 6(2)).

¹²⁶ *Re Z* [1992] NZFLR 614.

¹²⁷ Inglis B, *New Zealand Family Law in the 21st Century* (2007),730.

¹²⁸ *In the matter of A* [1996] NZFLR 359.

¹²⁹ PPPRA s6(1)(b)

the actual behaviours necessary to perform the act of communication. Thus the phrase "wholly lacks the capacity to make or to communicate decisions", should be interpreted in terms of "capability" or "power to act", not in terms of "mental capacity".¹³⁰

With this interpretation, it is possible that the inability to communicate decisions to the outside world could be construed as 'wholly lacks the capacity to communicate decisions'.¹³¹ After all the long title of the Act is for the protection of those "who are not fully able to manage their own affairs."¹³² Inability to carry out decisions means one cannot manage one's affairs.

If the person cannot obtain medical treatment due to lack of compliance by a caregiver, it is possible the court may take a more expansive view as to using the Act to achieve this. It could make a personal order by consent for medical treatment,¹³³ and make other orders to give effect to the personal orders.¹³⁴ Welfare guardians have been appointed to ensure compliance with personal orders for treatment.¹³⁵

However, it would be straining the PPPRA to interpret 'unable to communicate' decisions to include those who could not enforce them, and to find them incapable by dint of that alone. So although there maybe recourse under criminal law¹³⁶ for those responsible for others not providing them with medical care, for other matters it seems that the physically disabled, intellectually competent person may be at the mercy of their care giver, with regard to the PPPRA. Although the PPPRA is about the protection of personal rights, it is only aimed at the intellectually incapacitated and not the physically disabled, unless they are wholly incapable of communication. Nevertheless, the subject may have recourse via the Code of Patients' Rights,¹³⁷ or the *parens patriae* jurisdiction of the High Court.

¹³⁰ Bray A, 'The Protection of Personal and Property Rights Act 1988: Progress for people with intellectual disabilities?' (1996) 2(2) *BFLJ* 51.

¹³¹ PPPRA s12(2)(a).

¹³² PPPRA, long title.

¹³³ PPPRA ss15, 10(1)(f)

¹³⁴ PPPRA s10(4)

¹³⁵ *Re W [PPPR]* 11 FRNZ 108.

¹³⁶ Crimes Act 1962 ss151, 157.

¹³⁷ Right 4 is the right of consumers to be provided with services of an appropriate standard (which generally would include the right to be allowed access to treatment). This implies a duty on the provider to provide this access. Under The Health and Disability Commissioner Act 1994, s2, a "disability services provider" means any person who provides, or holds himself out as providing disability services. "Disability services" are goods and services and facilities provided to people with disabilities for care and support or to promote their independence

2.5 Incapacity and the appointment of a welfare guardian.

In many cases where there is severe intellectual handicap, discussion as to capacity is cursory. Often, the discussion arises when trying to determine the differences in capacity required between making personal orders and appointing a welfare guardian.

The jurisdictional criteria for the appointment a welfare guardian is set out in section 12(2). It reads:

- “(a) That the person in respect of whom the application is made wholly lacks the capacity to make or to communicate decisions relating to any particular aspect or particular aspects of the personal care and welfare of that person; and
- (b) the appointment of the welfare guardian is the only satisfactory way to ensure the appropriate decisions are made relating to that particular aspect or those particular aspects of the personal care and welfare of that person”¹³⁸

This differs to personal orders under section 6, where the person must wholly or partly lack the capacity to understand the nature and consequences of decisions. For section 12, the person must *wholly* lack the capacity to *make* a decision, but this need only be as to a *particular aspect* of personal care and welfare.

Lacking capacity to *make* a decision could be taken to suggest the inability to reach any sort of decision at all. However, it has been interpreted to mean the person lacks the ability to make a meaningful decision, so that any apparent choice is not a true choice at all.¹³⁹ In *Re G*¹⁴⁰ (1994, Judge Inglis):

“ I do not consider that the words in s 12(2) "wholly lacks the capacity to make . . . decisions relating to any particular aspect or particular aspects of . . . personal care and welfare" can be taken to mean that the

These broad definitions mean that even a family member caring for a disabled person is subject to the Act and the subject person may have recourse through the HDC Act or the Human Rights Review Tribunal.

¹³⁸ PPPRA s12(2).

¹³⁹ *Re G [PPPR: Jurisdiction]* (1994)11 FRNZ 643,648.

¹⁴⁰ *Re G [PPPR: Jurisdiction]* (1994)11 FRNZ 643 648

threshold is crossed only when it is shown that the patient is *totally incapable of making any decisions at all*".

However, by lowering the criteria to less than that of 'making' a decision blurs the boundary between section 12 criteria of wholly lacking the capacity to *make* decisions, and the section 6 inability to foresee the nature and consequences of decisions. As Bray points out the word "partially" was omitted in s12:

“presumably to provide a more stringent jurisdictional requirement for the serious limitations on autonomy imposed by such an order.”¹⁴¹

As Bray argued, using Judge Inglis QC's interpretation, orders for the appointment of a welfare guardian could be made for almost any person with partial incapacity for making decisions in one life area.¹⁴² As an example she quotes the decision in *Re G*¹⁴³ (1994), where Judge Inglis held G's naiveté and inexperience, resulting in unrealistic expectations, demonstrated a lack of capacity to make decisions.¹⁴⁴

Another example of blurring the criteria is *Re L*¹⁴⁵ (1994, Judge von Dadelszen). L was not seriously disabled, but lacked the ability to make “important” decisions and a welfare guardian was appointed. Again in *B v B*¹⁴⁶ (2007, Judge Smith) a welfare guardian was appointed due to the insistence of the medical professionals rather than a clear incapacity to make decisions. And in *Re LM*¹⁴⁷ (1992, Judge von Dadelszen), a welfare guardian was appointed as the subject person wholly lacked capacity in terms of personal hygiene and finance. Whilst this is a lack of capacity in a ‘particular aspect’ of her life, normally a personal order would suffice to rectify this. In reality the welfare guardian was appointed to protect the subject from interference by her son, which could not be a ground of jurisdiction alone.

As a consequence of these decisions, in many ways the difference between the two tests for incapacity does seem more apparent than real.¹⁴⁸

¹⁴¹ Bray A, 'The Protection of Personal and Property Rights Act 1988: Progress for people with intellectual disabilities?' (1996) 2(2) *BFLJ* 51.

¹⁴² Bray A, 'The Protection of Personal and Property Rights Act 1988: Progress for people with intellectual disabilities?' (1996) 2(2) *BFLJ* 51.

¹⁴³ *Re G [PPPR: Jurisdiction]* (1994) 11 FRNZ 643, [1994] NZFLR 445, 451.

¹⁴⁴ Bray A, 'The Protection of Personal and Property Rights Act 1988: Progress for people with intellectual disabilities?' (1996) 2(2) *BFLJ* 51.

¹⁴⁵ *Re L [PPPR]* [1994] 11 FRNZ 114.

¹⁴⁶ *B v B* unreported, 13 March 2007, Judge Smith, Family Court Dunedin, 2007-012-28.

¹⁴⁷ *Re LM (A Protected Person)* [1992] 9 FRNZ 555.

¹⁴⁸ *Re L* [2001] NZFLR 310

However, a welfare guardian is appointed if it is ‘the *only* satisfactory way’¹⁴⁹ of ensuring appropriate decisions are made. Therefore, even if a less demanding threshold of capacity is accepted, a welfare guardian will not be appointed if personal orders will suffice. For example in *Guardian Trust v Young*¹⁵⁰(1991, Judge von Dadelszen), the application to appoint a welfare guardian was refused in favour of a personal order. This was despite the fact that, as an elderly woman with Alzheimer’s disease, her capacity would only decrease over time.

So the difference between the tests of capacity for welfare guardian and personal orders appear subtle. What is the potential effect of this? A welfare guardian is able to consent for the subject person, as if they were the subject person.¹⁵¹ For patients where the level of incapacity is uncertain (so that both validity of consent and the ability to treat under the doctrine of necessity is debatable), having a welfare guardian to consent to procedure’s without having to recourse to the court (to assess capacity and make personal orders if appropriate), would facilitate and expedite treatment. However, by lowering the threshold of incapacity for a welfare guardian, it raises the potential for the appointment of a welfare guardian to someone who retains a level of decision making ability. This raises the potential of a welfare guardian being able to consent to treatment that the subject may be capable of consenting to, or refusing, themselves. This is against the express objectives of the PPPRA that the person be able to exercise such capacity as they have.¹⁵²

2.6 Impudent Decisions and Assessment of Capacity

The PPPRA states that jurisdiction is not established by virtue of a person making, or intending to make, a decision that a person of ordinary prudence would not make in the same circumstances,¹⁵³ and the same premise was clearly explicated in the English case of *Re T*.¹⁵⁴

¹⁴⁹ PPPRA s12(2)(b).

¹⁵⁰ *Guardian Trust v Young* [1991] NZFLR 282.

¹⁵¹ PPPRA s19.

¹⁵² PPPRA s8(b).

¹⁵³ PPPRA s6(3).

¹⁵⁴ *Re T (Adult: Refusal of Treatment)* [1992] Fam 95

However some authors have suggested that in reality the converse is true and that the competence is not assessed on the process of decision making but outcome, so

“that in deciding whether to accept a refusal of treatment, the Courts will assess the patient’s competence on the basis of the outcome of the choice that he or she has made.”¹⁵⁵

This assertion would be difficult to prove, as decisions that a ‘person of ordinary prudence’ would make are seldom challenged in Court. Generally only refusals of treatment that seem to be irrational or go against medical expectations are challenged. This was manifestly demonstrated in the caesarean cases in the UK in the 1990s,¹⁵⁶ where a number of women who refused to consent to caesarean sections were deemed incompetent, and therefore proceeding to surgery without consent was declared lawful.

However decisions under the PPPRA for medical treatment, or appointment of a welfare guardian, do not overtly demonstrate this tendency. In *Re Joe*¹⁵⁷ (1990, Judge Inglis), Joe had physical and mental disabilities and was living in squalid and unsanitary conditions. Social services believed he should be in a rest home. However, the Judge did not find him to be wholly incapacitated, and did not appoint a welfare guardian who would inevitably place him in a rest home, against ‘Joe’s’ clear wishes. Again in *Re RMS*¹⁵⁸ (1993), where the patient was elderly and requiring medical treatment, Judge Inglis observed there are two sides to the protective coin:

“...protection of the disabled person from the consequences of disability, and protection of the disabled person from intervention which crosses the threshold from protection into gratuitous interference.”

He did not make an order for the woman to be placed into care, or for a welfare guardian to be appointed, although he acknowledged that eventually the requested orders would need to be made.

¹⁵⁵ MacLean A, 'Advanced Directives and the Rocky Waters of Anticipatory Decision Making.' (2008) 16(1) *Med Law Review* 1, 6.

¹⁵⁶ *Bolton Hospitals NHS Trust v O* [2003] 1 F.L.R. 824, [2003] Fam. Law 319, [2002] EWHC 2871; *Re MB* [1997] 2 FLR 426; *Rochdale Healthcare NHS Trust v C* [1997] 1 FCR 274; *Norfolk & Norwich Healthcare Trust v W* [1996] 2 FLR 613.

¹⁵⁷ *Re "Joe"* [1990] NZFLR 260.

¹⁵⁸ *D v BMS [DDDD] (1002) 10 EDN7 287*

Conversely, some decisions on capacity may be based on the decisions that the patient has reached. In *R v M*¹⁵⁹ (2005, Judge Robinson), M decided she wanted a natural birth, but due to her mental illness she was prone to violence, putting staff, herself and her foetus at risk should she proceed. The Court held:

“she certainly displayed an appreciation of what she would undergo during her pregnancy and labour, an understanding of some of the risks involved, and an ability to manipulate the information she received, namely to follow a logical sequence of thought in order to reach a decision”

These are all indicia of competence. The Judge acknowledged that:

“If I am not satisfied that AB lacks capacity then the fact that she wishes to proceed with a natural birth, taking into account the risks that have been outlined by the psychiatrists, midwife and obstetrician, would not provide a justification for granting this application and empowering others to force birth by Caesarean section. Such a decision would be contrary to the provisions of the PPPRA.”

In the end, her incapacity was based on her inability to appreciate the risks of harm to herself and her baby arising out of her mental disorder, and not any current decisions surrounding the pregnancy and delivery.

Other cases do suggest a more overtly paternalistic attitude with the Court making orders on the grounds of what they think is best for the subject, rather intervention based on the level of incompetence. In *Re H and H [PPPR]*¹⁶⁰ (1999, Judge Inglis in a decision over property management and not medical treatment) expert opinion suggested the parties were competent, but the Court held that “the expert evidence is to be seen only as a part of the whole tapestry of fact that the Court must consider”.¹⁶¹ The intellectually handicapped couple had a financial windfall. They were held to lack capacity as: nothing in their education or background had equipped them to deal with this; they had done nothing to enhance their capabilities in this arena; Mr H demonstrated chauvinistic attitude that he should control the money to the detriment of Mrs H; he had a tendency to overspend; and while they both recognised the need to have specialist advice the Court held there

¹⁵⁹ *R v M* [2005] NZFLR 1095.

¹⁶⁰ *Re H and H [PPPR]* (1999) 18 FRNZ 297.

¹⁶¹ *Re H and H [PPPR]* (1999) 18 FRNZ 297, 212

was “no confidence in their ability to select an impeccably competent and trustworthy adviser or to judge the quality of the advice they receive”.¹⁶² Many people, who do not have an intellectual disability, would meet these criteria. While it is true that they already had property orders in situ, and this was a review of those orders, the finding of incapacity on the above criteria concentrates more on the deemed welfare and best interests than on the express objective of least restrictive intervention in the life of the subject.

¹⁶² *Re H and H [PPPR] (1999)* 18 FRNZ 297

Chapter Three:

The Objective of Least Restrictive Intervention in the Life of the Subject.

3.1 The Relationship between Least Restrictive Intervention and the Welfare and Best Interests.

Section 8 states “The primary objectives of a Court on an application for the exercise of its jurisdiction *under this Part* of the Act” (italics added). The objectives include: to make the least restrictive intervention possible in the life of the person in respect of whom the application is made, having regard to their degree of incapacity.¹⁶³ There is no express objective of acting for the welfare and best interests of the person.

Parts 2 and 9, dealing with welfare guardians and enduring power of attorney (EPOA) do not have an objectives section, but do have an express requirement for the welfare guardian or attorney to act for the welfare and best interests of the subject person.¹⁶⁴

3.2 The Tension between the Express and Implied objectives:

There is an inherent tension with in the PPPRA between the express objective of least restrictive intervention in the life of the person¹⁶⁵ and an implied objective of acting for the welfare and best interests of the person.¹⁶⁶ As Miller J said in 2004:

“the statute presumes that the welfare of a person who is subject to Part I is best served if intervention is directed to these objectives [in section 8].”¹⁶⁷

However, the least restrictive intervention possible may not always be in the best interests of a patient. This is particularly true of medical treatment where the least restrictive intervention possible may be no intervention. This potentially affects the provision of health care to the incapacitated, particularly in the arena of abortion and sterilisation.

¹⁶³ PPPRA s8(a).

¹⁶⁴ PPPRA s18(3); PPPR Amendment Act 2007 s98A (in effect from 25th September 2008).

¹⁶⁵ PPPRA s8.

¹⁶⁶ *In the matter of A* [1996] NZFLR 359.

¹⁶⁷ *KR v MR* [2004] 2 NZLR 847 860

The issue was initially discussed in *Re S (Shock Treatment)*¹⁶⁸(1992), Judge Twaddle held that the test for intervention was not what was in the welfare and best interests of the patient, but an enquiry into the degree of incapacity and then determining what is the least restrictive intervention possible in the circumstances. In that case the hospital wished to try aversion therapy, in the form of shock treatment, to stop the patient ‘ruminating’¹⁶⁹ as his health was suffering. Judge Twaddle held that this was not the least restrictive intervention and that other therapies should be tried first. Arguably, had the best interests test been applied, the aversion therapy may have been tried immediately, as no other treatment plans had been formulated, and the patient’s health was precarious. It was undoubtedly in the patient’s best interest to cease ruminating as quickly as possible. And indeed, with the benefit of hindsight, this was confirmed, as the delay in treatment resulted in S’s weight falling to a level where life-saving nasogastric feeding was required. Initially S had to be physically and pharmacologically restrained to enable this, and the nasogastric feeding was continued for twelve months, in conjunction with intensive nursing supervision.¹⁷⁰ This was far more interventionist than the proposed contingent shock therapy would have been.

In subsequent cases, Courts moved away from this isolated ‘least restrictive’ intervention possible test to the principle of paramountcy of the welfare and best interests taking into account the least restrictive means possible. As the High Court held *In the Matter of A*¹⁷¹(1996, Ellis and Doogue JJ):

“The Legislature would have expected the purpose and intention of the legislation to be given effect to without recourse to an over-refined consideration of why the Legislature may have thought it wise to use the words "welfare and best interests" in one place but not in another. It is quite apparent that the Act is concerned with the welfare and best interests of the persons in respect of whom applications are brought to the Family Court.”¹⁷²

¹⁶⁸ *Re S (Shock Treatment)*[1992]NZFLR 208.

¹⁶⁹ Ruminating is the continual regurgitating food and re-swallowing it, eventually vomiting it up.

¹⁷⁰ Mudford O, 'An Intrusive and Restrictive Alternative to Contingent Shock' (1995) 10(2) *Behavioural Interventions* 87.

¹⁷¹ *In the matter of A* [1996] NZFLR 359.

¹⁷² *In the matter of A* [1996] NZFLR 359 372

Judge Inglis adopted this in *In the Matter of A, G, W and B*¹⁷³ (1996):

“Each case, and what is required in dealing with it, must depend on its own individual facts and the welfare and interests of the particular patient, with his or her own individual needs and disabilities, treated as the first and paramount consideration.”

So it appears that the judicial interpretation grants paramouncy to the principle of welfare and best interests, with the objectives of least restrictive intervention only being aimed toward this. Potentially this could mean that a procedure could be undertaken if deemed to be more “in the best interests” than another procedure which involves less restrictive intervention. For example, it could be held to be more in the patient’s best interest to undergo a late termination of pregnancy than to allow the pregnancy to proceed to term, which would be the least restrictive intervention possible.

In *Re L*¹⁷⁴ (2001, Judge Mather) applied the same best interests test and in *Re F*¹⁷⁵ (2000) Judge Somerville applied a balancing test to see which decision would most promote the welfare and best interests of the subject, rather than the least restrictive intervention. Judge Somerville determined that the decision should be based on this, as:

“It is important to note, however, that this is not an application for an order under s 10(1)(d) and (e) but an application for approval of the exercise, by the welfare guardians, of the powers given to them by Judge Strettell. The primary objectives set out in s 8 only apply to decisions made by the Court under Part I of that Act. The present decision requiring approval is made under Part II of the Act so that the appropriate considerations are those set out in s 18(3) and (4). In deciding whether or not approval should be given to that decision, the Court must itself have regard to those same factors.”¹⁷⁶

This implies that when the decision is to empower the welfare guardian, the best interests of the subject are paramount, but when it is a personal order, the least restrictive intervention is paramount. However, in these cases the Court was dealing with issues regarding the potential relocation of residents of the Kimberly

¹⁷³ *In the matter of A, G, W and B* [1996] NZFLR 840.

¹⁷⁴ *Re L* [2001] NZFLR 310.

¹⁷⁵ *Re F* [2000] NZFLR 220.

¹⁷⁶ *Re F* [2000] NZFLR 220, 224.

Centre rather than consent to medical procedures. Has the same interpretation applied to orders relating to medical treatment?

3.2.1 Personal Orders for Medical Treatment and the Relationship between Best Interests and Least Restrictive Intervention.

In cases regarding medical treatment, the issue of which objective has paramountcy appears unresolved. This is particularly true of decisions that are irreversible in nature, and there is some inconsistency between decisions involving abortion and sterilisation, and those involving other aspects of health care.

In early cases decided before the High Court decision of *In the Matter of A*¹⁷⁷ (1996, Ellis and Doogue JJ), the least restrictive intervention approach seemed to be paramount. In *Re W*¹⁷⁸ (1994, Judge Bremner), where the patient was under the MH(CAT)A, the welfare and best interests of the patient were not discussed, but the use of personal orders authorising medical treatment, until the child was born, were considered the least restrictive intervention.

The objective of least restrictive intervention was also held paramount in *Re FT*¹⁷⁹ (1995). Judge Boshier made personal orders for the treatment of osteomyelitis based on the least restrictive intervention possible, without express reference to the welfare and best interests of the patient.

In *In the Matter of IMT*¹⁸⁰ (1994, Judge Green) a personal order for ECT¹⁸¹ was considered the least restrictive intervention, as the alternative was to utilise the MH(CAT)A to authorise treatment, which has more intrusive powers over the rights of the patient. The same reasoning was applied in *Re CMC*¹⁸² (1995, Judge MacCormick).

Had these cases been decided after *In the matter of A*¹⁸³ it is unclear if they would have been decided in the same way. It could be argued that it would be in the

¹⁷⁷ *In the matter of A* [1996] NZFLR 359.

¹⁷⁸ *Re W [PPPR]* (1994) 11 FRNZ 108.

¹⁷⁹ *Re FT* unreported, 11 January 1995, Judge Boshier, District Court, Auckland PPPR 68/94.

¹⁸⁰ *In the Matter of IMT* [1994] NZFLR 612.

¹⁸¹ Electroconvulsive Therapy.

¹⁸² *Re CMC* (1995) FRNZ 112.

¹⁸³ *In the matter of A* [1996] NZFLR 359.

patients' best interest to be placed under the MH(CAT)A to enable compulsory treatment for all aspects of their mental disorders.

After the decision *In the matter of A*,¹⁸⁴ the welfare and best interests of the patient became the paramount consideration. In *HLS v BDI*¹⁸⁵ (2005, Judge Grace) where a personal order for dental treatment was required, Judge Grace found best interests to be paramount. The issue was over whether restraint for treatment was too great an intervention. Judge Grace considered the common law test for necessity as described in *Re F*¹⁸⁶:

“It seems to me that there is a need for treatment when it is designed to preserve the life of a person or to ensure that their health and/or safety is not jeopardised by non-intervention.”¹⁸⁷

The patient's incompetent refusal of treatment was overruled. This suggests that the first consideration is whether treatment is necessary, and therefore in her best interest, then the least restrictive intervention is the last consideration.

It seems in this case was that the hospital was hoping to “cajole” the person into accepting treatment, but wanted personal orders should she refuse and they were required to use force. Judge Grace held that treatment did require authorisation as she met the threshold for jurisdiction under the Act, and therefore her consent could not be competent.

Compliance is neither consent, nor an indication of competence to consent. That the health professionals were prepared to proceed in this way possibly indicates that they thought the doctrine of necessity would cover them in the absence of using physical force, or that the reason for personal orders is to safeguard the staff from possible liability for assault or battery.¹⁸⁸ This demonstrates a misunderstanding of the purposes of the Act,¹⁸⁹ which is for the protection of those lacking capacity, and not the protection of medical staff. It reinforces the impression that the only cases proceeding to Court are those where there is marked non-compliance by the subject raising fear of liability by medical professionals over proceeding without consent.

¹⁸⁴ *In the matter of A* [1996] NZFLR 359.

¹⁸⁵ *HLS v BDI* [2005] NZFLR 795.

¹⁸⁶ *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

¹⁸⁷ *HLS v BDI* [2005] NZFLR 795,797.

¹⁸⁸ Protection from liability is undoubtedly an advantage of using the legislation, and may well encourage use of it, particularly where there is controversy over the proposed treatment.

¹⁸⁹ As expressed in the Long Title: “An Act to provide for the protection and promotion of the personal and property rights of persons who are not fully able to manage their own affairs.”

When a given treatment is the *only* choice of treatment, it has been held to be the least restrictive intervention, even when it is intrusive, such as the provision of ECT.¹⁹⁰

In cases involving the authorisation of caesarean section delivery, the best interests of the patient (and foetus)¹⁹¹ invariably appear paramount. In *In the Matter of V*¹⁹² (1997) Judge Inglis held the least restrictive intervention was secondary to the paramount consideration of patient's welfare and best interests (and that of her unborn child). The authorisation of caesarean section was granted, not because of any physical necessity, but for the potential effect on the woman's mental health. Again, in *R v M*¹⁹³ (2005, Judge Robinson) the justification for personal orders for a caesarean section under general anaesthetic, was for the safety of the subject and her child, i.e. welfare and best interests considerations. There was no discussion whether this was the least restrictive intervention possible. However, the Court made the personal orders conditional on her still being subject to a compulsory treatment order under the MH(CAT)A,¹⁹⁴ perhaps indicating that the least restrictive approach was a consideration. If she no longer met the criteria for mental disorder under the MH(CAT)A, this level of intervention would not be required.

Arguably the nature of the cases (that is, involving an unborn child) tempts the Court to put added emphasis on the welfare and best interests, rather than least restrictive intervention which may put the foetus at risk.

So it appears that after the decision of the High Court in *In the matter of A*¹⁹⁵ welfare and best interest became the paramount consideration when personal orders were made for medical treatment. However, it is not as simple as that.

3.2.2 Abortion and Sterilisation: Best Interests or Least Restrictive Intervention?

Decisions about sterilisation and abortion have irreversible consequences, and have elicited more discussion over the approach that should be taken. This is particularly true when the Court is asked to grant power to the welfare guardian to consent to the procedure, rather than making personal orders itself. The welfare

¹⁹⁰ *Re W [PPPR]* (1994)12 FRNZ 573.

¹⁹¹ *In the Matter of V* [1997] NZFLR 718, 720: "In the present case it is entirely appropriate to add the welfare and interests of the unborn child as a consideration of no less importance."

¹⁹² *In the Matter of V* [1997] NZFLR 718.

¹⁹³ *R v M* [2005] NZFLR 1095.

¹⁹⁴ Mental Health (Compulsory Assessment and Treatment) Act 1992.

¹⁹⁵ *In the matter of A* [1996] NZFLR 250.

guardian is under an express duty to act for the welfare and best interests of the subject, but judges making personal orders are under the express obligation to make the least restrictive intervention possible in the life of the subject. This was discussed in *Re H*¹⁹⁶(1993), one of the early cases abortion and sterilisation. Judge Inglis said:

“the Court, in considering whether the welfare guardian should be given power to consent to those procedures, and if so how she would be likely to exercise that power, is required to consider whether those procedures would make the least restrictive intervention possible in H's life having regard to the degree of her incapacity (s 8), and whether, if those powers were to be conferred and exercised, H's welfare and best interests, as the first and paramount consideration, would be promoted and protected (s 18(3)).”¹⁹⁷

It would seem that, even if the procedures were not the least restrictive intervention possible, but in the patient's best interests, the procedure would be authorised. In this case, Judge Inglis acknowledged there was a difficulty in that it was not possible to decide what was in H's best interest due to the severity of her intellectual disability. The power to consent to termination of the pregnancy was granted to the welfare guardian, the decision to be made according to her own conscience. However, as other non-invasive forms of contraception were available, sterilisation was not the least restrictive intervention possible nor in her best interests. Therefore it was not authorised. However, it could have been argued that a one-off procedure (especially if done at the same time as the termination) would be less restrictive intervention in the life of the patient, rather than continual provision of contraception, when both measures achieve the same ends.

In *KR v MR*¹⁹⁸ (2004) a welfare guardian sought permission to apply for a termination of pregnancy and sterilisation of the patient. The patient was opposed to both sterilisation and abortion, despite being found incapable of able to refusing treatment. On appeal to the High Court Miller J expressed reservations

¹⁹⁶ *Re H* [1993] NZFLR 225.

¹⁹⁷ *Re H* [1993] NZFLR 225.

¹⁹⁸ *KR v MR* [2004] 2 NZLR 847 860

the test for authorisation being that of least restrictive intervention as outlined in *Re S*¹⁹⁹:

“I agree with Judge Inglis that the welfare of the subject person lies at the heart of the jurisdiction under Part I of the Act. To the extent that the Family Court in *Re S (shock treatment)* [1992] NZFLR 208 held otherwise, I respectfully share his reservations regarding that decision”.²⁰⁰

However, Miller J went on to say:

“Nonetheless, from the point of view of the person in respect of whom the decision is being made, the principal objectives are a surer guide to the exercise of the decision maker's discretion than is a general appeal to the welfare principle.”²⁰¹

In the Family Court, Judge Fraser again discussed this issue, noting “It is unclear to what extent the welfare principle impacts on s 8”.²⁰² He discussed the difference in the wording between section 18(3), where the statute expressly states the welfare guardian is to consider the welfare and best interests of the person, and section 10 which does not. Judge Fraser said,

“It seems unclear, therefore, the extent to which the issue of welfare determines the position pursuant to ss 8 and 10 of the Act. As stated earlier, the need for mandatory and compellable procedures with respect to contraception force the Court's hand in that regard. Accordingly, any orders in regards to this aspect of the case will be dealt with pursuant to s 10, where the issue of promotion and protection of the welfare and best interests of the subject person cannot be relied on to the same extent as under s 18, if at all.”²⁰³

Therefore he held the least restrictive intervention was paramount and allowed the pregnancy to continue to term.²⁰⁴ It was held that sterilisation could not be performed as there were less restrictive interventions available.

¹⁹⁹ *Re S (Shock Treatment)*[1992] NZFLR 208.

²⁰⁰ *KR v MR* [2004] 2 NZLR 847.

²⁰¹ *KR v MR* [2004] 2 NZLR 847, 860.

²⁰² *KR v MR* [2004] 2 NZLR 847, 860.

²⁰³ *R v R (No 2)* [2004] NZFLR 817.

²⁰⁴ This was in part due to the late stage of pregnancy, where a termination is a more complicated procedure requiring a level of cooperation from the patient

When the Court is making a personal order for these types of medical treatments, the least restrictive intervention would appear to have ascendancy over the welfare and best interests. But when the Court is empowering a welfare guardian, the welfare interests gain precedence. This was confirmed by Judge Inglis in *Re G [PPPR: Hysterectomy]*²⁰⁵ (1993). He held the Court must first recognise the principle of least restrictive intervention but that the welfare and best interests are of first and paramount concern when granting a welfare guardian the ability to consent to a therapeutic hysterectomy. This may result in some inconsistency in the provision of health care as potentially a welfare guardian will be empowered to consent to the termination of a pregnancy (as in *Re H*)²⁰⁶ (1993, Judge Inglis), yet if the decision was made by the Court under a personal order it may not, in some circumstances, be held to be the least restrictive intervention and therefore not be authorised.

3.3 Welfare Guardian and Least Restrictive Intervention

There is no express requirement for the attorney, or welfare guardian, to act with the least restrictive intervention in the life of the person.²⁰⁷ The paramount consideration when making decisions is the welfare and best interests of the person.²⁰⁸

So whilst the Court, when making orders, must act in a way that has the least intervention on the life of the person, a welfare guardian or an attorney has no such express obligation. This may result in the attorney deciding to place the person into a rest home (perhaps in another city), or consent to treatment when a Court could not do so. Depending on the specific powers granted to the welfare guardians, they may also be able to do the same. It is ironic that, under different applications, the same piece of legislation could have such variable outcome. Until the Amendment Act²⁰⁹ came into force, there was no specific requirement for the attorney to even consider the welfare and best interests of the donor.

²⁰⁵ *Re G [PPPR: Hysterectomy]* (1993) 10 FRNZ 541.

²⁰⁶ *Re H* [1993] NZFLR 225.

²⁰⁷ As the section 8 objectives only apply to Part 1 of the Act, and the duties and responsibilities of the welfare guardian and attorneys are set out in Parts 2 and 8, it is argued they are not subject to the section 8 objectives.

²⁰⁸ PPPRA s98.

²⁰⁹ Protection of Personal and Property Rights Amendment Act 2007 s98A

However, according to Inglis,²¹⁰ the primary objectives of the Act must be applied to both the personal order and how the order is carried out. As the welfare guardian is the Court's delegate Inglis argues it is implicit that the principle of least restrictive intervention is implied into the actions of the welfare guardian.²¹¹ Nonetheless, section 8 states "Primary objectives of the Court in exercise of jurisdiction *under this part*" (italics added) which is Part 1 of the Act. The welfare guardian powers and duties are set out in Part 2 of the Act. The plain wording of the Act then seems to imply that the welfare guardians are not constrained by the least restrictive intervention. This was the approach adopted by Judge Somerville in *Re F*²¹² (2000).

As there is no requirement in the Act for the legal representative²¹³ of the patient to be informed of any decisions that the welfare guardian makes, or for any regular contact with the patient, there is no means by which to ensure the patient's rights are being realised.²¹⁴ Therefore, even if the objective of least restrictive intervention is implied into the welfare guardian's mandate, there is no satisfactory means to ascertain and ensure it is actually being adhered to.

3.4. Attorney and Least Restrictive Intervention.

Granting of an enduring power of attorney is a voluntary act performed by the competent donor. Unlike a welfare guardian the Court does not delimit the powers of the attorney upon appointment. The donor determines the scope of power the attorney has, subject to statutory restraints.²¹⁵ There is less argument here that the principle objective of least restrictive intervention is implied into the duties of the attorney, unless written into the instrument. There is no statutory requirement inform the attorney to act to ensure the least restrictive intervention in the life of the donor, and again the duties of the attorney are not set out in Part

²¹⁰ Inglis B, *New Zealand Family Law in the 21st Century* (2007), 20.2.6 (5).

²¹¹ Inglis B, *New Zealand Family Law in the 21st Century* (2007), 20.2.6 (5).

²¹² *Re F* [2000] NZFLR 220.

²¹³ PPPRA s65, a barrister or solicitor is appointed by the Court to represent the person in respect of whom the application is made.

²¹⁴ PPPRA s65(2) The barrister or solicitor must evaluate solutions for which an order is sought, taking into account the need to find a solution that has the least restrictive intervention and encourages the exercise of capacity. However, this gives no mandate to consider solutions for decisions where no personal order is being sought. But if the lawyer was informed of other decisions, and felt the welfare guardian was acting inappropriately, they could apply under s89 PPPRA for a review of the welfare guardian decisions.

²¹⁵ PPPRA s98(4) makes the attorney subject to the same limitations of the welfare guardian in s18(2), so that attorney cannot refuse standard medical treatment, consent to ECT, or consent to brain surgery for behavioural problems.

1 of the PPPRA, to which the principle of least restrictive intervention applies. While the Court may be restricted by a principle of least restrictive intervention, the attorney is not.

As the attorney can consent to treatment, or refuse treatment on behalf of the incapacitated person (subject to the restrictions in section 18(2)),²¹⁶ it is possible that they could make decisions that are more interventionist than the Court might authorise. Potentially an attorney, acting for the welfare and best interests of the donor, may decide to consent to radical invasive treatment, when a less invasive treatment may be available - perhaps consenting to surgery and not conservative management of a condition, or to treatment offered at distant facility and not locally.

Where the attorney does not act in best interests of the donor (e.g. opting for least interventionist treatment when radical surgery would have been in the patient's best interests), the Court then has discretion to revoke the appointment.²¹⁷ Deciding if the attorney has not acted in the best interest of the donor may include an assessment of how interventionist the attorney has been. So the Court may imply the objectives into the grant of attorney, even if the attorney is unaware of this responsibility. The literature suggests that there are instances of misuse of EPOA including failure to provide medical treatment or appropriate nursing care,²¹⁸ but resort to Court for remedy would appear to be exceptionally rare.

²¹⁶ PPPRA s98(4).

²¹⁷ PPPRA s105.

²¹⁸ Matthews F, 'Doctors, Elder Abuse, and Enduring Powers of Attorney' (2004) 117 *The New Zealand Medical Journal* 1202

Chapter Four:

The Express of Objective of Exercising and Developing Capacity

4.1 Welfare Guardians and the Exercise of Capacity

The other primary objective apply to Part 1 of the PPPRA is the objective of enabling the person to exercise and develop such capacity as he or she has to the greatest extent possible.²¹⁹

The issues that arise here are twofold: first that enabling the person to exercise such capacity as they have may result in a welfare guardian not being appointed in a timely manner for those of evolving and fluctuating incapacity, and secondly in some situations, contrary to this objective, there is the potential for a welfare guardian to override a competent refusal of consent.

4.2 Issues of Exercising Capacity to the Greatest Extent Possible

4.2.1 Evolving and Inevitable Incapacity and the Exercise of Jurisdiction.

Arguably, the issue of evolving incapacity is not adequately covered by the PPPRA. Even in the case of inevitable incapacity (such as progressive Alzheimer's disease) an order will not be made until the degree of incapacity warrants it. There have been a number of occasions when a welfare guardian has not been appointed, although it is almost inevitable that one will eventually be required.²²⁰

In light of the objectives of the Act, not appointing a welfare guardian before intervention is necessary, is undoubtedly correct. However, it seems counter-productive to delay the inevitable, especially when section 15 allows a welfare guardian to be appointed by consent. As the Act stipulates that the welfare guardian is to encourage the patient to exercise such capacity as they have,²²¹ it would seem more appropriate to have the guardian gradually beginning to fill the gaps in capacity act as the need arises, rather than having to react to problems once gross incompetence is manifest. As Inglis argues, the appointment of the

²¹⁹ PPPRA s8(b).

²²⁰ *Re RMS [PPPR]* (1993) 10 FRNZ 387; *Re "Joe"* [1990] NZFLR 260.

²²¹ *DDDD A 8(2)*

welfare guardian is not to be considered an act of last resort, but an appropriate measure when it is the least intrusive but the most effective intervention.²²²

Alternatively the patient has, while still competent, the option of granting an enduring power of attorney. For decisions that are not a “significant matter” the attorney may act when they believe, on reasonable grounds, that the donor is incapable.²²³ For decisions on significant matters the donor must be certified incompetent.²²⁴ This would allow the attorney to consent to minor medical treatment when the donor first shows signs of incompetence. As the power of attorney is voluntarily granted by the attorney, there is at least the possibility that there was some discussion between them as to the types of treatment or care the donor would like to receive.

But what if the competent person refuses to appoint an attorney, even in the face of inevitable incapacity? In this situation it would be useful to have a third option of a court-appointed attorney/guardian, granted while the person is still competent, but like an attorney only empowered to act as the patient becomes incapable. The objectives of the PPPRA could be written into the mandate for this role. This ensures that the rights of the patient are protected and that decisions are made in a timely fashion, rather than waiting until a crisis occurs. It is undesirable to have to rely on multiple personal orders, granted as competence deteriorates, to achieve this.

4.2.2. Fluctuating Incapacity

In cases of fluctuating competence, where the person apparently competently consents to medical treatment, and then apparently incompetently refuses or withdraws consent, it would be useful to have a welfare guardian who could then consent on their behalf. This was the reasoning behind the Doctors seeking the appointment of a welfare guardian to consent to treatment for a brain tumour in *B v B*²²⁵ (2007, Judge Smith). However, it has been held that a welfare guardian may only be appointed if the subject meets the criteria of incompetence at the

²²² Inglis B, *New Zealand Family Law in the 21st Century* (2007), 20.2.4.

²²³ PPPR Amendment Act 2007 s98(3)(b), (in force 25th September 2008).

²²⁴ PPPR Amendment Act 2007 s98(3)(a), (in force 25th September 2008).

²²⁵ *B v B* unreported 13 March 2007 Judge Smith Family Court Dunedin 2007-012-28

time of application, and not for some future time when might lack capacity *and* require intervention.²²⁶

Alternatively, consent or refusal of treatment could be by advanced directive. The idea of a psychiatric advance directive has been mooted.

“Psychiatric advance directives are intended for persons who already have experienced the sort of crisis that they anticipate may recur. Thus they are able to use their past experience to better plan for their needs in similar situations in the future.”²²⁷

However, the authors also felt, at least with regard to participation in research, that the appointment of a surrogate decision maker was more important for protecting rights, than a detailed directive.

It could seem that an EPOA would solve problems of authorising consent to treatment for a person with fluctuating capacity, as it becomes active when the donor becomes incapable. However, if the patient regains competence presumably the attorney then loses the power to act. When, and who, decides this is not clear, again raising the possibility of the competent refusal being overridden. Additionally, as the donor must be certified incompetent²²⁸ before the attorney can make important decisions on their behalf, there is the potential for multiple or repeat certifications, with consequential delays before the attorney can act.

There is a problem if the attorney wishes to refuse consent to treatment, on instructions made by the donor when competent. The attorney, like the welfare guardian is unable to refuse consent to standard medical treatment or procedure intended to save the persons life or prevent serious damage to the person's health.²²⁹

²²⁶ *Vukor v McDonald* [1998] 17 FRNZ 545. In this case the patient did lack capacity at the time, but the jurisdiction was not exercised, as he was under the MH(CAT)A, and required no further intervention.

²²⁷ Backlar P, 'A choice of one's own research advance directives: Anticipatory planning for research subjects with fluctuating or prospective decisionmaking impairments' (1999) 7(2) *Accountability in Research* 117,121.

²²⁸ PPPR Amendment Act 2007, s98(3)(a).

²²⁹ PPPR Amendment Act 2007, s98(3)(a).

4.3 Appointment of a Welfare Guardian by Consent

Section 15 enables the appointment of a welfare guardian by consent. This section seems to run counter to the whole philosophy of the Act, as it almost implies that the presumption of capacity does not have to be rebutted to proceed under it. It is easy enough to imagine scenarios where property orders could be made with consent, for example the elderly who may recognise they are struggling to understand complex financial or business transactions. Even consenting to some personal orders made for complex medical treatment could be understandable, but the appointment of a welfare guardian by consent seems an extreme solution. If the person has the ability to consent, then it would seem more appropriate to donate an EPOA which would then activate if they became incapacitated. Otherwise, there is a risk that a competent person, who consents to having a welfare guardian appointed, could then have their own competent refusal of consent overruled by the welfare guardian. Alternatively they may not be given an opportunity to give informed consent to a procedure.

This reservation has been expressed by the courts.²³⁰ Consequently it has been held that a welfare guardian be appointed by consent, only in the rare instance when a person wholly lacks capacity to make decisions, but is able to recognise this.²³¹ In general the ability to consent has been held as evidence that the person has not rebutted the presumption of capacity and jurisdiction is not established.²³²

It would seem useful to be able to employ this section for patients with fluctuating incapacity. They could consent to the appointment of a welfare guardian during periods of lucidity, and the welfare guardian could act on their behalf during periods of incompetence. The problem is, during the periods of lucidity they may not reach the jurisdictional criteria of incompetence to enable the appointment of a welfare guardian.²³³

Possibly appointment by consent could be appropriate in situations where the person is becoming so physically incapacitated that communication is becoming physically impossible (perhaps with motor neurone disease, or other progressive

²³⁰ *In the matter of M* [1994] NZFLR 164; *Re "Rosemary"* [1990] 6 FRNZ 479.

²³¹ Arguably, the type of scenario where appointment by consent would be appropriate was demonstrated in *B v B* unreported, 13 March 2007, Judge Smith Family Court Dunedin, 2007-012-28. There, due to compliance and capacity issues, doctors were unwilling to start treatment of B without the appointment and consent of a welfare guardian. Eventually B (unwillingly) seemed to accept this appointment was necessary for her to receive treatment.

²³² *In the matter of M* [1994] NZFLR 164; *Re "Rosemary"* [1990] 6 FRNZ 479.

degenerative diseases affecting both speech and motor skills), so that a welfare guardian would be the only practical means of granting consent. Although it would be more appropriate to employ an EPOA to achieve this, in the borderline situation, where the patient may not yet wholly lack the capacity to communicate, but it is extremely difficult to do so, the welfare guardian appointed by consent would be able to act, even when an attorney may not.

4.4 Partial Incapacity and Appointment of a Welfare Guardian

Capacity has been described as a continuum, with full capacity at one end and full incapacity at the other.²³⁴ How far along the continuum the person is, relative to the seriousness of the decision, will determine if they have the requisite capacity to make that particular decision. Therefore it can be difficult to determine the boundary between a person who partly lacks capacity and one who wholly lacks capacity for a particular decision.²³⁵

The patient may be cognitively unable to appreciate or evaluate the risks, or expected outcomes, of a proposed treatment plan - although it is conceivable that he may appreciate the risks of the individual components of that plan. Thus, a patient with diminished capacity may be capable of consenting to a blood test or scan for diagnosis, but not have the requisite capacity to be able to consent to the treatment for the disease itself.

A welfare guardian is appointed for persons who wholly lack the capacity to make decisions “relating to *any particular aspect or particular aspects* of the personal care and welfare of that person”.²³⁶ This raises the potential to appoint a welfare guardian for someone who still retains some level of capacity in other areas. And although the court order may delimit the welfare guardian’s powers, there is potential for a court order that encompasses areas where the person retains competency.

If authorisation for treatment is required for something beyond what the welfare guardian has been empowered to consent to, the matter is remitted back to Court, and the capacity requirement will be re-examined.

²³⁴ Gunn M, 'The Meaning of Incapacity' (1994) 2 *Med Law Review* 8.

²³⁵ *NZ Guardian Trust v Young* [1991] NZFLR 282.

²³⁶ *DDDD A 612(2)*

As with mental illness,²³⁷ even when the patient has been appointed a welfare guardian, the presumption of capacity for individual decisions is not rebutted. In *KR v MR*²³⁸ (2004) Miller J held that:

“the question of capacity to make the decision that is the subject of the application is a threshold question that must be considered in every case, because jurisdiction to make any order under s 10 depends on it.”²³⁹

It seems counter-intuitive, that someone who wholly lacks capacity to the extent that a welfare guardian is appointed, could then be considered capable to make other decisions. However, a welfare guardian is appointed when the patient wholly lacks capacity in ‘particular aspects’ of their personal care and welfare.²⁴⁰ As was pointed out by Judge Inglis *In the Matter of F (No3)*²⁴¹ (1992) “there is a need to intervene only in the areas where the subject’s blind spot creates incompetence.” A patient may still retain capacity to consent to some medical procedures, despite having a welfare guardian for other aspects of their personal care and welfare. But what of the situation where the welfare guardian is granted the authority to consent all medical treatment?

In the case of *B v B*²⁴² (2007, Judge Smith), the application for a welfare guardian was instigated by the medical professionals in charge of her treatment. Her incapacity was sufficient for the appointment of a welfare guardian even though she was (currently) consenting to the medical treatment proposed. She had previously executed an EPOA, but the medical professionals did not believe she had capacity at the time of its execution, and refused to act on the authorisation of the attorney. They also believed any consent or refusal now elicited would not be competent, and despite believing the surgery to be in her best interests, refused to operate without the appointment and consent from a welfare guardian.

She did not want a welfare guardian,

“T’s articulated view is that no order is necessary whatsoever. In my view, T was able to articulate clearly, her distress at the invasive nature of the Orders being proposed under the

²³⁷ *In Re C (Adult: Refusal of Medical Treatment)* [1994] 1 All ER 819, C had a mental illness but was capable of refusing consent to non-psychiatric treatment.

²³⁸ *KR v MR* [2004] 2 NZLR 847.

²³⁹ *KR v MR* [2004] 2 NZLR 847, 854.

²⁴⁰ PPPRA s12(2)(a).

²⁴¹ *In the Matter of F (No 3)*, 31 January 1992 Judge Inglis, District Court Levin PPPR 031 020 91.

²⁴² *B v B* unreported, 13 March 2007, Judge Smith, Family Court Dunedin, 2007 012 28

Protection of Personal Property Rights Act 1988. She intuitively understands, if not cognitively so, that such Orders remove from her, even if exercised in the most caring and least destructive ways, her ability to manage her own personal property and financial affairs herself. In that regard, T has some significant insight, in my view, as to the effect of any such Orders.”²⁴³

The finding of incapacity was almost forced upon the Judge, who clearly had reservations, but accepted the findings of the clinician. The patient too seemed to accept that to get the medical treatment she required, a welfare guardian would need to be appointed, at least on an interim basis.

A welfare guardian was appointed for six months and granted broad ranging powers to the welfare guardian. They included: To consent to any medical procedure whatsoever; administration of any medicine and determination as to post-surgery care of both medical and residential requirements.²⁴⁴ Although by virtue of section 18(3) of the Act the welfare guardian must act in the patient’s best interests and encourage the person to develop and exercise such capacity as that person has,²⁴⁵ the welfare guardian has the ultimate “signing power” and may override the wishes of the patient.

Conceivably in this situation the patient may be competent or have regained competency. It is then possible the welfare guardian may consent to follow up treatment such as chemotherapy, even although the patient may competently decide that the treatment side-effects are so unpleasant she wishes to discontinue it; or that her expected quality of life after the surgery so low that she wishes to cease treatment altogether. Statutorily, the clinician is under no obligation to see if the patient concurs with the decision of the welfare guardian, or give effect to their wishes if they are not in agreement.²⁴⁶

Alternatively, the welfare guardian may agree with the patient that continuing treatment is not in her best interests. However the welfare

²⁴³ *B v B* unreported, 13 March 2007, Judge Smith, Family Court Dunedin, 2007-012-28, para 11.

²⁴⁴ *B v B* unreported, 13 March 2007, Judge Smith, Family Court Dunedin, 2007-012-28.

²⁴⁵ PPPRA s18(3).

²⁴⁶ PPPRA s10(2).

guardian may not refuse to consent to any standard medical treatment or procedure intended to save that persons life, or prevent serious damage to their health.²⁴⁷ The issue may then revolve around defining 'standard medical treatment' (if not standard treatment the welfare guardian could withdraw consent). However, it is likely the clinician will make his own assessment of the patient's capacity, and in discussion with the patient and welfare guardian reach a decision.

Similar issues may arise when welfare guardians are faced with end of life decisions. If, for example, standard medical treatment for pneumonia is the provision of antibiotics, they would be unable to refuse this treatment, even if the treatment is only prolonging the inevitable in a terminally ill person. If the doctor felt ethically obliged to seek the consent of the welfare guardian (to not provide treatment) rather than to simply not treat, then the welfare guardian could not provide this consent, placing the doctor in an unenviable position.

The alternative is to make personal orders for the provision of medical treatment, in broad terms, allowing the doctors to treat in the patients best interests. In *Re W*²⁴⁸ (1994) a pregnant woman was too incapacitated to consent to procedures surrounding the delivery of her baby. Judge Bremner did not appoint a welfare guardian to provide consent, as the decisions needing to be made were medical, so he granted a personal order to achieve this end.²⁴⁹ However, Judge Bremner did point out that the orders were for a specific event (i.e. the birth of the child) and not longer term medical care where the appointment of a welfare guardian may have been appropriate.

A difficulty arises where the personal order directs or empowers the medical fraternity to treat, in situations where the patient may not be completely incompetent. The doctors then have court sanctioned approval to overrule a potentially competent person's refusal of consent. If they choose not to, then refusing to comply with a court order may potentially place them in contempt of court.²⁵⁰ However, the risk of this is negated if

²⁴⁷ PPPRA s18(1)(c).

²⁴⁸ *Re W [PPPR]* (1994)11 FRNZ 108.

²⁴⁹ Under PPPRA s10(1)(f).

²⁵⁰ Contempt of Court is any action that disregards the authority of the Court. A person may be in contempt of Court when they disobey Court orders. *Buttworths Law Dictionary*, 6th

the court order merely authorises rather than compels treatment. The potential remains for both personal orders and welfare guardians to overrule the wishes of a partly competent person, in their zone of competence. This is a far cry from promoting the exercise of capacity.

Even if the patient is incompetent, but strenuously refusing treatment, there may be a clash between the medical ethics of enforced treatment and the legal power to do so. This would be especially relevant if the treatment was not for an underlying mental disorder (causing the incompetence) or a life threatening condition. As Judge Inglis said *In the Matter of F*²⁵¹:

“It is another thing for the Court to say that a surgeon must forcibly carry out that treatment against the patient’s stated opposition, despite the patient’s lack of capacity to consent or oppose. That is a problem of medical professional ethics into which the Courts ought not to trespass. All the Court can say that if appropriate medical treatment were carried out on Mrs F with her welfare guardian’s consent, such treatment would be lawful.”

Failure to carry out treatment may leave the clinician open to criminal liability if the health or safety of the patient under his care is endangered.²⁵²

So where does this leave us? The express objective of the PPPRA is to allow the subject to exercise as much capacity as they have to the greatest extent possible.²⁵³ Whilst the PPPRA is designed for the protection of rights, it appears that rights, such as the right to refuse treatment, *could* sometimes be overridden.

In particular as the level of incapacity required for the appointment of a welfare guardian has been applied inconsistently, potentially allowing for the appointment to be made to a partly capable person. This may result in the patient’s competent consent (or refusal) being overruled.

ed.(2005).The jurisdiction exists to ensure that Court orders are complied with *Taylor Bros. Ltd v Taylors Group Ltd* [1991] 1 NZLR 91, 93.

²⁵¹ *In the matter of F (No 3)* (1992) 31 Jan 1992, Judge Inglis FC Levin, PPPR 031 020 91.

²⁵² Crimes Act ss 160, 151(2), 160(2)(b), s145.

²⁵³ *DDDD A 68(b)*

At the other end of the spectrum, for patients with inevitable or fluctuating incapacity there is little ability to provide protection until such time as they become manifestly incompetent, which may result in a delay in obtaining treatment in situations where their competence is only dubious and their ability to refuse treatment unclear.

Chapter Five

Conclusions

Failures in the Application of the Objectives of the Act.

The PPPRA provides a mechanism to provide consent or authorisation to medical treatment for incapacitated patients. The objectives of the Act are to make the least restrictive intervention in the life of the patient, and to enable and encourage them to exercise and develop such capacity as they have to the greatest extent possible. Despite these objectives, decisions are often not based on the least restrictive intervention, but on the welfare and best interests of the patient which is not an express objective of the PPPRA. The result is that a patient may be subjected to a more invasive procedure if deemed in their best interests, even if a less invasive procedure was available, for example, a general anaesthetic for a caesarean section rather than a natural delivery.

Although there is no express objective for acting for the welfare and best interests of the patient, the Courts usually apply this as a paramount principle when making personal orders for medical treatment. This means for the majority of decisions, an implied provision has greater influence than an express objective. However, this is not consistently applied and when the decision involves controversial procedures, such as sterilisation and abortion, the principle of least restrictive intervention seems to gain ascendancy. As a result of this is there is inconsistency in applying the objectives of the Act, leading to uncertainty in the law. It is possible then, that rather than face this uncertainty of outcome, that Doctors may not seek Court authorisation for some procedures (for example sterilisation) but treat patients under the Doctrine of Necessity, defeating the purpose of the Act.

Another complicating factor is whether a Court is authorising a welfare guardian to consent for treatment (in which case, under section 18(3) the welfare guardian has a duty to act for the welfare and best interests of the patient), or if a Court is making a personal order under section 10(1)(f) which is subject to the objective of making the least restrictive intervention in the life of the patient. If the objectives are antipathic (e.g. a non-therapeutic abortion may be in the patients best interests, but is not the least restrictive intervention possible) this leaves the Court in a difficult position. The two methods of resolving this seem to be either by making a personal order instead of granting authorisation to the welfare

guardian (and therefore applying the principle of least restrictive intervention),²⁵⁴ or grant authorisation to the welfare guardian and give paramountcy to the welfare and best interests.²⁵⁵ This inconsistency in application could mean different outcomes on the same facts.

Additionally as the objectives in section 8 apply only to Part 1 of the Act,²⁵⁶ it is argued that the welfare guardian and attorney are not expected to act to ensure the least restrictive intervention possible in the life of the patient but only for their welfare and best interests. Therefore they are able to make decisions that involve more intervention than a Court could authorise via a personal order. Again, this would appear to defeat the objectives of Part 1 of the Act.

However, in reality it is likely that on many occasions the concepts of least restrictive intervention and acting for the welfare and best interests of the patient achieve the same outcome. The Act does provide a forum for the merits of each procedure to be traversed, which therefore protects the patient rights.

The other objective in section 8 is to enable a person to exercise such capacity as they have. A person is unable to exercise capacity if their competent consent is overridden. The provisions within the PPPRA can be interpreted, or applied, so that a partly competent person's refusal for consent to treatment can be overridden by a welfare guardian, even though the decision was made in their zone of competence.

Although the appointment of a welfare guardian can only be made if the person wholly lacks capacity to make decisions in a particular aspect of their personal care,²⁵⁷ the inability to make decisions has been interpreted as the inability to make meaningful²⁵⁸ or important decisions,²⁵⁹ which is a lower level of incapacity and could result in the partly incapacitated person being appointed a welfare guardian with extensive authority, potentially overriding competent decisions.

As the incapacity need only relate to one aspect of the persons welfare, again there is the potential for a welfare guardian to be appointed to fill this gap in capacity, but for authority to stretch beyond it. For example, if a welfare guardian

²⁵⁴ *R v R* (No 2) [2004] NZFLR 817.

²⁵⁵ *Re H* [1993] NZFLR 225.

²⁵⁶ PPPRA s8.

²⁵⁷ PPPRA s12(2).

²⁵⁸ *Re G [PPPR: Jurisdiction]* (1994)11 FRNZ 643.

²⁵⁹ *Re L [PPPR]* (1994) 11 FRNZ 114.

is appointed to consent to all medical treatment relating to a particular condition, (e.g. removal of a brain tumour) but the patient still retains a degree of capacity, the welfare guardian may overrule a competent refusal of consent for a part of that treatment, such as a scan or blood test. Although the appointment of the welfare guardian must be the only satisfactory way to ensure appropriate decisions are made, some of the appointments appear to be made even when personal orders would suffice, suggesting this objective is also not strictly adhered to.

Additionally there is provision for the appointment of a welfare guardian by consent.²⁶⁰ For this consent to be valid the subject person must retain a level of competence. This raises the potential for a welfare guardian being appointed to a partly competent person and their authority to extending into their zone of competence. For example, if appointed to consent for medical treatment, this may mean they can override a person's decision for any procedure, even if that person still retains enough competence to consent or refuse some procedures.

While there is no clear evidence that competent consent is being overridden by welfare guardians, the potential to do so (contrary to the objectives of the Act, the doctrine of informed consent and the Code of Patients' Rights), should be taken into consideration when considering an application for the appointment of a welfare guardian.

Issues of evolving and fluctuating incapacity are not adequately dealt with under the PPPRA. Until the person has reached the jurisdictional criteria of incapacity there is no means of putting in place protective measures. In light of the wording of the PPPRA this is undoubtedly correct, but for persons who have fluctuating incapacity or whose capacity is inevitably failing, these provisions act counter to their best interests of having someone available to step as their incompetence becomes manifest, rather than having to apply to the Court at that stage with its inevitable delays. Although an enduring power of attorney would be appropriate at this stage, this relies on a competent donor deciding to grant one in advance.

The objectives of the PPPRA should provide the framework on which all decisions are reached. So it is unfortunate that there is a lack of clarity as to when

²⁶⁰ DDDDA 615

and to whom the objectives apply. This could be rectified with making the section 8 objectives explicitly applicable to all parts of the PPPRA or by building them into the provisions relating to the welfare guardian and attorneys. Likewise, express mention of the welfare and best interest paramountcy principle in section 8 would provide clarity to the PPPRA. The issues around the potential for a welfare guardian to be appointed to a person retaining capacity are not easily solved, except by careful consideration at the time of the appointment, with instructions that where the patient retains competence the welfare guardian may not override their decisions. However, this would be difficult to enforce, and it is not clear that this potential conflict occurs in reality. Additionally, it is hoped that medical professionals will assess the competency of their patients during treatment and act appropriately.

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