

SAVE THE CHILDREN?

*Processes and principles to be applied when the
court is asked to override parents' refusal to
consent to a child's life-saving medical treatment*

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I. INTRODUCTION

In February 1999 New Zealand's attention was focused on a three-year-old boy and his family, hiding out far from home. They were hiding from the "uncompromising approach" of HealthCare Otago who had been administering the child's chemotherapy treatment.¹ Soon they were also hiding from the court order that took custody away from the parents and made the young boy a ward of the state.

Liam Williams-Holloway was three years old when he was diagnosed in November 1998 with neuroblastoma, a life-threatening child cancer. Liam's oncologist prescribed the treatment "rapid cojec" comprising seven intensive chemotherapy sessions at ten day intervals followed by a stem cell transplant and a course of cis-retinoic acid.² The second session was just before Christmas and while there were no medical complications, Liam was not coping well. He was using a wheelchair, wetting the bed, had diarrhoea and repeatedly told his parents that he didn't want the treatment.³ After Christmas he suffered a severe nose bleed, vomited up coagulated blood, and required a blood transfusion.⁴ His parents, who were firm believers in natural therapies, wanted to try something less invasive. They had read about the quantum booster, an alternative cancer treatment, and wanted to give it a go.⁵ When HealthCare Otago said any alternative therapy would have to go alongside chemotherapy and not in place of it, Liam and his parents disappeared.⁶

After it became clear that the family would not return, HealthCare Otago made an ex parte application to the Dunedin Family Court, seeking an order placing Liam under the

¹ "Parents of young cancer sufferer to remain in hiding", *The Otago Daily Times*, 13 February 1999, 1

² Dr Sullivan (interview).

³ "Liam's little miracle", *New Idea*, 24 May 1999, 5.

⁴ *Holmes*, 6 May 1999, Television New Zealand, TV1 7:00pm, per Brendan Holloway.

⁵ The quantum vibration machine reportedly vibrates at a specific frequency, killing cancer cells and parasites in the body; "The cure", *Listener*, 29 May 1999, 21.

⁶ Dr Sullivan emphasised that the parents disappeared into hiding *before* any action was taken, so it was not a case of the court action forcing them to become fugitives. In fact, the parents' "covert" action was one of the reasons Dr Sullivan did decide it was necessary to go to court; (interview).

guardianship of the court. The order was granted and consent was granted for the medical treatment.⁷ With the goal of aiding efforts to find Liam and his parents, the Family Court released details of the case to the media.⁸ The public's interest was aroused before a "media gag" was imposed just two weeks later.⁹ At the same time, unbeknownst to the media, the treatment order was suspended and an order was made that Liam could not undergo chemotherapy without consent from the court.¹⁰ The intention of these orders was to encourage Liam's parents, who were frightened and needed time to "think and reflect", to produce him for assessment only.¹¹ However they refused to come out of hiding until all the orders were completely discharged.

Eventually it became clear that Liam's best interests were not being advanced by the continuing delay. Through their lawyer, the parents gave an undertaking that Liam would be returned for assessment if all orders were discharged.¹² Fifteen weeks after

⁷ 22 January 1999; *HealthCare Otago v Williams-Holloway*, unreported, Family Court Dunedin, 18 March 1999, Judge Blaikie, FP 012/23/99. Ten days later, on 1 February 1999, the Children, Young Persons and Their Families Agency applied for and was granted custody of Liam. A warrant was issued to enforce the custody order.

⁸ *Idem*; 11 February 1999; Judge Blaikie said that in hindsight, it may have been the wrong thing to do, as the media frenzy that ensued took the focus away from Liam. In late February rumour got out that Liam and his family had been found, and television cameras set up to film the "tug of war" that would ensue when the police tried to remove Liam from his parents' custody. This was clearly not in Liam's best interests. It became clear that the media and the parents had contact, indicated by the fact that the television media had information regarding confidential directions issued by the court; Judge Blaikie (interview).

⁹ *HealthCare Otago v Williams-Holloway*, unreported, Family Court Dunedin, 25 February 1999, Judge Blaikie, FP 012/23/99; application by HealthCare Otago and supported by counsel for child and CYPFA. Judge Blaikie said that "the continuing media interest" in Liam's whereabouts was "likely to have an adverse effect on the child's privacy and may be a contributing factor in the parents' decision to remain in hiding." The media appealed to the Family Court, which dismissed the appeal; *HealthCare Otago v Williams-Holloway*, unreported, Family Court Dunedin, 4 March 1999, Judge Blaikie, FP 012/23/99. It was then appealed to the High Court who held that the Family Court judge had not given suitable consideration to the freedom of expression in the New Zealand Bill of Rights Act 1990, and that the "gag order" was not specific enough. The right of freedom of speech should not be suppressed unless it impinges on the rights of the child. The case was sent back to the Family Court for reconsideration; *Newspapers Publishers Association of New Zealand (Incorporated) v The Family Court* [1999] NZFLR 397. The media gag was later lifted when all the orders were discharged; *HealthCare Otago v Williams-Holloway*, unreported, Family Court Dunedin, 6 May 1999, Judge Blaikie, FP 012/23/99.

¹⁰ *Williams-Holloway*, 25 February 1999, supra n 9; The treatment order was suspended three days after Liam's parents applied to have all the orders discharged. They were told to file affidavits in support of that application but never did so.

¹¹ Judge Blaikie (interview).

¹² Dr Sullivan did not believe that it was too late to help Liam, and wanted to assess and re-discuss his treatment. If assessment showed that the cancer had spread, then further treatment would not be recommended because it would be too late for a cure; (interview).

the initial application, the Family Court discharged all the orders.¹³ Liam and his family came out of hiding and were headline news in the media.¹⁴

This case highlighted the difficulty faced by the court when asked to make these decisions. This thesis will suggest a process that should be followed by a court asked to override parents' refusal to consent to medical treatment for their children, when that refusal will, in the medical opinion, result in the child's death.¹⁵

By outlining the history of the guardianship and wardship doctrines it will be shown that both the High Court and the Family Court have the jurisdiction to intervene in cases where parents have refused to consent to necessary life-saving treatment. After a brief outline of some of the procedures available to the Family Court, the principles that are apparent from the cases in this area will be analysed and other relevant principles will be considered. Through an application of those principles to Liam Williams-Holloway's case, it will be shown that while in most cases preservation of life will be the primary goal, other principles are also relevant, and in some cases, will outweigh the presumption of preservation of life.

¹³ *Williams-Holloway*, 6 May 1999, supra n 9; The application was made by HealthCare Otago and had the approval of the Director-General of Social Welfare and counsel for child.

¹⁴ The suspicion that the parents were in contact with the media was confirmed on 6 May 1999, as Liam and his parents were interviewed by TVNZ several hours before the decision discharging the orders was delivered; Judge Blaikie (interview). In spite of the parents' undertaking, Liam has never been returned to the hospital, and it is rumoured that his condition has deteriorated. While the parents have stated that they would bring Liam in for assessment if they saw evidence that the alternative treatment had not worked, Dr Sullivan noted that by the time Liam shows visible signs of illness, the cancer will have progressed too far to be able to treat; (interview).

¹⁵ This thesis will not discuss the further issues that are raised when the child is competent to understand the situation and express his or her own views, and for that reason focuses on cases involving pre-school aged children.

II. THE EVOLUTION OF GUARDIANSHIP AND WARDSHIP

Before discussing what process and principles the courts use when deciding whether to intervene with parents' refusal to consent to their child's medical treatment, it is necessary to establish whether the courts have the jurisdiction to consider the problem at all. This question can be answered by examining the roots of the guardianship and wardship doctrines to establish whether they do extend to such situations.

A. Historical background

In ancient Roman times, a father had full rights of ownership over his children. He could sell, marry off or even kill his children with no intervention from the state. His absolute rights stemmed from the *patria potestas* doctrine and the belief that because he gave his child life he could control it.¹⁶

Centuries later in feudal times fathers still had absolute guardianship rights to the exclusion of the mother, although those guardianship rights were somewhat more limited than in Roman times. A father had a right over the person of his child and could inflict reasonable punishment upon it, but would be criminally liable for abuse of the child.¹⁷

It was in feudal times that the doctrine of wardship emerged, and was used primarily to exploit orphaned children.¹⁸ When a tenant who held land under military tenure died and left an orphaned heir, the landlord resumed control of the land and became the child's guardian, responsible for the maintenance of the child. The landlord could then

¹⁶ Dannenbring R, *Roman Private Law*, (translation of Max Kaser, *Romisches Privatrecht*), (1968, 2nd ed) Butterworths, at 256.

¹⁷ Blackstone, *Commentaries on the Laws of England*, vol I, at 452.

¹⁸ Lowe N V & White R A H, *Wards of Court*, (1979) Butterworths, at 1.

ensure the child would grow up to be a good tenant, and in the case of females, could ensure she did not marry an enemy.¹⁹ As guardian of the child the landlord kept all the profits generated from the child's property until it reached majority.²⁰ The landlord also had property rights in the person of the heir and could sell the child's marriage for his own profit. This made it a lucrative business for landlords, and one that ensured the child's exploitation for profit.

When a tenant-in-chief died, the orphaned child became a ward of the Crown with the state fulfilling the role of guardian.²¹ Again the doctrine was used to generate profit for the state, and the personal well-being of the child was not a major consideration, although the Crown was charged with the maintenance and education of the wards. In fact, wardship was so profitable for the Crown that in 1540 the Court of Wards was established to enforce the Crown's rights of wardship over the orphaned heirs to tenants-in-chief.

In contrast with military tenure was the socage tenure system.²² When a tenant of land held in socage died, his child was placed under the guardianship of the nearest relative who controlled the child's property and person until majority.²³ Guardians were not able to exploit the child's property for profit, as there was an obligation to protect the ward's interests. This form of wardship was not used as a source of revenue, as it was in military tenures, but was more protective.

In 1660 the Tenures Abolition Act abolished military tenures and replaced the Court of Wards with the Court of Chancery. Since the fourteenth century the Court of Chancery had been exercising jurisdiction over heirs in relation to custody and property disputes,

¹⁹ Holdsworth, *A History of English Law*, (1966, 5th ed) vol iii, at 61.

²⁰ The age of majority for males was 21 years, and for females was between 14 and 21; Seymour J, "Parens Patriae and Wardship Powers: Their Nature and Origins", (1994) 14 *Oxford Journal of Legal Studies* 159, at 163.

²¹ A tenant-in-chief leases land direct from the Crown.

²² Seymour, *supra* n 20, at 163.

²³ Under socage tenure the age of majority was 14 for both males and females; *ibid* at 164.

but did not yet have a parental role.²⁴ It was accepted that the King, and through him the Court of Chancery, had the obligation and the right under the *parens patriae* doctrine to supervise all children in the state. Under the Court of Chancery, wardship from military tenures gradually gave way to the socage form of wardship, which was far less exploitative. Wardship was still used exclusively to protect the property of wealthy children, but once a child was under the umbrella of the Crown's protection, wardship was exhaustive and "tried to offer all the protection of a parent."²⁵

By the early eighteenth century the court felt able to override the wishes of a father regarding a testamentary guardian.²⁶ In 1790 the court's jurisdiction widened even further to allow the protection of a child from his living father.²⁷ By the nineteenth century the use of wardship as a parental jurisdiction under the *parens patriae* doctrine was clearly recognised and the emphasis on personal protection became prominent.²⁸ The need for the child to possess property before the state could intervene was finally abandoned in 1847.²⁹

The nineteenth century showed the first signs of the state's willingness to interfere with family life, both through the court's *parens patriae* jurisdiction and in legislation. In 1886 the welfare of the child principle was first introduced into custody law.³⁰ While the child's welfare was not yet the paramount consideration,³¹ this was the first piece of legislation to place clear emphasis on the child's interests.³² It resulted in a change in attitude by the courts and in 1893 the Court of Chancery said that the welfare of the

²⁴ Ibid at 166.

²⁵ Report of the Committee on the Age of Majority (1967) Cmnd 3342 para 193, cited in Lowe & White, supra n 18, at 5.

²⁶ *Beaufort v Berty* (1721) 24 ER 579.

²⁷ *Creuze v Hunter* (1790) 30 ER 113.

²⁸ Bevan H K, *The Law Relating to Children*, (1973) Butterworths, at 411.

²⁹ *In re Spence* (1847) 41 ER 937.

³⁰ Guardianship of Infants Act 1886 (UK), s 5. The first reference to child's welfare was actually in the Custody of Infants Act 1873 (UK) which permitted a father to give custody to the mother, provided it was for the child's benefit.

³¹ The welfare of the child was ranked equally with other considerations.

³² This legislation was adopted in New Zealand in the Infants Guardianship and Contracts Act 1887 and later re-enacted in the Infants Act 1908, s 6.

child was the “dominant” matter for consideration by the court.³³ The legislature adopted this approach in 1925 by giving the welfare of the child express paramountcy.³⁴ The introduction of the welfare paramountcy principle was not considered at the time to be a major legislative change and received “scant attention in the legislative debates”, but it was in fact a major breakthrough and has led to the courts having a wide discretion in all cases involving children.³⁵

The gradual change from total patriarchal autonomy to a greater state interest in children’s welfare can be seen. Clearly in Roman times a father would have had the right to consent to or refuse medical treatment for his child. In England the state’s jurisdiction gradually widened from only orphaned heirs with property to all children in the state. As the state’s jurisdiction widened, parents’ powers were narrowed.

B. Modern law

The law of wardship is today governed by statute, although the inherent jurisdiction of the High Court under *parens patriae* remains.³⁶ An application can be made to the

³³ *In re McGrath (Infants)* [1893] 1 Ch 143, at 148.

³⁴ Guardianship of Infants Act 1925 (UK), enacted in New Zealand as the Guardianship of Infants Act 1926; Mothers’ rights were also highlighted, and the Act stated that both parents should be on equal legal footing, subject to the welfare of the child. Until the mid-nineteenth century fathers had had the sole right to guardianship of their children. A mother’s only chance to gain guardianship and custody had been to show that the father was unfit due to “cruelty or of contamination by some exhibition of gross moral profligacy”; *R v Greenhill* (1836) 111 ER 922, 928. A major campaign by women in the early 1800s resulted in the enactment of ‘Talfourd’s Act’ (Custody of Infants Act 1839 (UK)) allowing mothers to seek custody of children under 7 years, stopping some of the power husbands traditionally had over their wives. An amendment in 1873 allowed mothers to have custody of children up to 16 years of age.

³⁵ Austin G, *Children: Stories the Law Tells*, (1994) Victoria University Press, at 19.

³⁶ The inherent jurisdiction of the High Court is preserved by Judicature Act 1908, ss 16 & 17. The Guardianship Act, s 10E(2) also preserves the court’s rights in respect of wards that it had before the Act was enacted. The High Court has noted that using the inherent *parens patriae* jurisdiction is appropriate when there is a one-off decision to be made, whereas wardship is more suitable when there is an ongoing situation where repeated applications to the court would be required if the inherent jurisdiction were invoked: *Re Norma* [1992] NZFLR 445. Note that in England the concept of *parens patriae* is split into a “protective” and a “custodial” jurisdiction. The English court has held that the welfare principle does not hold when the court is acting in its protective jurisdiction; *Re X (A minor)* [1975] 1 All ER 697. This distinction does not apply in New Zealand: *Pallin v Department of Social Welfare* [1983] NZLR 266, at 272; *Re Norma*, at 451.

Family Court or the High Court to place a child under the guardianship of the court.³⁷ This takes away the guardianship rights of the parents from the time the application is made until it is discharged, although the parents may still have custody of the child.³⁸

Today wardship has clearly been widened and is available to protect all children whether they have property or not and whether they are orphaned or not. Wardship is based on the principle that the welfare of the child is the first and paramount consideration.³⁹ From the moment a wardship application is made, the child is under an “umbrella of protection” of the court and once a wardship order is in place, no major decision involving the child can be made without the court’s consent.⁴⁰

The Guardianship Act does not give any guidance as to when a child may be placed under the guardianship of the court, nor does it set out any rules or requirements to be satisfied before wardship will be appropriate. The situations where wardship can be used has been set out in case law. It appears to be almost unlimited and should no longer be considered an exceptional remedy.⁴¹ The court has discretion when deciding whether or not to make a child a ward of the court, but must exercise that discretion responsibly, carefully and sparingly.⁴²

³⁷ Guardianship Act 1968, ss 10A & 10B; Previously only the High Court had the jurisdiction to make a child a ward, but the 1998 amendment to the Guardianship Act has given the same power to the Family Court. The term ‘wardship’ is no longer correct, as the term ‘guardianship of the court’ is used in the Act; *W v Director-General of Social Welfare* [1990] NZFLR 353, at 358. In colloquial and common language the terms can be used interchangeably, as they will be in this thesis.

³⁸ Guardianship Act 1968, s 10E.

³⁹ Guardianship Act 1968, s 23. This “welfare principle” applies to all proceedings involving the guardianship of a child. Guardianship includes controlling the “upbringing” of a child, of which a child’s medical treatment is clearly a part.

⁴⁰ *W v Director-General of Social Welfare*, supra n 37, at 358.

⁴¹ *Wilkinson v C [Wardship]*, [1999] NZFLR 569, per Judge Inglis QC. Wardship is continually being widened by the courts. Examples of situations where it has been used include ordering a third party not to associate with a ward (*Re M (an infant)* [1974] 2 NZLR 401); denying a parent communication with the ward (*In the Guardianship of B* unreported, High Court Auckland, 8 December 1983, M728 & 1020/82); preventing proposed sterilisation procedure (*Re D (a minor) (wardship: sterilisation)* [1976] 1 All ER 326).

⁴² *Re C (Wardship: Blood Transfusion)* (1992) 9 FRNZ 570, at 575; *Pallin v Department of Social Welfare*, supra n 36, at 272.

The jurisdiction of the court to protect children must and does extend to overriding parents' refusal to consent to medical treatment. Over time wardship was extended from a jurisdiction over orphaned children only, to cover all children. This extension was based on the still existing *parens patriae* doctrine which allows the state to protect those unable to protect themselves. It has now been over two hundred years since the court first intervened in the life of a child whose parents were still alive, and the law of precedent means that this extension of law is irrefutably valid today.

Ensuring the adequate protection of all children necessarily requires the state to intervene into parents' decisions. The state has not only the right but the duty to intervene when a child is being abused within its family.⁴³ To allow the court to protect its subjects from this type of harm, but to restrict it from protecting children harmed in other ways would cause definitional problems that would be impossible to reconcile. The state must be able to intervene whenever a child is at risk, even if it means overriding the parents' wishes.

The state's ability to intervene in a child's life is not an unfettered discretion. The state, through the courts, must only use its ability to intervene when such intervention will be in the child's best interests.⁴⁴ In some instances, a parent's decision to refuse consent for a child's medical treatment will not be in the child's best interests, and in that situation the court has the ability to intervene to ensure that the child's best interests are advanced. The difficulty arises in the decision as to what actions will be in the best interests of the child, and it is that decision that the court must make in wardship cases.

⁴³ Children, Young Persons and Their Families Act 1989, ss 14 & 17. Under s 110 of that Act the court can appoint a guardian for a child in need of care and protection. Such an order can be overridden by a wardship order made pursuant to the Guardianship Act (Children, Young Persons and Their Families Act 1989, s 117(2)), showing that the wardship jurisdiction has not been limited by subsequent, modern legislation.

⁴⁴ Guardianship Act, s 23.

III. PROCESSES IN THE FAMILY COURT

A. Philosophy of the Family Court

The Family Court deals solely with family-related matters.⁴⁵ It was set up to be primarily a conciliation service with court proceedings being a last resort.⁴⁶ The Family Court and all counsel appearing before it are required to promote a conciliatory attitude and the disputing parties are encouraged to resolve their own differences, with help provided in the way of counselling, conciliation and mediation.⁴⁷ Family Court judges are chosen for their experience and personality suited to the court's conciliatory approach.⁴⁸ The procedure and atmosphere of the Family Court are designed to be informal to aid parties in conciliation.⁴⁹ Hearings in the Family Court are conducted in private and decisions may not be reported without leave from the court.⁵⁰

B. Ex parte applications

An ex parte application is filed without notice being given to the other party to the dispute. If the application is granted, an order can be made without hearing any evidence from the other party. A Family Court order may only be made on an ex parte application if the court is satisfied that “the delay that would be caused by proceeding on notice would or might entail serious injury or undue hardship.”⁵¹ The Court of Appeal has stated that the words “undue hardship” are not “words of art”, but should be construed in a commonsense way.⁵² The making of an ex parte order is a “serious and extraordinary step, only to be sought if truly necessary, and to be granted only where

⁴⁵ Family Courts Act 1980, s 11.

⁴⁶ Report of the Royal Commission on the Courts 1978.

⁴⁷ Family Proceedings Act 1980, ss 8 & 19. These sections relate to disputes between spouses.

⁴⁸ Family Courts Act 1980, s 5(2)(b).

⁴⁹ Family Courts Act 1980, s 10.

⁵⁰ Guardianship Act 1968, ss 27 & 27A; Family Courts Act, s 159.

⁵¹ Family Proceedings Rules 1981, rule 16(2)(a)(i).

⁵² *S v Beaton* [1987] 1 NZLR 493, at 496.

there is a proper evidential base to support it.”⁵³ The issue is whether there is a “proper opportunity for everyone having a legitimate interest to be heard to the extent that such is possible”.⁵⁴ The parents’ views should be heard whenever there is a possibility of interference with parental rights, but only to a reasonable extent.⁵⁵ Inter partes proceedings should be held whenever possible, whatever the circumstances.⁵⁶ When there is a possibility that parents views may be overridden by the state the the system should ensure that “justice is seen, and felt, to be done.”⁵⁷

In *Re C* the High Court upheld the Family Court’s granting of an ex parte application. The affidavits produced stated that without immediate surgery, the two-year-old child’s pain and suffering would increase “dramatically.”⁵⁸ While the affidavit also contained information about the child’s growing and malignant tumour, and about her life expectancy without treatment, it was the information about the child’s pain that was emphasised, and thus an ex parte order was warranted.⁵⁹

In *Re P* Ellis J observed that whether a case should proceed on an ex parte basis will inevitably depend on the facts of the particular case and that it is not appropriate to suggest a standard procedure to be followed.⁶⁰ Authors Papps and Cathcart have submitted however that a set of guidelines is precisely what is needed to ensure consistency and certainty in the use of ex parte orders to override parents’ refusal to consent.⁶¹ They state that a proper judicial inquiry must consider all the relevant facts and that this is impossible in an ex parte hearing. They claim that the initial court

⁵³ *C v K* (1994) 12 FRNZ 368, at 372, per Robertson J.

⁵⁴ *Re CL* [1994] NZFLR 352, at 355.

⁵⁵ *Idem*; In this case Robertson J found that there had been no detriment to the parents as they were kept fully advised by the other party.

⁵⁶ *Re O (A Minor) (Medical Treatment)* [1993] 4 MedLR 272, at 275, per Johnson J.

⁵⁷ *Idem*.

⁵⁸ *Re C (Wardship: Blood Transfusion)* (1992) 9 FRNZ 570 at 579.

⁵⁹ *Idem*.

⁶⁰ *Re P* [1992] NZFLR 94, at 96; endorsed by Robertson J in *Re CL*, supra n 54, at 355 and by Williamson J in *Re C*, supra n 42, at 579.

⁶¹ Papps S & Cathcart W P, “Ex parte orders for medical intervention on Jehovah’s Witnesses: the risk of injustice”, (1994) 1 BFLJ 136.

application often presents the matter as “a cut and dried choice between the life or death of a child” but that the court must recognise the uncertainty and subjectivity of medical practice.⁶² The court can not assess the necessity of the treatment on the basis of one medical opinion and full disclosure of all the available alternatives is necessary for the court to make an informed decision. The authors point out that this evidence will often not be put to the court in an ex parte proceeding. However, Robertson J has noted that a decision to proceed ex parte placed an “enormous burden” on the applicant to put before the court all the reasonably relevant material.⁶³

C. Evidence

When dealing with guardianship applications, the Family Court may receive any evidence that it thinks fit, whether it would be otherwise admissible or not.⁶⁴ This relaxing of traditional evidentiary rules is in keeping with the informal nature of the Family Court. Judge Inglis QC has noted that the court has “the discretion whether or not to admit any particular item of evidence in any particular manner or in any particular form.”⁶⁵ The general principles of legal admissibility will only help to determine to what extent the content of the evidence is material, and what weight and relevance it will be accorded.⁶⁶

The Family Court is not restricted to making a decision based solely on the evidence put before it, and is entitled to ask for whatever other evidence it believes is relevant to the decision.⁶⁷ The court has the power to call its own witnesses and examine and re-

⁶² Ibid at 136-138.

⁶³ *C v K*, supra n 53, at 371; Robertson J found that there had been insufficient evidence to warrant ex parte orders being made in the Family Court.

⁶⁴ Guardianship Act 1968, s 28; The burden of proof, as in all civil cases, is to the balance of probabilities.

⁶⁵ *Re L [Videotaped Evidence]* (1997) 15 FRNZ 637, at 641. The judge noted that when speaking of evidence in the Family Court context, the term “allowable” is more accurate than “admissible”.

⁶⁶ Idem.

⁶⁷ For example, the court can request a “section 29A report” from any qualified medical practitioner, psychiatrist or psychologist on any child the subject of guardianship proceedings; Guardianship Act 1968, s 29A.

examine them.⁶⁸ Thus the Family Court operates in a more inquisitorial manner than the traditional adversarial manner, where strict evidentiary rules may apply.

D. The use of ex parte orders in Liam's case

In Liam's case, the situation was first brought to the court's attention by way of an ex parte application for wardship orders. When faced with the application, the Family Court judge had to make a decision whether or not to allow the case to be heard ex parte. The court was presented with affidavit evidence from Liam's paediatric oncologist, Dr Sullivan, and from a child protection co-ordinator at HealthCare Otago. No other evidence was heard or requested. The application was granted the same day with only a file note attached⁶⁹: "Application granted. Ex parte procedure appropriate having regard to urgent health issues."

At the time of the hearing, Liam had missed almost four weeks of treatment. There was affidavit evidence stating that if chemotherapy did not recommence within a few days then the tumour would have the opportunity to recover, and the chemotherapy would lose its effectiveness. Liam's oncologist believed this was "likely to be highly prejudicial to a positive outcome."⁷⁰ The affidavit went on to state that a further two weeks without treatment would "definitely compromise" Liam's chances of survival.⁷¹ Liam had been fitted with a catheter, which needed changing every week to avoid infection. The catheter could not have been changed for at least two weeks at the time of the hearing and the fact that Liam had never been vaccinated increased the chance that he would develop a serious infection.

⁶⁸ Guardianship Act 1968, s 28A.

⁶⁹ *Williams-Holloway*, 18 March 1999, supra n 7, at 1.

⁷⁰ *Ibid* at 6.

⁷¹ *Idem*.

Liam and his parents had gone to Auckland, leaving no contact address, after agreeing to return on 25 January. HealthCare Otago had made considerable efforts to find the family, including asking the parents' families and friends. On 20 January Liam's grandfather indicated to Dr Sullivan that the family would not be returning on the agreed date.⁷² The Children, Young Persons and Their Families Agency had also exhausted their resources looking for the family.

Liam's case was not one where he would die within hours or days if treatment was not ordered. Nor was there evidence of any immediate pain, as there was in *Re C*.⁷³ However, there was evidence that stated that Liam's treatment was behind schedule, and that further delay would have serious consequences for the success of the treatment. It was clear to the court that the parents did not want to be found. If the court had adjourned in order for notice to be served on the parents, it would have resulted only in further delay. The medical evidence indicated that delay was "*likely* to be highly prejudicial" to the success of his treatment, and his chances of survival "*would definitely* be compromised" after a further two weeks.⁷⁴

Judge Blaikie was aware of the "serious implications" for Liam's parents of granting the application *ex parte*, but Liam's critical cancer condition, the need for him to resume medical treatment and the "uncertainty regarding the ability of the Court to locate the parents" were the persuasive factors leading to the decision.⁷⁵ The *likely* prejudicial effect of delay was sufficient to warrant the *ex parte* order being made immediately, as finding the parents could clearly have taken several weeks, by which time Liam's diagnosis would have *definitely* been compromised.

⁷² Trena's father told Dr Sullivan to expect a letter on the 25 January. The letter stated that they were continuing with alternative treatments and would not return to Dunedin for at least a fortnight.

⁷³ *Re C*, supra n 42.

⁷⁴ *Williams-Holloway*, 18 March 1999, supra n 7, at 6, emphasis added.

⁷⁵ *Ibid* at 8.

IV. PRINCIPLES RELEVANT TO WARDSHIP DECISION MAKING

When faced with any application concerning the guardianship of a child, the court is required to consider the welfare of the child as the paramount consideration.⁷⁶ The United Nations Convention on the Rights of the Child 1989⁷⁷ requires that the welfare of the child be a primary consideration in all actions concerning children.⁷⁸ When deciding whether to make a child a ward of the court so as to consent to medical treatment and override the parents' wishes, the court must make the decision that will be in the best interests of the child. There is no statutory definition of the best interests of a child, and it is this question that the courts struggle to answer.

There are several factors that emerge from the decisions determining welfare in child consent cases. A proper decision can not be made by considering only one of these factors. The relevant principles are:

- preservation of life
- quality of life and pain and suffering
- parental choice
- cultural considerations
- likelihood of the treatments' success
- bodily integrity

A. Preservation of life

The New Zealand Bill of Rights Act 1990 guarantees that everyone has the right not to be deprived of life.⁷⁹ The Convention guarantees that every child has an inherent right

⁷⁶ Guardianship Act 1968, s 23(1).

⁷⁷ Hereinafter referred to as "the Convention".

⁷⁸ Art 3.

⁷⁹ New Zealand Bill of Rights Act 1990, s 8; hereinafter called "the Bill of Rights".

to life and requires governments to ensure to the maximum extent possible the survival and development of the child.⁸⁰ It also recognises the child's right to health care services and facilities for treatment.⁸¹

The case *Re J*⁸² concerned a three-year-old boy who was in intensive care after suffering a life-threatening nose bleed. There was the possibility that he would require blood transfusions in the near future, but his parents, who were Jehovah's Witnesses, refused to give consent for them.⁸³ The Director-General of Social Welfare applied to the High Court for an order placing J under the guardianship of the court for the purpose of consenting to the treatment.⁸⁴

Counsel for the parents emphasised that Jehovah's Witnesses do not want to martyr or sacrifice their children, but their religion forbids the use of blood products. They believe that by receiving blood products a person's spiritual life will be affected.⁸⁵ The parents did not want a complete cessation of J's treatment, but wanted alternatives to blood products to be used, arguing that there is accepted medical opinion showing there are inherent dangers in blood transfusion treatment.

Ellis J referred to evidence which showed that J's condition was improving, that there was a "possibility" of deterioration that could require an immediate blood transfusion and that a blood transfusion would be "desirable" to keep J's haemoglobin level up. He

⁸⁰ Art 6.

⁸¹ Art 24.

⁸² *Re J (An Infant), B & B v D-GSW* [1996] NZFLR 337 (CA).

⁸³ J had suffered the severe nose bleed on a Saturday afternoon. Doctors thought it necessary to administer an immediate blood transfusion to save his life. The parents would not consent, but in an urgent hearing a District Court judge granted an order permitting the doctors to use a blood transfusion in an operation that afternoon. The next day J developed ARDS, a life-threatening respiratory disorder that can be caused by blood transfusions. It was because of this complication that J was in intensive care.

⁸⁴ The High Court found that the District Court judge did not have jurisdiction to make the order and so quashed it, while finding that a valid order could have been made.

⁸⁵ Papps & Cathcart, *supra* n 61, at 136; The fact that the transfusion is out of the person's control does not make a difference, as it is the blood itself that is forbidden.

accepted that the medical experts' assessment was "prudent and reasonable".⁸⁶ Ellis J concluded that the court should only intervene when the child's life or well-being is "seriously threatened" or "in serious jeopardy" and there is no reasonable medical alternative available.⁸⁷

After Ellis J set out the "serious jeopardy" test the appropriate thing would then be to apply this test to the facts to determine whether J's condition was sufficiently threatened. However no such analysis of the facts took place. The only evidence, set out earlier in the judgment, was of the "possibility" of a need for a transfusion, which does not appear to reach the level of certainty that is required to describe J's condition as "seriously threatened." Ellis J made an assumption that J's condition was serious enough without proper reference to and analysis of the medical evidence. A proper analysis could have found that the "possibility" of the need for a future transfusion did not put J in "serious jeopardy."

The parents appealed to the Court of Appeal on the grounds that their rights under the Bill of Rights had been breached.⁸⁸ The court was faced with a conflict between the section 8 right to life and the section 15 right to manifest religion, which extends to the right to bring up children according to one's beliefs. However, this right to manifest one's belief is a personal right and can not be absolute.⁸⁹ If the parents' right to manifest their belief included the right to refuse consent to treatment, then their right would conflict with the child's right to life.

⁸⁶ *Re J* [1995] 3 NZLR 73 (HC), at 80.

⁸⁷ *Ibid* at 86 & 88.

⁸⁸ *Re J* (CA), *supra* n 82, at 138; The Court of Appeal held that Ellis J's finding was fully supported by evidence given by the doctor in charge. The Court of Appeal may not overturn findings of fact, but in this case it endorsed the finding that J's well-being was in serious jeopardy.

⁸⁹ International Covenant on Civil and Political Rights, art 18(3). Art 14.3 of the Convention sets out a similar limit on the freedom of religion and belief.

The court stated that this should not be seen as a case where the state is limiting the parents' rights, but rather as a case where the state is enforcing the child's rights.⁹⁰ As such, the rights need to be defined so as to be compatible with each other. The court defined the scope of the parental right under section 15 to exclude doing or omitting "anything likely to place at risk the life, health or welfare of their children."⁹¹ This definition gave effect to the welfare paramountcy principle in the Guardianship Act, but required a lower threshold than the test used in the High Court. Without referring to the test used by Ellis J, the Court of Appeal replaced it with the "likely to place at risk" test.

It was assumed that the use of blood transfusions was in J's best interests. There was no discussion of whether acceding to the parents' wishes could have been in J's best interests, as there was no consideration given to the possibility of alternatives to blood products being successful.⁹² The court treated the decision as one between life or death, without acknowledging that J's parents also wanted J to live. The court was wrong to assume that upholding J's right to life required that J be made a ward of the court. The analysis should have been of the advantages and disadvantages of the different available treatments. Because no such analysis was performed, the court may have unnecessarily superseded the parents' decision.⁹³

In *Re Norma*⁹⁴ the High Court granted a wardship order stating that the child's welfare "must be dominated" by the chance of saving her life. Norma was a 19 month old Samoan baby diagnosed with bone cancer. There was medical evidence from her paediatrician that without the amputation of her leg and chemotherapy, she would die. Her parents had removed her from hospital where chemotherapy had begun, and Norma was receiving traditional Samoan treatment at home. A specialist radiologist gave

⁹⁰ *Re J* (CA), supra n 82, at 146.

⁹¹ *Idem*.

⁹² However the judgments do not indicate that any evidence was offered by the parents in this regard.

⁹³ Without further evidence of the alternatives to blood transfusions it is hard to assess whether the court made the right decision.

⁹⁴ *Re Norma*, supra n 36.

evidence that an x-ray taken since the traditional therapy showed that the tumour may have become benign. The paediatrician disagreed and said further investigation was necessary to establish malignancy. With these tests and, if necessary, the recommended treatment, the paediatrician estimated there was a fifty percent chance Norma would survive, although there was still “a real possibility” that she would die.⁹⁵ Without discussion Tompkins J accepted the evidence of the paediatrician, thereby rejecting the evidence of the radiologist.

After considering factors such as culture, parental choice and quality of life, Tompkins J stated unequivocally that saving Norma’s life must dominate his decision. Clearly he believed that preservation of life outweighed any and all other relevant factors.⁹⁶ He then stated that to save Norma’s life, it was “obvious” that conventional treatment was necessary.⁹⁷ The fact that this was “obvious” to the judge indicates that he found as a fact that Norma’s life could only be saved by conventional medicine, and not by traditional treatment. He did not do a careful analysis of the facts to determine which treatment would “save her life”, but simply accepted the evidence of the paediatrician. Of course, apart from the x-ray evidence, there was no medical information provided about the traditional treatment. A more detailed analysis of the alternatives may have established that there was a chance for Norma’s life to be saved using traditional methods.

In *D-GSW v B*⁹⁸ the young girl required urgent surgery to remove a cancerous tumour. Her mother felt there may have been no cancer at all, and refused consent to operate, believing that God would heal the child. Fisher J stated that the welfare of the child must “be dominated by the most fundamental objective of all, namely to save her life.”⁹⁹ The clear medical evidence was that without surgery the girl would die within two

⁹⁵ Ibid at 449 & 452.

⁹⁶ See below for discussion of the other relevant factors in *Re Norma*.

⁹⁷ *Re Norma*, supra n 36, at 452.

⁹⁸ *D-GSW v B* [1994] NZFLR 517.

⁹⁹ Ibid at 518.

years, and there was no evidence given to support the mother's views. After stating that preservation of the child's life was the dominating factor, the judge was bound to order the treatment, as there was no medical evidence of any kind in support of the mother's views.

Tipping J in *Re Ulutau*¹⁰⁰ granted an urgent ex parte order making an unborn child a ward of the court from the moment of its birth, as the parents refused to consent to blood transfusions. The medical evidence was that there was a "substantial likelihood" that a transfusion would be necessary, and that without it there was a "grave risk" that the child would die or be severely handicapped.¹⁰¹ The judge granted the order stating that he had no doubt that it was in the best interests of the child to have proper medical care. It is implicit in the judgment that the preservation of the child's life was the sole motivation behind the decision, there being no reference made at all to any other considerations. Also implicit is the finding that the child's life would only be preserved with a blood transfusion. In this case there was no evidence of alternatives offered to the judge, as the application was made ex parte.

In the English case of *Re T*¹⁰², the Court of Appeal noted that there is a "strong presumption" for preserving life, but it is not irrebutable, and account must be had of pain and suffering and quality of life.¹⁰³ The New Zealand High Court has agreed that in all but the most exceptional cases, the court is required to preserve life.¹⁰⁴

The judgments show that preserving life has been a primary aim of New Zealand judges asked to make these decisions. When a decision has to be made in an emergency situation, the court is unlikely to consider anything other than preservation of life, and when making the assessment will tend to rely on the available conventional medical

¹⁰⁰ *Re Ulutau* (1988) 4 FRNZ 512.

¹⁰¹ *Ibid* at 513.

¹⁰² *Re T (A minor)(Wardship: Medical Treatment)* [1997] 1 All ER 906.

¹⁰³ *Ibid* at 913.

¹⁰⁴ *Auckland Healthcare Services Ltd v L* (1998) 17 FRNZ 376, at 380. Also known as *Baby L's* case.

opinion alone. While preservation of life must always be a consideration, in order to uphold the rights guaranteed under the Bill of Rights and the Convention, in some cases it should not be the only deciding factor. It will be seen that quality of life considerations may outweigh preservation of life considerations.

B. Quality of life and pain and suffering

The Convention recognises that disabled children have a right to live a full and decent life with dignity.¹⁰⁵ It leaves unanswered the question as to when a life may not be dignified.

In the English case of *Re T*,¹⁰⁶ the young boy suffered from a life-threatening liver defect. Medical opinion was that the child would die by the age of two and a half without a liver transplant, of which “the prospects of success were good.”¹⁰⁷ The doctor considered that there was a “good chance” that transplantation would result in many years of normal life and no treatment necessary other than immuno-suppression. The child had undergone an unsuccessful operation at the age of three weeks and had suffered considerable pain and distress due to the operation and the follow-up treatment. This, and the fact that the parents were child health care professionals, were the reasons that the parents refused to consent to further treatment. Counsel submitted that it was better to allow the child a short life where he was well and happy than to cause him to undergo surgery where there were risks, distress, a lifetime of drugs and the possibility of further surgery and treatment. The English Court of Appeal was not prepared to interfere with the parents’ views in this regard, although in the end, quality of life considerations were not the sole basis for the court’s decision not to order treatment.¹⁰⁸

¹⁰⁵ Art 23. Presumably children who are not disabled have a similar right to dignity.

¹⁰⁶ *Re T*, supra n 102. This case is not binding on New Zealand’s courts, but can be persuasive authority.

¹⁰⁷ *Ibid* at 910 & 918.

¹⁰⁸ See further discussion of *Re T* below.

In the recent well publicised case of *Baby L*, the hospital sought an order consenting to the discontinuance of the treatment that was keeping the baby girl alive.¹⁰⁹ The medical opinion was that there was no chance whatsoever that the child would survive, with or without medical intervention. There was evidence that baby L was suffering from the treatment and doctors considered continued intervention to be inhumane. The court accepted that this was a case where medical treatment was not prolonging her life, but was only prolonging her death. Because there was no chance of survival, and because treatment was causing the baby pain, it was in the best interests of the child to allow doctors to discontinue intervention. *Baby L's* case shows that when there is no chance at all that a child will survive, and when the child is suffering from continued treatment, preservation of life will be outweighed by pain and suffering considerations.

In extreme cases where the child will have no chance to lead a 'normal' life, the quality of that life becomes highly relevant. In the English case *Re J (A Minor)*, the child was born twelve weeks premature suffering from severe brain damage, but was not in the process of dying.¹¹⁰ This was not a case of terminating life or accelerating death but a question of whether or not to prolong his life in light of the lack of quality of life. Medical evidence was that J would not live beyond his teens, and would probably die much younger; he was quadriplegic, epileptic, blind, deaf, and would never speak. His only normal reaction was of pain. He had suffered several convulsions requiring resuscitation and the medical opinion was that J should not be resuscitated if he suffered a further convulsion. The Court of Appeal upheld the lower court's decision that this was in J's best interests. While there is a strong presumption in favour of prolonging life, it must be weighed alongside considerations of quality of life and pain and suffering.¹¹¹

¹⁰⁹ *Baby L*, supra n 104.

¹¹⁰ *Re J (A Minor)(Wardship: Medical Treatment)* [1991] 2 WLR 140. Note that the fact that J was not dying distinguishes this case from *Baby L's* case where there was no possibility that the child could survive.

¹¹¹ *Ibid* at 149.

The court found that quality of life could override the presumption of preservation of life where the life that would be preserved would be “so cruel as to be intolerable” to that child.¹¹² It was also appropriate to take account of the pain and suffering caused by the treatment itself. The test is whether that child, having known no other life, would find his life intolerable. It was not a question of whether a normal healthy person would tolerate the life, and it must be remembered that human beings have a strong instinct to survive. The court paid considerable attention to the fact that resuscitation was invasive and distressing for the baby who was able to feel pain. Ventilation is a hazardous procedure which could threaten the prognosis itself and, if the question of resuscitation did arise, then J’s condition and prognosis would have necessarily already deteriorated. The doctors were unanimous in their opinion that the baby should not be resuscitated. The court concluded that this baby was suffering from the ventilation itself, and that his quality of life was such that he should not be resuscitated. The court did not actually apply its test to the facts and conclude that baby J’s life was “intolerable”, but this was the implicit conclusion. The fact that he could feel pain, together with the fact that he would have a low quality of life, were the main reasons for the decision.

The issue of quality of life and pain and suffering can in some cases be the primary focus in the decision making process. Where pain and suffering is such that life is intolerable, or where treatment is only prolonging an inevitable, immediate death, then preservation of life will not be the dominating factor. *Re T* shows that quality of life issues may be relevant in cases where there will be on-going care or where the treatment itself is invasive and distressing. However where a complete recovery is expected and the quality of life after treatment will be normal, the treatment should always be ordered, even if it will cause temporary pain and suffering. No child should be denied the chance to live a full life on the basis that temporary pain might be suffered.

¹¹² Ibid at 157.

C. Parental choice

It is universally assumed that parents do have certain rights in respect of their children although it is less acceptable today to talk of ‘owning’ one’s child.¹¹³

The long title of the Guardianship Act states that its purpose is to define and regulate the authority of parents as guardians of their children.¹¹⁴ The rights of guardianship of a child are defined in the Act as the right to custody (possession and care) of a child, and the right of control over the upbringing of a child.¹¹⁵ Guardianship includes all rights, powers, and duties in respect of the upbringing of a child that existed at common law, but the Act does not clarify what the existing law was.¹¹⁶ Guardianship is the responsibility and right to decide and regulate the upbringing of a child and to enhance and safeguard the child’s welfare, interests and development.¹¹⁷ Parents are given powers of guardianship to make decisions for the child, to protect the family from outside interference and to impose responsibilities on the parent for nurturing the child.¹¹⁸ The question for the court is whether these rights extend to refusing medical treatment.

One of the aims of the Children, Young Persons and Their Families Act 1989 is to advance the well-being of children as members of families. The Act deals with children in need of care and protection and young offenders, and states that wherever possible, matters relating to children should be dealt with by their own family. The Act was

¹¹³ McDowell M A, “Supervening parental rights: religion and the refusal of consent to a child’s medical treatment”, [1998] 1 BFLJ 233, at 237.

¹¹⁴ Note that guardianship is limited in some ways as the child grows older: *Gillick v West Norfolk AHA* [1985] 3 WLR 830. Once a child is old enough to express his or her own wishes, the court is required to take those wishes into account; Guardianship Act, s 23(2); United Nations Convention on the Rights of the Child, art 12. This dissertation will not address the issues that arise when a older child is able to express his or her wishes.

¹¹⁵ Guardianship Act 1968, ss 2 & 3.

¹¹⁶ Guardianship Act 1968, s 3.

¹¹⁷ *C v B* [1983] NZ Recent Law 360, per Judge Inglis QC; “Upbringing” is wider than just the education and religion of a child.

¹¹⁸ *Neho v Duncan*, [1994] NZFLR 157, at 160, per Judge Inglis QC.

enacted in response to criticism that decisions involving children were being made by distant professionals. The Act emphasises a presumption in favour of families making decisions and recognises that intervention into family life should be kept to a minimum.¹¹⁹ These principles are subject to the welfare and interests of the child which are paramount.¹²⁰ Such legislation suggests a move toward family-based decision making.

The Bill of Rights, which applies to acts done by the state, does not mention rights of parents directly, but guarantees the right to religion and belief, and the right to manifest that belief in practice.¹²¹ There is also the right not to be deprived of life.¹²² These issues were discussed in *Re J* where a young boy's parents claimed that the right to religion gave them a right to refuse his treatment on religious grounds.¹²³

The Convention recognises the responsibilities, rights and duties of parents.¹²⁴ Parents have the primary responsibility for the upbringing and development of the child and the best interests of the child are their main concern.¹²⁵ The emphasis in the Convention is on the *responsibilities* of parenting rather than on the term *right*, which is used in the Guardianship Act.

Authors Goldstein, Freud and Solnit advocate that it is in a child's best interests to have autonomous parents.¹²⁶ Parents should be free to determine what is best for their children, and state intervention is damaging to a child's relationship with its parents. They agree that a child's interests are paramount but claim that a policy of minimum state intervention will in almost all cases satisfy this goal. When a child's family life is

¹¹⁹ Section 13.

¹²⁰ Section 6.

¹²¹ Sections 13 & 15.

¹²² Section 8. The rights can only be limited if the limit is demonstrably justified in a free and democratic society, s 5.

¹²³ *Re J*, supra n 82. This case is discussed further below.

¹²⁴ Art 5.

¹²⁵ Art 18.

¹²⁶ Goldstein J, Freud A & Solnit A, *Before the Best Interests of the Child*, (1979, Free Press).

interrupted by state intrusion, the premature realisation by the child that its parents are not in charge of its life will necessarily have a detrimental effect on its development and relationship with its parents. Even if some parents do threaten the well-being of their children, the state will often make a tolerable situation worse by intervening. They do accept however that when a child's life depends on treatment for which the parents refuse to consent, and with treatment the child would live a normal, healthy life or a life worth living, the state is justified in intervening.¹²⁷

(i) Parent/child relationship

In *Re T* Waite LJ believed that medical treatment cases are not an occasion to talk about the rights of parents or the child.¹²⁸ The court confirmed that the welfare of the child is the paramount consideration but added that the parents' refusal to consent is important when considering the child's welfare.¹²⁹ Butler-Sloss LJ was greatly influenced by the evidence of a paediatrician who believed that the total commitment of the primary caregiver was essential to the success of the treatment. The paediatrician was of the view that "coercing" the mother into caring for her son during the aftermath of surgery could cause the treatment to be less successful.¹³⁰ For that reason he said he would not carry out the operation if the mother was against it.¹³¹ Waite LJ accepted that the child's post-operative care would be "injuriously affected" if his mother was forced to care for him against her wishes.¹³²

Butler-Sloss LJ considered that the welfare of the child depended on the complete commitment of the carer in this case and went so far as to say that the mother and child

¹²⁷ Ibid at 91.

¹²⁸ *Re T*, supra n 102, at 916.

¹²⁹ Ibid at 913, 917-918.

¹³⁰ Ibid at 914; The parents were not married so the mother alone had parental responsibility; Children Act 1989 (UK), s 2(2)(a).

¹³¹ Ibid at 910.

¹³² Ibid at 917.

were “one”.¹³³ She concluded that it was not in the best interests of the child to direct his mother to take on a total commitment of care when she did not agree with the proposed treatment. The best interests of the child required that his parents be given the autonomy to decide upon his treatment. This type of reasoning, if carried out in New Zealand, would be consistent with the overall philosophy of the Children, Young Persons and Their Families Act. This decision also reflects the minimum intervention philosophy of Goldstein, Freud and Solnit.¹³⁴ However, saying that the mother and child are “one” ignores the fact that the child is an individual in its own right. Such a comment fails to give regard to the rule that the child’s welfare is paramount.

Waite LJ concluded that where there is “genuine scope” for the parents’ differing views, the court will be inclined to leave the decision as to care to the parents “to whom its care has been entrusted by nature.”¹³⁵ At the other end of the scale is the situation where parental opposition is prompted by “scruple or dogma” and is “patently irreconcilable” with the medical view. In such a case he implies that intervention will be proper. In *Re T* Waite LJ clearly considered there was “genuine scope” for the parents’ views. He emphasised that the parents’ decision was based not only on “instinct”, but also on the fact that they were medically trained themselves, and as such had an awareness of the procedures.¹³⁶ The parents’ argument had “sufficient cogency” to lead one of the doctors involved to say he would not operate without the parents’ approval. The fact that the parents had “practical” experience, and that they were “loving and devoted” and had given the situation “anxious consideration” led Waite LJ to the conclusion that there was genuine scope for opposition. This genuine opposition meant that the court could entrust the decision to the parents and not interfere.

¹³³ Ibid at 915.

¹³⁴ See for example Freeman M, “Child Rearing: Private Matter or Public Concern?”, in Meulders-Klien M (ed), *Droit Comparé des Personnes et de la Famille*, (1998) Bruylant Brussels 255, who claims at 274 that the judgments “ooze with sentiments that could have been taken from the writings of Goldstein *et al*” and are “not calculated to respect the integrity, the individuality or the citizenship of children”.

¹³⁵ *Re T*, supra n 102, at 918.

¹³⁶ Ibid at 916.

Waite LJ's obiter reference to "scruple or dogma" suggests that if the parents' opposition was based on religious belief, such as Jehovah's Witnesses' objection to blood transfusions, then it would be a case where the court should intervene. His reasoning means that where the parents have "practical" and "genuine" reasons for refusing, their decision should stand, but where the refusal is based on "belief", the court should intervene. However in both cases the child's life may be at risk, and the parents' reasons for refusal should not dictate the result. If a child's welfare is upheld by preserving his life, then that applies regardless of the parents' reasons for refusing consent. The reason for refusal should have no bearing on the decision making process.

Butler-Sloss and Roch LJ listed several "practical considerations" of requiring the child to be returned to England, saying that the High Court judge erred by failing to balance these considerations when making his decision.¹³⁷ The practical considerations included the difficulty in travelling back to England, the father possibly facing unemployment, having to make arrangements for staying in England, the possible inability of the mother to cope and the financial difficulties the family would suffer.¹³⁸

Such a discussion of "practical considerations" was improper as they were not directly related to the child's welfare. It is dangerous to make such a decision by considering the difficulties that will be faced by the family. All cases where a child is seriously ill will give rise to various practical difficulties for the parents, and consideration of such could lead to conflicting results. It has been suggested that life or death becomes a lottery for these children: the situation of their parents dictates whether they will live or die.¹³⁹ It is

¹³⁷ Ibid at 915.

¹³⁸ Ibid at 915-916, 919. Other "practical considerations" were the possible necessary proceedings in New Zealand to compel her return, the loss of the father's support or alternatively his job, the financial instability of the family, making arrangements to stay in England, the difficulty in choosing which hospital to use, how the child would be affected by its mother's conflict, the possibility of further court action if the mother refused to consent to future treatment, the situation if the mother and child return to New Zealand and further treatment became necessary.

¹³⁹ Bainham A, "Do Babies Have Rights?", (1997) 56 Cambridge Law Journal 48, at 50.

difficult to see how the child's best interests can be advanced when the parents' situation is the governing feature. Differing family situations should not form the basis of a decision between the life or death of a toddler. The focus on the practical consequences for the parents detracts from the issue that it is the child's interests that must be examined. Just as the reason for the parents' refusal should have no bearing on the decision made, the practical problems caused to the parents should be irrelevant also.

In *D-GSW v L* doctors recommended that the two-year-old boy have a testicle removed to combat the diagnosis of testicular cancer.¹⁴⁰ Successful treatment would require the "active and co-operative participation" of the parents, but they were finding it difficult to deal with the possibility of post-operative care.¹⁴¹ Salmon J acknowledged that the parents' beliefs were so "fundamental and emotional" that ordering treatment could affect their relationship with their son, but granted the wardship order, noting that counsel for child believed that the parents would not in the end let the treatment order affect their relationship with their son.¹⁴²

In *Re Norma Tompkins* J noted that welfare is not just physical, but is also bound up with the child's family.¹⁴³ If a course of treatment would cause disruption in the family, then that would affect the child, and as such, the child's welfare. He was aware that his decision to order treatment would cause "distress and emotional upset" on Norma's parents and family.¹⁴⁴ Norma's parents would have had to care for her after the treatment, as in *Re T*, but they did not introduce evidence that without their full commitment Norma's after-care would be threatened. This was a compelling reason for the decision made in *Re T*, and may have influenced the court to a greater extent than the general evidence of Norma's parents' "emotional upset".

¹⁴⁰ *D-GSW v L*, unreported, High Court Auckland, 5 November 1997, Salmon J, M708/97.

¹⁴¹ *Ibid* at 4.

¹⁴² *Ibid* at 6.

¹⁴³ *Re Norma*, *supra* n 36, at 451.

¹⁴⁴ *Ibid* at 452.

The court was correct in refusing to place Norma's parents' interests above Norma's own interests. In all cases where parents are forced to watch their child undergo medical treatment there may be feelings of resentment, frustration or anger. Parents may find it difficult to deal with after-care when they do not believe in the treatment at all. Focusing on the parents' ability to provide after-care takes the focus away from the child's situation, and as such does not ensure the child's welfare is paramount. Preservation of the child's life cannot be overridden by the fact that the parents may find it difficult to provide after care. Where this is the case, alternative care arrangements may have to be made.

(ii) Parental rights

In *Baby L's* case, the court noted that the parents wanted the baby to live as long as possible, but because prolonging her life was not in the child's best interests, the parents' right to make their own decision had to be overridden.¹⁴⁵

Re J highlighted the conflict between a child's right to life and parents' right to decide on their child's treatment. Ellis J considered that a child's right to life overrides the parents' rights to decide on medical treatment in cases where there are no alternatives.¹⁴⁶ In support, he cited the Canadian Supreme Court who found that while a wardship order does deprive parents of their right to choose medical treatment for their child, this limit is "demonstrably justified in a free and democratic society"¹⁴⁷ as there is a state interest in protecting children at risk.¹⁴⁸

¹⁴⁵ *Baby L*, supra n 104, at 384.

¹⁴⁶ *Re J* (HC), supra n 86, at 82.

¹⁴⁷ Canadian Charter of Rights and Freedoms, s 1. The New Zealand Bill of Rights Act uses the same words in s 5.

¹⁴⁸ *B (R) v Children's Aid Society of Metropolitan Toronto* [1995] 1 SCR 315; cited in *Re J* (HC), supra n 86, at 81.

The parents appealed to the Court of Appeal, further challenging the High Court order as contrary to the parents' rights under Bill of Rights.¹⁴⁹ The court felt it was not appropriate to invoke section 5 of the Bill of Rights¹⁵⁰ as this would presume that parents' rights are superior to those of the child.¹⁵¹ Instead the parents' rights are not absolute and must be defined so as to be compatible with the child's right to life. There was no question that the parents' beliefs were not genuinely held, yet the court still felt it should intervene. While the court accepted that there was a "genuine belief", it did not consider that this was a case where there was genuine scope for opposition that allowed the parents to make their own decision.

A comparison of *Re J* with *Re T* shows that the New Zealand Court of Appeal has similar views to those expressed two years later by Waite LJ in *Re T*. J's parents' refusal was based on religious beliefs, and not 'practical' reasons, such as in *Re T*. This comparison of two cases where both children faced death shows how considering the basis for the parents' refusal leads to confusion. The beliefs or status of the parents should not make a difference to the decision. What matters is whether their decision upholds the child's best interests. As such, arguments based on "rights" issues cannot succeed.

(iii) Reasonability of parents' decision

In *Re T* the High Court judge found that the mother's refusal to consent to the operation was due to her lack of understanding of the situation, and as such was not a decision a reasonable parent would make.¹⁵² The Court of Appeal ruled that the judge's exercise of discretion was flawed, as the reasonableness of the mother is not the issue, as the test

¹⁴⁹ Counsel also unsuccessfully challenged the jurisdiction of the High Court to make wardship orders.

¹⁵⁰ As undertaken by the majority in *B(R) v Children's Aid Society of Metropolitan Toronto*, supra n 148, under section 1 of the Canadian Charter of Rights and Freedoms.

¹⁵¹ This would be contradictory to s 23 of the Guardianship Act.

¹⁵² *Re T*, supra n 102, at 910.

is the best interests of the child.¹⁵³ However, after restating this principle, Roch LJ did look to the decision and conclude that it was the decision of “devoted and responsible parents” and therefore almost certainly reasonable. Butler-Sloss LJ also held that the mother’s decision was reasonable¹⁵⁴ and Waite LJ’s refusal to interfere with the decision because there was “genuine scope” for it was an alternative way of concluding that the decision was reasonable.

While reasonability has not been used in the guardianship context, it is commonly used in judicial review proceedings, where it is also known as irrationality.¹⁵⁵ Tribunals, lower courts and public bodies may be subject to judicial review by a higher court. Tribunals and specialist courts such as the Family Court are established by statute to deal with issues within their range of expertise. The courts are headed by people with specialist knowledge and expertise in the area, and are designed to be efficient and easily accessible.¹⁵⁶ A specialist court is entrusted with making decisions in its area of expertise. Higher courts are not able to check up on all these decisions, their role being only to police the outer limits of the decision making, where issues are less well defined.

The focus of judicial review is on the way in which the decision was reached, and not on the merits of the case itself. The reviewing court is not entitled to substitute its own decision merely on the grounds that it does not like the decision that was made.¹⁵⁷ Under the ground of irrationality, the issue is whether the decision was so unreasonable that no reasonable decision-maker could ever have made that decision.¹⁵⁸ A court may

¹⁵³ Ibid at 914.

¹⁵⁴ Idem; Butler-Sloss LJ noted that the mother was aware that her son would die, but wanted him to spend the rest of his life in peace, without the pain and stress of surgery and as such it was a reasonable decision.

¹⁵⁵ Fordham M, *Judicial Review Handbook*, (1994) Bookcraft (Bath) Ltd, at 319.

¹⁵⁶ See for example Family Courts Act 1980.

¹⁵⁷ Fordham, supra n 155, at 101.

¹⁵⁸ *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1947] 2 KB 223, at 229.

not interfere merely on the basis that the correct or objectively reasonable decision is other than the decision that was made.¹⁵⁹

Several similarities between judicial review and child consent cases can be seen. Both parents and tribunals are given decision making power by statute because they are assumed to have specialist knowledge. Giving parents the decision making power in relation to their children is efficient in terms of fewer court hearings. When a court is asked to override parents' refusal to consent, it is effectively being asked to review the parents' decision. However, in these cases the court often does substitute its decision on the merits of the case. An analogous review process would mean the court would ask itself whether the parents' decision was reasonable. If the reasons given for the decision made by the parents still leave a "gap of logic" to be leaped, then, if a reasonable parent could not have made that leap, the decision is unreasonable.¹⁶⁰ Otherwise, if it is a decision that a reasonable parent could make, the court may not interfere.

Such a process would not put parents' interests first but would still require the child's interests to be paramount. A reasonable parent is assumed to have their child's best interests at heart, and a decision that was not in the best interests of the child would be deemed unreasonable. While at first glance this approach does not seem to add anything to the existing approach, it would in fact change the focus of the court. Rather than approaching the case as if it were the primary decision maker, the court would start with the assumption that the parents' decision is the right one. The court would not be able to overturn the parents' decision on the merits of the case but would have to find that the decision was so unreasonable that no reasonable parent could have made it. Requiring the court to find that the parents' decision was unreasonable would stop the court from imposing its own decision simply because it thought the parents' decision was 'wrong' which is what happens in cases at the present time. If the parents have

¹⁵⁹ *R v Secretary of State for the Home Department, ex p Brind* [1991] 1 AC 696; to allow this would be allowing the court to act as an appeal court, which would be an abuse of power.

¹⁶⁰ Taylor G, *Judicial Review: A New Zealand Perspective*, (1991) Butterworths.

considered all the principles set out in this thesis, and reached a decision that upholds the child's best interests, then that decision is reasonable and should not be interfered with.

D. Cultural considerations

The Children, Young Persons and Their Families Act emphasises the role of family, whanau, hapu, iwi and family group in the upbringing of children.¹⁶¹ The Code of Health and Disability Services Consumers' Rights provides that everyone has the right to health services that take into account the values of different cultural, religious, social and ethnic groups. The Convention guarantees children a right to their identity¹⁶² and children from ethnic minorities are guaranteed the right to enjoy their own culture, religion and language in community with others of the same group.¹⁶³

In *Re Norma* the child's parents removed her from hospital after six weeks of treatment, believing that the recommended chemotherapy treatment was harming her. Instead they arranged for Norma's great-grandmother to administer traditional Samoan healing techniques, consisting of prayer and massage with leaves and oil. The great-grandmother was regarded amongst the Samoan community as being highly skilled in traditional medicine. The parents were satisfied with the results of the treatment and by the time of the hearing, both parents believed that Norma was cured. Tompkins J acknowledged that this case concerned "a pronounced clash of New Zealand and Samoan cultures."¹⁶⁴

Tompkins J gave a sympathetic judgment where he clearly considered the cultural and family issues involved in this case. He was aware of the conflict between the Samoan

¹⁶¹ Section 5.

¹⁶² Art 8.

¹⁶³ Art 30.

¹⁶⁴ *Re Norma*, supra n 36, at 446.

and European medical practices and because the court could not reconcile the two opposing cultural views, it was the court's role to decide which view was in Norma's best interests. The judge accepted that it was the parents' genuine belief that Norma's well-being would be best served by treating her in the traditional Samoan way, in keeping with the Samoan culture of her family. Counsel for the parents submitted that the depth of the parents' feeling meant that it was in Norma's best interests to allow the family to hope for a miracle, and if it did not happen, to allow her to die within her family.

Tompkins J did not accept that cultural concerns were such that Norma's welfare would be best served by allowing her culture to dictate her treatment. There was no discussion that this could even be in her interests. Instead, he implicitly held that cultural considerations were overridden by the desire to save her life. He accepted the medical opinion that Norma's welfare would be best served by conventional medical treatment without commenting further on x-ray evidence that suggested the traditional treatment may have been working. There was the opportunity for Tompkins J to decide that this was a case where Norma's best interests depended on her culture, which would have reflected the philosophies in the Children, Young Persons and Their Families Act and the Convention.

In *D-GSW v L*, the parents, who were Cambodian, refused to consent to an operation to remove their son's testicle because of their belief that Cambodian herbal treatment would cure the cancer.¹⁶⁵ Salmon J accepted that the parents were loving parents who wanted the best for their son. The medical evidence showed there was a ninety-nine percent chance that the boy had a malignant tumour from which he would die without treatment. Conventional medicine had a high chance of success but there was no evidence to suggest that herbal medicine would cure the cancer.¹⁶⁶ The parents'

¹⁶⁵ *D-GSW v L*, supra n 140.

¹⁶⁶ Salmon J also noted that the parents' main concern, that the child would not be able to father children, was not correct.

concerns could not override the importance of the child's welfare, which the judge clearly considered would be best advanced by saving his life. Salmon J referred to the decision in *Re Norma* as being particularly relevant, but did not discuss cultural issues any further. He did not consider the possibility that herbal treatment would be in the child's best interests simply because it was part of his culture.

Had *Re T* been decided prior to *Re Norma* and *D-GSW v L*, it would have been open for the court to have found that there was "genuine scope" for the parents' decision. There are no significant differences in the facts of the cases, other than the reasons behind the parents' refusal. Tompkins J accepted that Norma's parents had a genuine reason for their refusal and Salmon J also accepted that the Cambodian parents had genuine beliefs. However, the context of Waite LJ's "genuine scope" test suggests that for an argument to be "genuine" it must be backed up by scientific and medical evidence. Waite LJ may well consider that cultural traditions fall into the category of "scruple or dogma" in which case the court should intervene.

E. Likelihood of the treatments' success

If a decision comes down to choosing between two treatments, the conventional and an alternative, statistical chances of success are clearly relevant when deciding which one is in the best interests of the child. Where the orthodox treatment clearly has a better chance of success (twenty percent better or more), that treatment should be chosen over the alternative method. Where the two treatments have similar chances of success (within twenty percent), then the parents' choice should be respected, as the similar chances of success do not warrant the parents' decision being interfered with.¹⁶⁷

¹⁶⁷ These figures of twenty percent were suggested by Dr Sullivan. He would respect a parent's decision to refuse conventional medicine in these situations. Often parents do choose to go ahead with treatment, even when the chance of success is very low; (interview).

Where there is no alternative treatment proposed, the chance of success of the conventional treatment should still be considered. If the chance of success of the conventional medicine is very low (below twenty percent), the parents' decision should not be interfered with. Where the chance of success is greater than twenty percent, then, unless the pain and suffering is so great as to render the child's life intolerable, treatment should be ordered.¹⁶⁸

In *Re T* the fact that there was only a "good chance" of success was one of the reasons the parents refused consent, although it was not the sole reason for the court's decision.¹⁶⁹ In *Re Norma* there was a fifty percent chance of survival. The judge acknowledged that the treatment may be for nothing, but the fact that there was a chance at all of saving her life meant that he still granted the order.¹⁷⁰ He did not discuss the chance of success, so it is not clear at what point, if any, he would have made a different decision. The fact that the chance of saving her life "dominated" his decision may mean that even if there had been a ten percent chance of success, for example, he would have made the same decision. In cases where the chance of success is extremely low, there is more space to uphold parental views, and considerations of pain and suffering, culture and bodily integrity can be given more weight.

F. Bodily integrity

Every adult New Zealander has a right to bodily integrity, and unwanted touching can amount to a criminal assault¹⁷¹ or a tortious trespass.¹⁷² This right to refuse unwanted touching through medical treatment is affirmed in the Bill of Rights.¹⁷³

¹⁶⁸ See discussion on quality of life and pain and suffering, *supra*.

¹⁶⁹ *Re T*, *supra* n 102, at 912.

¹⁷⁰ *Re Norma*, *supra* n 36, at 452.

¹⁷¹ Crimes Act 1961, s 196.

¹⁷² Todd (ed), *The Law of Torts in New Zealand*, (1997) Brooker's Ltd.

¹⁷³ Section 11.

Not all medical treatment without consent will be a tort, as there exists a common law defence of implied consent.¹⁷⁴ When an unconscious patient is unable to consent to necessary treatment, the medical practitioner may treat the patient as impliedly consenting to the treatment and is thus justified in treating that patient to preserve his or her health.¹⁷⁵ However the doctor may not administer a blood transfusion to an unconscious patient who carries a card requesting that it not be done.¹⁷⁶ That is, a doctor may not treat a patient when it is known the patient would refuse to consent if they were able to.

A child is in a similar situation as an unconscious person who temporarily lacks capacity to consent. Taking such a view would lead to the question in a child consent case being: “Would this child consent to this treatment if he or she were competent to do so?” The fact that there is a strong human instinct for survival would lead courts to assume that a child would consent to treatment that would save its life. However, in cases where a child’s parents are refusing on religious grounds, the court would have to consider the fact that the child would most likely grow up to have the same beliefs as its parents. This could lead to the conclusion that the child, if competent, would not consent, and so to preserve the child’s bodily integrity, treatment should not be ordered. Of course, the assumption that a child will grow up to have the same religious beliefs as its parents is not absolute and it would be dangerous for the court to refuse to intervene on that ground alone.

The Guardianship Act states that where the child expresses views on an issue, the court is required to take those views into account, but only to the extent appropriate having regard to the child’s age and maturity.¹⁷⁷ A pre-school aged child, while having a good understanding of pain and suffering, is unlikely to comprehend issues of life and death,

¹⁷⁴ Todd, *supra* n 172, at 1097.

¹⁷⁵ Fleming J, *The Law of Torts*, (1998, 9th ed) Law Book Company Ltd.

¹⁷⁶ *Malette v Shulman* (1990) 67 DLR (4th) 321 (Ont CA).

¹⁷⁷ Guardianship Act 1968, s 23(2).

especially the meaning of his own death. When the child is of a pre-school age, any views must be given minimal weight as the child is not competent to weigh up decisions involving life or death. The court must realise that the child's focus will be on the immediate pain and suffering, and not on any long term consequences of the treatments.

The courts have not specifically referred to bodily integrity issues when deciding the cases in the past. The issue of whether the child itself would consent to the treatment is relevant, and should be part of the decision making process. In *Re J (A Minor)*, the court clearly stated that the test when deciding whether life would be intolerable for the child, was to look at that life from that child's perspective, and not from the perspective of the decision-maker or of a healthy child.¹⁷⁸ Thus the court should put itself in the position of the child and ask what the child would decide, based on the principles set out in this thesis. This test can not be the sole one but should be considered in light of all the other principles.

¹⁷⁸ *Re J (A Minor)*, supra n 110, at 158.

V. APPLICATION OF THE PRINCIPLES TO LIAM'S CASE

In January 1999 HealthCare Otago applied for guardianship and treatment orders from the Family Court. At this point the court had two decisions to make: whether to hear the application for guardianship *ex parte*, and whether to grant the application.¹⁷⁹ Judge Blaikie agreed to hear the matter *ex parte*, at which time the question was what was in the best interests of Liam: making a wardship order, or leaving Liam's parents' decision alone?

The Family Court was not faced with an application concerning a child in immediate pain or in need of immediate surgery and as such had the time to consider the principles set out in past cases dealing with parental refusal to consent. The evidence in the initial hearing was advanced by way of affidavit from Liam's oncologist, Dr Sullivan.¹⁸⁰ There was no evidence offered to the court by Liam's parents at any stage, even after the initial *ex parte* hearing.¹⁸¹ The following analysis and application of the principles will include evidence that may have been available to the court if the parents had been heard.

A. Preservation of life

Clearly the Family Court felt that Liam's welfare depended upon the preservation of his life. The parents have at no time disputed this. They have not argued that they would rather Liam died peacefully, as was the argument in *Re T*, but have argued that alternative treatment is the best way to save his life. Even if the parents had been in court, the decision for the court may not have been between the preservation of life and the other principles discussed, but between the two proposed treatment therapies.

¹⁷⁹ The *ex parte* procedure was discussed *supra*, part III.

¹⁸⁰ There was also an affidavit from the HealthCare Otago child protection co-ordinator, Gerard Kenny.

¹⁸¹ *Williams-Holloway*, 6 May 1999, *supra* n 9.

The court heard evidence of the conservative medical opinion that with intense chemotherapy, Liam had a fifty percent chance of survival, and that without it, the cancer would “inevitably kill him” within a short period of time.¹⁸² Of that the paediatric oncologist was “absolutely certain.”¹⁸³ The chance of a cancerous tumour being cured without any treatment at all is incredibly low.¹⁸⁴ The parents later claimed that Liam’s treatment was still experimental, that there is a high recurrence rate of neuroblastoma and that Liam’s overall survival rate was actually forty-five percent as there was a five percent risk of complications.¹⁸⁵

Liam’s parents had not told the hospital what type of alternative therapy they were pursuing. It later emerged that Liam’s treatment depended on many aspects, including a diet of organic food, supplements and mental visualisation.¹⁸⁶ HealthCare Otago had been happy for Liam to be treated with herbs, homeopathy, spirulina and bee pollen extracts, but in conjunction with the chemotherapy.¹⁸⁷ After stopping the chemotherapy, Liam’s parents ensured he ate an organic diet with no sugar, additives or dairy products.¹⁸⁸ He was treated with a multi-frequency “quantum booster” that is said to vibrate the cancer cells at a specific frequency and shatter the cancer cells while

¹⁸² *Williams-Holloway*, 18 March 1999, supra n 7, at 5, per Dr Sullivan. Dr Sullivan’s affidavit stated that Liam’s cancer was in stage 4, the most advanced stage. In actual fact Dr Sullivan had proof only that the cancer was in stage 3. Because Liam’s parents would not consent to a biopsy being carried out on a lump found in Liam’s abdomen, Dr Sullivan was unable to confirm whether the cancer had spread or not. To ensure Liam got the necessary treatment, Dr Sullivan had to assume that Liam’s cancer had progressed to stage 4. Stage 4 cancer requires far more intensive chemotherapy than stage 3. The survival rate for stage 3 neuroblastoma is eighty percent. The fact that Liam is still alive to date (October 1999) suggests two things: one, that the two cycles of chemotherapy did work, and two, that the cancer was not in stage 4 at all; (interview).

¹⁸³ *Williams-Holloway*, 18 March 1999, supra n 7, at 6. His assessment was supported by other chemotherapy experts in New Zealand and overseas; Dr Sullivan (interview).

¹⁸⁴ New Zealand cancer specialist Dr David Perez has seen 2 out of 10,000 cases where a tumour has shrunk for no apparent reason. None has ever gone away completely; *Listener*, supra n 5, at 23.

¹⁸⁵ “Statement about Liam issued by Williams-Holloway family”, *The Otago Daily Times*, 13 February 1999, 3, per Brendan Holloway & Trena Williams. In fact, the estimated life expectancy for neuroblastoma incorporates the chance of recurrence. That is, there was at least a fifty percent chance that Liam’s cancer would be completely cured, with no recurrence, and with a normal life span. All cancer treatment is “experimental” because clinical trials are continually being carried out, and treatments are continually being improved; Dr Sullivan (interview).

¹⁸⁶ *New Idea*, supra n 3, at 9, per Brendan Holloway & Trena Williams.

¹⁸⁷ Dr Sullivan endorsed the use of nutritional supplements. He estimates that forty to fifty percent of child cancer patients receive alternatives treatments alongside the conventional treatment; “‘No trend away’ from traditional treatment”, *The Otago Daily Times*, 18 June 1999, 3.

¹⁸⁸ *New Idea*, supra n 3, at 9, per Brendan Holloway & Trena Williams.

enhancing the body's immune system.¹⁸⁹ Liam was undergoing twice daily sessions with the booster as well as “painful body therapy” where acupuncture points are held down until they burn.¹⁹⁰ After four months of alternative treatment, the parents felt that Liam was cured.¹⁹¹

In *Re Norma*, there was some evidence that the alternative treatment was having an effect on Norma's tumour, but this evidence was outweighed by the conventional medical evidence. Liam's parents said that his tumour had decreased by eighty percent in size within three weeks of going into hiding, attributing it to the alternative treatment. However Dr Sullivan pointed out that the tumour was already decreasing after the two sessions of chemotherapy and the further decrease in size would be due to that treatment. The decrease in size showed that the cancer was reacting favourably to the chemotherapy, and there was a very small chance that the cancer could have been cured after just two cycles.¹⁹² If it was not cured, it would recur and progress, as neuroblastoma can become drug-resistant if chemotherapy is interrupted.¹⁹³

There was no medical evidence offered to the court to suggest that the quantum booster treatment would be successful. In fact, Liam's parents were aware that the healers they saw had never treated neuroblastoma. The alternative therapists that treated Liam did not claim that the booster can cure cancer, but that as part of a comprehensive holistic process, they can treat the “underlying condition” that has caused the cancer.¹⁹⁴

¹⁸⁹ “Quantum booster can't cure, says specialist”, *The Sunday Star Times*, 9 May 1999, A5. The quantum booster was invented in the 1930s by Royal Rife. He claimed to have completely cured all 16 cancer patients who used the machine. The machine sends various frequencies through the body, confusing the cancer cells while boosting the immune system.

¹⁹⁰ “Electrical pulses used in treatment”, *The Otago Daily Times*, 7 May 1999, 3; *Listener*, supra n 5, at 23, per Dawn Uys, an alternative therapist who treated Liam.

¹⁹¹ *New Idea*, supra n 3, at 9, per Trena Williams.

¹⁹² “Mind that child”, *Listener*, 22 May 1999, 18, at 19.

¹⁹³ Dr Sullivan (interview).

¹⁹⁴ <http://naturalhealthvillage.com/newsletter/990515/liam.htm>, per Gerard Uys, a natural therapist who treated Liam.

The Family Court paid particular regard to the Court of Appeal decision in *Re J*. The test in that case was that intervention was appropriate if the parents' refusal was "likely to place at risk the life, health or welfare of their child." Judge Blaikie found, on the evidence made available, that the parents' refusal was likely to place Liam's life at risk.¹⁹⁵ As the court noted, the conventional medical opinion was "clear and abundant": without chemotherapy treatment Liam would die.¹⁹⁶ This implicitly rejects any notion that alternative treatments could be successful.

It is highly unlikely that the parents could have offered evidence that showed Liam's life could be saved with alternative treatment, as they themselves accepted that neuroblastoma had never been treated that way. Thus, even if the parents had been in court, the evidence would have shown that Liam's life depended on chemotherapy, and the same conclusion would have been reached.

B. Quality of life and pain and suffering

Liam's parents were not happy with the side effects and pain that Liam was suffering with chemotherapy. Rather than deciding that their child would be better off dying peacefully, as in *Re T*, they felt alternative medicine would minimise Liam's pain and suffering.¹⁹⁷ Liam was very unhappy and sick and told his parents he did not want the treatment. Liam's parents noted that ten day intervals of chemotherapy is very severe.¹⁹⁸ When he woke up with intravenous drips attached, Liam became very distressed and at one stage he hit his doctor.¹⁹⁹ He was treated with radioactive dye which meant he could have no contact with his pregnant mother and had to take several

¹⁹⁵ Judge Blaikie (interview)

¹⁹⁶ *Williams-Holloway*, 18 March 1999, supra n 7, at 7.

¹⁹⁷ *The Otago Daily Times*, supra n 185.

¹⁹⁸ For many cancers chemotherapy is given in 21 or 28 day cycles; "Health 'fugitives' relive the agony", *Sunday Star Times*, 9 May 1999, A5, per Trena Williams. Ten day intervals increase the chance of success, but do not cause any more side effects; Dr Sullivan (interview).

¹⁹⁹ Liam had been disturbed and anxious since first being presented to Dr Sullivan; (interview).

other precautions.²⁰⁰ To the media, the parents gave examples of the side effects suffered by Liam, including diarrhoea, bed wetting, vomiting and blood loss.²⁰¹ Other acute side effects include anorexia, poor appetite, nausea, anaemia, kidney and renal damage, high frequency hearing loss, neurotoxicity and infection, although the effect of some side effects can be minimised with treatment.²⁰² The only side effects Liam suffered were a low blood count, some nausea and one episode of vomiting.²⁰³

Without treatment a child cancer patient will suffer “side effects” of the cancer itself. As the cancer spreads throughout the body, the child may suffer infections, chest pain, bone pain and fractures, anaemia, renal and liver failure, physical obstruction of blood vessels and airways, bleeding and haemorrhaging. The relentless progression of the cancer eventually leads to death.²⁰⁴

This was not a case where Liam’s life would be completely intolerable, as in *Re J (A Minor)*, nor one where his immediate death was inevitable, as in *Baby L*, so considerations of pain and suffering and quality of life could not alone outweigh preservation of life.

After six doses of intense chemotherapy Liam was to be subjected to a final, extremely high dose of chemotherapy. Then a stem cell transplant would take place, followed by a

²⁰⁰ *New Idea*, supra n 3, at 7, per Brendan Holloway.

²⁰¹ *Idem*.

²⁰² For example, anti-vomiting agents, anti-nausea drugs and blood products. The drugs used to combat chemotherapy-induced vomiting are very potent and effective. Anticipatory vomiting caused by anxiety is kept to a minimum by creating a friendly environment for the children. A child’s blood count, hearing and kidneys are continually monitored. If there is any sign of impairment treatment ceases immediately; Dr Sullivan (interview).

²⁰³ The parents told the media that after Christmas Liam picked his nose and it bled profusely until Liam swallowed so much blood that he vomited up a mass of coagulated blood. Liam had to be helicoptered to hospital for a blood transfusion; *Holmes*, supra n 4. Platelets in the blood cause clotting and Dr Sullivan points out that a low platelet count is expected after chemotherapy. For that reason Liam’s parents were advised to remain in Dunedin after Liam was discharged early for Christmas. Instead the Williams-Holloways took the train to Middlemarch, where Liam’s bleeding began. Had the parents stayed in Dunedin, Liam could have had a blood transfusion before the bleeding became excessive; Dr Sullivan (interview).

²⁰⁴ Dr Sullivan (interview).

course of cis-retinoic acid.²⁰⁵ The entire course of treatment must be done in the recommended time to be effective and Liam's course would have been finished by June 1999. A young chemotherapy patient must be re-assessed regularly for a number of years. The assessments, made up of x-rays, blood tests and examinations, are monthly for about three years and then yearly until the child reaches adulthood.²⁰⁶ If chemotherapy is successful, the patient will have a normal quality of life.

Thus while Liam was clearly suffering from the chemotherapy, and this was a relevant consideration in *Re T*, chemotherapy is a "tolerable" treatment.²⁰⁷ Liam's case is quite different to the situation in *Re T*, where the child was facing a life time of drugs and treatment, even if the surgery was successful. Liam could expect to live a normal, full life after treatment. As such, while considerations of quality of life and pain and suffering could have been considered, the level of suffering by Liam would not have been sufficient to override the importance of preservation of life.

C. Parental choice

The desires of Liam's parents were clear by the time the guardianship application was made.²⁰⁸ The court was aware of their beliefs regarding alternative therapies and that they did not want Liam to receive chemotherapy treatment, although there was no indication as to what type of therapy they were seeking.²⁰⁹

²⁰⁵ A stem cell transplant is a bone marrow transplant of the patient's own bone marrow. Cis-retinoic acid is a form of vitamin A which is administered in pill-form for about six months to all child cancer patients post-chemotherapy. It has been proven to help kill off remaining cancer cells; Dr Sullivan (interview).

²⁰⁶ Dr Sullivan (interview).

²⁰⁷ Dr Sullivan (interview).

²⁰⁸ Liam's parents told HealthCare Otago on 5 January 1999 that they were seeking alternative treatments for Liam. On 11 January Liam's father agreed that Liam would be returned for treatment on 25 January and was to confirm this on 22 January. When the hospital did not hear from Liam's parents on 22 January, it immediately made the application to the court.

²⁰⁹ *Williams-Holloway*, 18 March 1999, supra n 7, at 6.

The Williams-Holloways, who prior to Liam’s diagnosis had virtually no knowledge of cancer at all, had researched, analysed, weighed up the odds, and chosen what they believed was the best treatment for their child.²¹⁰ They had evidence of serious side effects that can be caused by the rapid cojec treatment and the high recurrence rate of neuroblastoma. Liam’s father claimed he was told by an oncologist that chemotherapy may be deemed “barbaric” in five years time.²¹¹ These factors were all part of the reason they had chosen non-invasive treatment.²¹²

This was not a case where the parents were well-informed, but was a case where they were acting on “dubious” information.²¹³ The parents had been told by an alternative therapist that chemotherapy would destroy Liam’s immune system and damage any chance of recovery. This advice was based on outdated 1980s data and was not consistent with cancer success rates in New Zealand and overseas.²¹⁴ The parents refused to accept credible scientific information, preferring to rely on information from non-experts. When asked by Dr Sullivan what treatment the parents were using, Liam’s father talked about a “conspiracy” by orthodox doctors to suppress the treatment, refusing to elaborate further. This reference to a conspiracy indicated that the parents were acting on unfounded information when making their assessment and decision.

This case can be compared to *Re T*, where the parents’ choice not to consent to treatment was upheld by the court, because there was “genuine scope” for the decision.

In *Re T* the parents were “loving and devoted”, had given the decision “anxious

²¹⁰ *Holmes*, supra n 4, per Trena Williams.

²¹¹ *Sunday Star Times*, supra n 198.

²¹² “Parents of young cancer sufferer to remain in hiding”, *The Otago Daily Times*, 13 February 1999, 1.

²¹³ *Listener*, supra n 192, at 20, per David Becroft, paediatric pathologist.

²¹⁴ Cancer research is progressing so quickly that publications are almost immediately out of date. The overall success rate for child cancer in New Zealand is seventy to eighty percent and in Otago is seventy-eight percent. The increase, up from a ten percent success rate in the 1960s, is due to clinical research and drug analysis worldwide. Cancer research is continually advancing and the latest research on neuroblastoma was published internationally in October 1998, one month before Liam was diagnosed; Dr Sullivan (interview). The New Zealand Medical Association argues that there should be regulation of alternative therapists to avoid “unscrupulous practitioners” from preying on patients’ fears; “Call for regulations for alternative healers”, *The Otago Daily Times*, 20 March 1999, 3.

consideration” and their decision was backed up by one doctor who said he would not go ahead without the parents’ consent. Liam’s parents too are loving and devoted, and had certainly given great consideration to their decision by researching cancer treatments and alternatives. The court in *Re T* was also influenced by the parents’ knowledge of medical care, which Liam’s parents do not have, Dr Sullivan believing they were misguided in their beliefs. Waite LJ’s obiter dicta in *Re T* left it open for a court to find that a belief in alternative therapies is an example of a “dogmatic” opposition that is “patently irreconcilable with principles of child health.” While the reason that the parents are refusing treatment should not influence the decision, where parents are relying on scientifically unproven or false information, there can not be genuine scope for that decision.

Liam’s parents did not have a religious objection to the treatment, but there could still have been a Bill of Rights issue, as section 15 guarantees the right to manifest one’s “belief”, in this case, their belief in the viability of alternative medicine. As the Court of Appeal in *Re J* held, a parent’s right must be compatible with the child’s right to life, and can not override the child’s right to life. The Family Court was aware of this binding Court of Appeal case, and could not have allowed a rights argument on its own to succeed.

If a reasonability approach had been taken in this case, the court would have started on the premise that Liam’s parents were the preferred decision makers. The court would then have looked at the decision and asked whether Liam’s parents’ decision was so unreasonable that no reasonable parent could have made it. The parents were clearly loving, devoted and genuine in their belief. They argued that alternative medicine involved less pain, resulted in a better quality of life and had a higher chance of success. These arguments concerning pain and quality of life are analogous to the successful arguments advanced in *Re T*. Those parents were concerned primarily with the after-care, but were also concerned that the treatment itself was invasive and distressing. The

only difference between the cases is in the parents' solution: in *Re T* it was that his best interests would be served by no treatment at all, and in Liam's case that alternative treatment would best serve his interests.

The court must look at the reasoning given by the parents and see if there was a "leap of logic" made. Here, the parents felt that Liam was suffering from chemotherapy, and that alternative medicine would cure him. There was a leap of logic: their assumption that alternative medicine would cure Liam was not proven by any reliable means. The court must then decide whether a reasonable parent would have made this leap of logic. No reasonable parent would base a decision concerning the life of their child on unfounded data. As such, any decision that is based on unreliable data must be unreasonable and the court should interfere.

It is possible that Liam's parents did in fact have the same goal as the parents in *Re T*. While there is no evidence of this, they may have chosen alternative medicine as a way to relieve Liam's pain as he died from the cancer. Had they made this argument in court, they would not have been seen as unreasonable parents relying on unproven "quack" medicine, but may have been seen in the same light as the parents in *Re T*: as reasonable parents wanting their son to die peacefully. However, while Liam was clearly suffering the side effects of chemotherapy, it was not to the extent that the child in *Re T* suffered. Liam's suffering, while distressing, would be short lived, lasting only a few months, with no long-term effect on his quality of life. This can be compared to the lifetime of after care that was required in *Re T*.²¹⁵ Reasonable parents would not allow their son to die to avoid painful, but not unbearable treatment, when the quality of life after the treatment would be normal, especially where the relentless death caused by the disease itself would cause significant suffering.

²¹⁵ The after care required for a liver transplant is more involved than for chemotherapy; Dr Sullivan (interview).

The court may not allow an argument based on parents' rights to decide on treatment, but may consider whether there is genuine scope for the parents' decision. The reasonableness approach is the most appropriate test for the court to use, as it allows for genuine differences of opinion, but still keeps the welfare of the child paramount, and requires the court to justify its intervention. The use of the reasonableness test in Liam's case would likely have led the court to decide that the reliance by the parents on unproven evidence, in the face of substantial evidence to the contrary, was unreasonable.

D. Likelihood of the treatments' success²¹⁶

The evidence was that with conventional medicine Liam had a fifty percent chance of survival and without it would inevitably die.²¹⁷ The chance of Liam dying from the adverse effects of the chemotherapy treatment was less than two percent. There was no evidence whatsoever that alternative therapy would have any success at all. The parents believed that chemotherapy would destroy Liam's immune system and if alternative medicine was going to work, there was only one chance to do it before Liam's body was "ravaged" by chemotherapy.²¹⁸

In Liam's case the court had to rely on the evidence put before it and was compelled to accept that chemotherapy had a higher success rate than alternative medicine. Even if the chance of success had been lower, the Family Court could still have ordered treatment, as in *Re Norma* the fact that there was any chance at all to save the child's life meant that the judge ordered treatment.

²¹⁶ There are no cultural considerations in Liam's case. While some may feel that believers in alternative medicine belong to a quasi-culture of their own, it is really a "belief" rather than a "culture".

²¹⁷ Although note that if Liam had only stage 3 neuroblastoma his survival rate was eighty percent. Liam's parents claimed (*The Otago Daily Times*, supra n 185) that there was no long term survival rates available, and that neuroblastoma has a high recurrence rate. However, this objection by the parents indicates that they did not properly understand the information given to them. The survival rate given for child cancer patients is the chance of *complete cure*, with no recurrence and a normal life span; Dr Sullivan (interview).

²¹⁸ *Holmes*, supra n 4, per Brendan Holloway.

Dr Sullivan has said that if the chance of a cure is “very low”, less than twenty percent, it may be appropriate to use only alternative treatments. But a fifty percent chance of success is too good a chance to use alternatives alone.²¹⁹ Where the chance of success with orthodox treatment is below twenty percent, it would be appropriate for the court to give greater weight to the parents choice than to preservation of life.²²⁰ If there was evidence that the alternative medicine had a thirty percent chance of success, compared to the fifty percent chance with chemotherapy, Dr Sullivan would not have interfered with the parents’ decision.²²¹ It would appropriate for the court to take a similar line.

E. Bodily integrity

Liam understood that they had to get rid of the lump on his face.²²² The chemotherapy, Liam said, was “yuck” and “made me more sicker (sic) . . . ‘cos of the chemicals.”²²³ He repeatedly told his parents that he did not want the chemotherapy treatment. While the court would have been required to take Liam’s views into account, his view was coloured by the fact that he was only three years old.²²⁴ Understandably Liam did not like the treatment he was undergoing, but his objection was based solely on the physical pain he felt. At three years of age it is highly unlikely that he could have understood the consequences of choosing alternative treatment over chemotherapy. It is unlikely that his parents ever explained to him that there was a chance he could die, and even if they had, he could not have comprehended the meaning of his own death. Thus, while the court could consider the fact that Liam did not like the chemotherapy treatment, it could not give great weight to it.

²¹⁹ *Listener*, supra n 5, at 23.

²²⁰ Dr Sullivan would not consider making a court application if the chance of success was that low, but would respect the parents’ decision; (interview).

²²¹ In actual fact, in the medical world alternative therapies are called “alternative” *because* there is no evidence that they work. It is therefore anomalous to compare the success rates of conventional and “alternative” treatments; Dr Sullivan (interview).

²²² *Holmes*, supra n 4, per Trena Williams.

²²³ *Ibid*, per Liam Williams-Holloway.

²²⁴ Guardianship Act 1968, s 23(2).

The Family Court could have asked itself what Liam would be likely to choose if he was competent to make an informed decision. The question is whether Liam would choose to undergo chemotherapy with all its side effects, or would choose alternative therapies with fewer side effects but a lower chance of success. This would depend on whether Liam held the same views towards alternative therapies as his parents. If he also believed that the therapy would cure him, then clearly he would choose that. However, if he was aware of, and believed, the statistical evidence regarding the treatments, he would then have had to make his decision based on a consideration of the side effects. The human instinct to survive would indicate choosing the chemotherapy, especially as this is a young boy who has not yet had a chance to experience adulthood.

Testicular cancer in young males has an equivalent curability to neuroblastoma. Dr Sullivan has said that “very, very few” of these patients refuse chemotherapy treatment.²²⁵ This information could be used by the court to conclude that it would be highly unlikely that Liam would refuse to undergo conventional treatment if he were competent.

While it is appropriate to consider the child’s views, it will never be appropriate for a court to base its decision entirely on the child’s wishes. It is also proper for the court to step back from the parents’ arguments and ask itself what the child would want. In cases where there is a lot of pain and suffering, and no good quality of life can be expected, it may be appropriate to conclude that the child would not want the orthodox treatment. However, in cases where the quality of life will be tolerable, it should be assumed that the child’s instinct to preserve his life, so he will reach adulthood, would mean he would consent if he were competent, despite the fact that the treatment involves considerable pain and suffering. While Liam did not like the chemotherapy, it is unlikely that he would forfeit his chance to live a normal adult life for the sake of

²²⁵ Dr Sullivan (interview).

saving himself three months of painful treatment. Thus, if the Family Court had considered Liam's bodily integrity, it would still have made the same decision.

VI. CONCLUSION

Preservation of life will always be the primary principle in these decisions. Looking at the success rates of the treatments proposed will indicate to the court which treatment would be most likely to save the child's life. Where the chances of success of two proposed treatments are within twenty percent, or the chance of survival with either treatment are below twenty percent, the parents' decision should not be interfered with. Outside these ranges, treatment should be ordered in all cases except those where the quality of life after treatment would be such that the child's life would be intolerable. In all but these extreme situations, quality of life considerations alone should not be decisive. When a child's whole life is before it, it is not appropriate to deny that life because treatment will be temporarily painful.

The court should ask itself what this child would be likely to choose, if it were competent. In doing so, the court must keep in mind the human instinct to survive, and, where quality of life is at issue, the fact that a young child will have known no other life.

Any argument about parental "rights" can not succeed. However, the court should look at the parents' decision and ask whether it is a decision that a reasonable parent could make. The conclusion is reached by looking at all the principles discussed and asking whether a reasonable parent, who had considered all of these principles, would make the decision to refuse consent. If there is a "leap of logic" that no reasonable parent could make, then the court can overturn the decision.

The reasonable-parent approach is the most appropriate test to use, as it involves considering each of the principles discussed. The test starts with the presumption that

parents are the preferred decision makers, because they have the specialist knowledge of their child. This presumption is clearly set out in the United Nations Convention.²²⁶

As in judicial review cases, the court should not re-consider the case on its merits, but should determine whether the parents' decision is one that reasonable parents could make. This upholds the parents' statutory right to make decisions regarding their child. If the parents have considered preservation of life, quality of life, pain and suffering, cultural issues, the chances of success of the treatments and bodily integrity and reached a decision that, with regard to those principles upholds the child's best interests, then that decision should not be interfered with. The reasonability of the decision will depend on an analysis of the principles discussed here.

In Liam's case, the correct decision was made by the Family Court. Liam's parents were not making a reasonable decision. Liam was suffering from the chemotherapy, but it was only temporary, and there was a good chance that he could look forward to a full and normal life after treatment. His parents were relying on unproven and unreliable evidence that the quantum booster would save Liam's life. Even if their true goal was to allow Liam to die quietly, they were unreasonable to deny him a full adult life on the basis that there would be three months of distressful chemotherapy.

This thesis sets out a framework that the courts should follow when deciding whether to override parents' refusal to consent to life-saving medical treatment. In all but the most urgent of cases the court has the time to use the reasonability test to determine whether the parents' decision is reasonable having regard to all the relevant principles.

²²⁶ Art 18. This presumption is also acknowledged in the Guardianship Act, the Children, Young Persons and Their Families Act and by Judge Inglis QC in *C v B*, supra n 117, at 360 and *Neho v Duncan*, supra n 118, at 160.

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