When I was first asked to contribute the foreword to this edition of the New Zealand Law Students’ Journal (NZLSJ), I confess to some hesitation. With esteemed predecessors like the Chief Justice, the Governor-General, the Solicitor-General and Sir Geoffrey Palmer, I felt markedly under-qualified for the job. But, as was pointed out to me by the Editor, the very purpose of this publication is to provide a student voice in the world of academic scholarship. As such, I am pleased to introduce this latest instalment of the NZLSJ.

The purpose of this Journal is to provide a dedicated platform for the publication of student work. The value in doing so is twofold. First, it is a means by which New Zealand’s law students can contribute to contemporary legal commentary. Not having been exposed to practice, students bring unique perspectives to legal issues. The NZLSJ, which is in the business of collating the thoughts of the country’s sharpest up-and-coming legal minds, ensures that these perspectives are heard. Undoubtedly, academic debate is enriched as a result. Secondly, the NZLSJ affords students a dedicated avenue through which to have their work published. Often, the students — many of whom are yet to graduate or are recent graduates — submit research and writing generated in the course of their studies. The submission of students’ Honours papers is not uncommon. Having a piece of academic writing published can be a satisfying reward for a job well done. It is also a valuable part of the educational experience that law students are at university to undertake.
The NZLSJ is now entering its eighth year (2014), having been established in 2006. It has already outlived its predecessor, the New Zealand Students’ Law Journal (note the crucial order of the words), which was started as a similar initiative of the New Zealand Law Students’ Association (NZLSA) in 2002. Unfortunately, it did not last the distance. So much more impressive, therefore, is the continued publication of this Journal. Congratulations to the Chief Editorial Board for their sustained commitment and hard work in producing another fine edition of the NZLSJ. Long may it continue.

Congratulations also to all of the students whose work is included in this edition. Without exception, the research and writing is of a very high standard. From my own recent memory, I know how long one can spend poring over every word and every footnote of an essay; it is clear that considerable care has been taken with each of the papers presented. Now the authors have the reward of knowing their meticulously crafted work will pass before the eyes of many interested readers.

The topics covered are also universally fascinating. Many of them have a health law focus. Emma Sherratt examines advance directives given by Alzheimer’s disease patients prior to their loss of capacity. Similarly, Philip Arnold engages in a thorough consideration of the interface between patient capacity — both to refuse treatment and where there is none — and the views of medical practitioners. Rebekah Mapson reviews the treatment of children under the Mental Health (Compulsory Assessment and Treatment) Act 1992, concluding that more could be done to tailor the regime to New Zealand’s youngest citizens. And Samantha Beattie weighs up the extent to which a right to informational privacy might be included in the Code of Health and Disability Services Consumers’ Rights. Outside of the operating
theatre, Natalie Jones investigates the fascinating new science of geoengineering (engineering the environment), which is growing in prominence in response to climate change. She asks what challenges this new science might pose for international law and policy. Finally, legal historians and economists will be interested to read Yoon Tae Nam’s contemporary appraisal of the United States’ Sherman Antitrust Act 1890.

The NZLSA is proud to be affiliated with the NZLSJ. Once again, congratulations to everyone involved in the production of this edition of the Journal, and good luck to all those involved in the future.

I commend this edition of the Journal to the reader.

Seamus Woods
NZLSA President 2013
EDITORIAL

TIHO MIJATOV
LLB(HONS) STUDENT, UNIVERSITY OF OTAGO

As the present issue marches the New Zealand Law Students’ Journal into its third volume I cannot help but feel proud of the shape the “NZLSJ” is taking. Our national student law journal is becoming an institution.

It certainly maintains its status as a New Zealand law journal. The members of the Chief Editorial Board, each of whom I thank for their proficient and passionate efforts over the past months, hail from law faculties all around New Zealand. The articles submitted for consideration came from nearly every law campus in the country. The six articles eventually published in this issue should make their law schools proud.

The range of topics covered by the articles reinforces this as a law journal, but it also reminds us just how broad “law” can be. Between them the six articles canvass and question law’s interaction with living wills, refusal of emergency treatment, children’s mental health, privacy, geoengineering, and competition in the marketplace. Instead of shying away from gnarly social issues, each article does the legal community a service by focusing on them in a coherent and crisp way.

Such confidence may well be the great benefit of ours being a student law journal. These articles provide readers with glimpses at what some of the best law students – future lawyers, academics, judges, politicians, activists and others – have been committing their brainpower to. In my own reading of the articles, I was struck by many authors’ concerns
about vulnerable groups in our society – children, the old, the sick and even the unconscious. Not a few of the authors called for legislative change to get justice through greater certainty. Some were unashamedly practical, looking forward to a better legal system. Another burrowed down into the past to critique accepted truths. If research and writing can be a window into the intellectual, moral, and cultural makeup of those behind it, this issue should assure the legal community that the law is passing into competent and careful hands.

Tiho Mijatov
Editor, 2013
ARE WE FORGETTING SOMETHING?
ADVANCE DIRECTIVES IN THE CONTEXT OF
ALZHEIMER’S DISEASE

EMMA SHERRATT *

Introduction

One of the many challenges faced by those diagnosed with Alzheimer’s disease is the loss of capacity to make decisions about medical treatment. As a society, we place a high value on autonomy and the right to refuse healthcare services.¹ Using an advance directive is a way to exercise this right to self-determination. But are advance directives an effective legal avenue for those with Alzheimer’s disease to maintain control of their medical treatment once competence has been lost? This article outlines the law on advance directives in New Zealand by exploring the common law derived from the United Kingdom and Australia. It will define the nature of Alzheimer’s disease and highlight the advantages of Alzheimer’s patients using advance directives. This article will then address the issues that may arise including the possibility that an advance directive is not followed or is invalid. It will be argued that New Zealand should promote the use of advance directives to the elderly and create legislation to avoid the problems

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¹ New Zealand Bill of Rights Act 1990, s 11.
arising from minimal guidance. A statute formalising the law on advance directives would provide much needed direction to health professionals and consumers.

A. Advance Directives

1. Definition and description

An advance directive, also known as a living will, is a statement made by a competent person indicating consent or refusal of consent to medical treatment once they have lost competence. It is an “embodiment of the patient’s autonomy and right of self-determination.” In New Zealand, the Code of Patients’ Rights specifies that “every consumer may use an advance directive in accordance with the common law”, and it can be made orally or in writing. This includes the ability to refuse services or withdraw consent. It does not entitle a person to receive the exact treatments they would prefer, but wishes may be expressed and these will be met where practical. Advance directives may also be overridden by legislation.

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2 Robin Jacoby “Ethical and Legal Aspects of Dementia” (2004) 3 Psychiatry 33 at 34.
3 HE v A Hospital NHS Trust [2003] EWHC 1017, 2 FLR 408 (Fam) at [37].
4 Code of Patient’s Rights, Right 7(5).
5 Part 4.
6 Right 7(7).
7 Right 7(8).
The common law relevant to the creation and implementation of an advance directive is found predominantly in the United Kingdom and Australia.\(^9\) In addition to case law, the United Kingdom has recently introduced legislation guiding the use of advance directives. The Mental Capacity Act 2005 (UK) sets out the formalities required for an “advance decision”, including that it must be in writing and signed by a witness.\(^10\)

There are, however, no specific or formal requirements for the creation or revocation of an advance directive in New Zealand, so witnesses or particular formats are not needed.\(^11\) Instead, overseas authority likely to be applied in New Zealand indicates an advance directive is valid and legally binding when four key elements are satisfied: \(^12\)

1. The individual was competent to make the particular decision(s);
2. They were free from undue influence when they made their decisions;
3. They were sufficiently informed to make the decision; and
4. They intended the directive to apply to the present circumstances.

\(Re\ T\) confirmed these conditions for the validity of an advance directive and stated that if the refusal of treatment is vitiated by an “overbearing [of] the patient’s independent will,” the advance directive

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\(^10\) Mental Capacity Act, ss 24-26.


\(^12\) Phillippa Malpas “Advance directives and older people: ethical challenges in the promotion of advance directives in New Zealand” (2011) 37 J Med Ethics 285 at 286.
will not be valid.\textsuperscript{13} This framework has been codified in the United Kingdom by the Mental Capacity Act.\textsuperscript{14}

Not only does an advance directive make lawful the failure to provide treatment where there would otherwise have been a duty,\textsuperscript{15} it can make the treatment unlawful if consent was refused in the advance directive.\textsuperscript{16} Advance directives are considered to be a fundamental part of respecting a person’s autonomy and this right to refuse medical treatment was discussed at length in the English case \textit{Airedale NHS Trust v Bland}.\textsuperscript{17}

\ldots if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so \ldots To this extent the principle of the sanctity of human life must yield to the principle of self-determination.

This statement was, however, qualified by the requirement that “all necessary steps have been taken to be sure that this is what he or she really desires.”\textsuperscript{18} \textit{Auckland Area Health Board} confirms that in New Zealand the right to refuse medical treatment allows a patient to “require support systems be discontinued.”\textsuperscript{19}

\begin{flushleft}
\textsuperscript{13} \textit{Re T} [1992] 3 WLR 782, [1993] Fam 95 (CA) at 116.  \\
\textsuperscript{14} Mental Capacity Act 2005 (UK), s 3(1).  \\
\textsuperscript{15} Skegg and Paterson, above n 11, at 233.  \\
\textsuperscript{16} At 233.  \\
\textsuperscript{17} \textit{Airedale NHS Trust v Bland} [1993] AC 789 (HL) at 864.  \\
\textsuperscript{18} At 892.  \\
\textsuperscript{19} Auckland Area Health Board v Attorney-General [1993] 1 NZLR 235 at 245.
\end{flushleft}
B. Advance Directives in the Context of Alzheimer’s Disease

1. Definition and description of Alzheimer’s Disease

Approximately 40,000 New Zealanders suffer from dementia,\textsuperscript{20} of which Alzheimer’s disease is the most common form.\textsuperscript{21} Although not exclusively found in elderly people, Alzheimer’s is predominantly found in those over 70 years old.\textsuperscript{22} Alzheimer’s disease results in a gradual deterioration of intellectual functions, including an inability to learn new things, understand language, perform daily tasks, and the progressive loss of memory.\textsuperscript{23} This cognitive impairment is caused by the deterioration of brain cells, which happens for an unknown reason.\textsuperscript{24}

2. Advantages of Alzheimer’s patients using advance directives

Alzheimer’s disease generally has a gradual onset,\textsuperscript{25} allowing a patient time to think and consider their preferences for treatment and make an advance directive before they lose competence. Patients are likely to make advance directives anticipating cognitive decline with the knowledge of the end-of-life issues they may face, so they can plan accordingly. From this perspective, advance directives will be beneficial for patients with early stage Alzheimer’s disease to extend their autonomy beyond loss of competence.

\textsuperscript{20} Malpas, above n 12, at 286.
\textsuperscript{21} Mental Health Foundation of New Zealand “Dementia” (booklet, 2002) at 6.
\textsuperscript{22} Malpas, above n 12, at 286.
\textsuperscript{23} Mental Health Foundation of New Zealand, above n 21, at 6.
\textsuperscript{24} Alzheimer’s Society “What is Alzheimer’s Disease?” (factsheet, March 2012) at 3.
\textsuperscript{25} Mental Health Foundation of New Zealand, above n 21, at 6.
The foreseeability of Alzheimer’s also means that family members and doctors can be made aware of the presence of the advance directive. This avoids an advance directive not being followed due to healthcare providers being unaware of its existence. It is also useful for ensuring that the advance directive is carefully considered and made with the awareness of all possible consequences of the expressed choices.

Significantly, advance directives promote autonomy and informed decision making, encouraging patients to look at all treatment options. This model of healthcare challenges the traditional notion of paternalistic medicine where a patient is told what is best for their treatment or quality of life without dialogue or consideration of the consumer’s opinion. Honouring advance directives can help healthcare providers perform their duties, particularly to give effect to the autonomy rights of their patient. Advance directives can also be used as a guide for treatment, shedding light on patients’ values and ideals which can influence what a doctor might determine as the patient’s best interests.

Additionally, the use of advance directives is helpful for families. Watching a loved one gradually deteriorate as a result of Alzheimer’s disease can be a painful and emotional experience for friends and family members. One advantage of an advance directive is that it can reduce the burden of decision making or other concerns during end-of-life treatment. For example, a decision that has already been made in the form of an advance directive means that families are not left with the difficult decision whether to withdraw life support. The family is able to

26 Wareham, McCallin and Diesfield, above n 8, at 357.
27 At 357.
28 At 357.
reassure themselves that the patient is receiving the healthcare they wanted and specifically asked for while competent, reducing the likelihood of distress for family members in a traumatic situation.29

3. Use and promotion of advance directives

Because of these advantages, recommending advance directive creation should be an important part of treating or caring for an Alzheimer’s patient. There is little knowledge of advance directives and their use or endorsement in New Zealand,30 but statistics from the United States indicate completion rates of advance directives sit at only ten percent of healthy Americans.31 This suggests that New Zealand should consider educating the public and promoting the use of advance directives, particularly to the elderly and those who care for them.

Currently, advance directives are promoted by several organisations including Alzheimer’s New Zealand Incorporated and The Voluntary Euthanasia Society of New Zealand. Among other societies, these organisations promote writing down preferences for medical treatment as the best way to create an advance directive.32 However, when hospitals in Canada and the United States have tried to encourage patients to write advance directives, “the take-up rate has been low”.33 Perhaps this can be attributed to a society that prefers not to think

30 Wareham, McCallin and Diesfield, above n 8, at 356.
32 Malpas, above n 12, at 286.
33 Jacoby, above n 2, at 34.
about or plan for death. The cultural norm can be seen as fear or denial of death, and so the concept of advance directives is generally not appealing. Arguably, education about end-of-life issues and planning is necessary to alter society’s perceptions, and therefore make extension of autonomy a possibility for everyone.

Health providers are “ideally placed to educate consumers about advance directives.”34 Ron Paterson, former Health and Disability Commissioner, advised general practitioners (GPs) and others caring for the elderly to encourage and be involved in the creation of an advance directive.35 He stressed the importance of healthcare provider involvement in order to make sure a patient is informed, and to enable advance directives to be easily followed and understood in end-of-life treatment. This communication can be useful to garner a general understanding of a patient’s wishes or values. It is also a requirement set out in the Code of Patients’ Rights.36 If a GP is involved in the creation of an advance directive it is likely that there will be less contention surrounding the preferences of a patient.

Phillipa Malpas, however, argues that the constraints within the general practice setting, particularly on consultation time, mean it is difficult for GPs to promote living wills.37 The end-of-life discussion requires a holistic assessment of the patient’s values, potential future medical

35 Ron Paterson, Health and Disability Commissioner “Advance Directives, Living Wills and Questions of Competence” (presentation to the NZ Hospitals Association Conference ‘Chance or Choice – Staying Motivated in Aged Care’, 7 March 1997).
36 Code of Patient’s Rights, Right 6(1).
37 Malpas, above n 12, at 287.
issues, and outcomes of treatment. Many GPs also may not have the skills or support to execute such a consultation accurately. Therefore, although GPs are the best placed to promote and assist with the creation of an advance directive, several consultations are likely to be required and GPs need to be “adequately skilled at communicating with older persons about end-of-life issues.”\footnote{At 287.} This requirement is likely to create a cost and therefore an access issue.

Malpas also points out that “caution should be exercised in promoting advance directives to older people” with areas of concern including ageist attitudes and stereotypes.\footnote{At 285.} Considering that many advance directives are aimed at refusal of treatment, they could be used as a way to cut costs on the extremely expensive healthcare required in chronic illnesses, where it could be seen that treatment merely prolongs the dying process. The ageing population in New Zealand, combined with requirements for extended treatment, are arguably a burden on limited resources.\footnote{John Bryant and others “Population ageing and health expenditure in New Zealand, 1951-2051” (Ministry of Health, Wellington, 2004).}

However, promoting the use of advance directives in order to solve financial constraints, or even family burdens, limits the integrity of an important medium which should be promoting the right to autonomy. For this reason, Malpas argues that advance directives could be viewed by elderly as a way for doctors to justify redirecting funds elsewhere, instead of being concerned with the patient’s treatment preferences.\footnote{At 286.}
Determining the validity and possible implementation of advance directives creates an opportunity for health professionals and family to make value judgments about the worth of an individual’s life, in direct opposition to the principle of sanctity of life. It may not even be an intended or conscious judgment about the rationing of funds, but this would still be contrary to the right to life. For example, among nurses the general attitude was found to be that old people are “bed-blockers” who focus limited resources away from those who have the potential to live longer with a greater quality of life.42

Concerning moral principles, ageist attitudes influencing rationing should not be assisted by advance directives being used for the wrong reasons. To combat this problem, it is suggested that advance directives are promoted in conjunction with relevant training of health professionals, and guidelines for both doctors and patients. Further, care should be taken in how advance directives are offered. Living wills should not be forced on people but instead promoted as an option to be explored and used if they wish. Assurances should be provided to patients that advance directives are not used to redirect funds or ration healthcare, and are instead important for extending their autonomy beyond loss of competence.

4. **Advance directives not followed or consulted**

One significant issue limiting the usefulness of advance directives for those with Alzheimer’s is that they may not be adhered to. “The principle of autonomy all too often succumbs to society’s interest in preserving life.”43 One study showed that doctors are more likely to make subjective value judgments concerning quality of life rather than

42 At 286.
43 Sam McMullan, above n 9, at 360.
follow an advance directive created by the patient, while another found that in most cases involving emergency medicine, advance directives are not even consulted. The disregard for previously expressed wishes is also evident at the wider level of healthcare providers. Two New Zealand District Health Boards have expressed in their guidelines that “a cautious approach to advance directives should be taken.” A hospital or aged care facility with a policy that their medical professionals should not be guided by advance directives is creating an unnecessary barrier to the implementation of living wills and should be addressed.

The nature of an advance directive is that it requires a doctor “with statutory and ethical obligations ... to provide the necessaries of life” to instead follow directions not to treat – in accordance with the right to refuse medical treatment. The natural instinct of a health professional, and the general requirement we place on our doctors, is to save lives to the best of their ability. The overarching duty of a doctor is to act in the best interests of the patient, yet obeying an advance directive may fly in the face of this central principle. Omitting to provide treatment, even if the non-action is requested, goes against the obligations and nature of the healthcare profession. Additionally, health professionals who are

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46 McMullan, above n 9, at 360.
48 Paterson, above n 35.
both highly skilled and more knowledgeable than patients on issues of
treatment do not like having their work dictated to them by the patient.

As a result of loss of control and the potential ethical dilemmas,
advance directives may be disregarded by health professionals who are
swayed by factors such as family opinion, implementation difficulty,
fear of the legal consequences of omitting treatment, or an advance
directive that is non-specific. It is easy to see how a doctor may choose
to interpret an advance directive in accordance with what they or the
family are most comfortable with, rather than truly considering the
wishes of their patient. In contrast, if a healthcare provider agrees with
the decisions expressed by a patient in an advance directive, it will rarely
be questioned.49

A different observation was made in a study looking at whether
advance directives were followed in rest homes in the US.50 It found
that advance directives were treated seriously and preferences regarding
feeding tubes in end-of-life treatment were honoured ninety-three
percent of the time. It also found that residents in nursing homes were
more likely to have created an advance directive than those cared for at
home or in hospitals. Advance directives were a key part of the
decisions made for treatment by staff, resulting from a culture of open
dialogue and information, where the creation of advance directives in
the context of holistic care meant autonomy was promoted to a high
standard. Considering the value New Zealand places on the right to
bodily integrity, this kind of environment is one to strive for in end-of-
life care.

49 Paterson, above n 35.
50 Cheryl Monturo “Advance Directives at End-of-Life: Nursing Home
Preferences for Artificial Nutrition” (2007) 8 J Am Med Dir Assoc 224.
Studies addressing healthcare professionals’ compliance with patients’ wishes as articulated in advance directives revealed that the greater the level of information concerning patients’ wishes, the higher the compliance with those requests.\(^{51}\) These findings encourage the use of disease-specific advance directives, which are more likely to describe in detail patients’ precise treatment choices. This method of selecting medical intervention preferences could be seen to provide the greatest level of control over treatment possible for someone who has lost their capacity to communicate. Others suggest that the best advance directives are those specifying the quality of life the patient would like to have, or their values that might influence a treatment decision instead of disease-specific choices.\(^{52}\) These are also considered to be more palatable to doctors. Such living wills could include preferences such as: not being left incontinent, objection to receiving intrusive treatment, or not wanting to be in pain.

Specific treatment directions may be detrimental because the unpredictable nature of medical events could mean that refusal of consent will be applied even if the situation is not what the competent creator intended.\(^{53}\) Additionally, new treatments improving quality of life may exist that were not known when the advance directive was made. Expressing values, rather than imposing specific treatment refusals, arguably has greater potential to be followed by healthcare professionals. Such advance directives do not intrude on the treatment

\(^{51}\) Natalie Evans and others “A critical review of advance directives in Germany: Attitudes, use and healthcare professionals’ compliance” (2012) 87 Patient Education and Counselling 277 at 277.

\(^{52}\) Simon Towler and others “A National Framework for Advance Care Directives” (Australian Health Minister’s Advisory Council, Australia, 2001) at 33.

\(^{53}\) At 33.
decisions of doctors, instead allowing the experts to use their knowledge and experience to do what is best for the patient within the preferences communicated through the advance directive. Arguably, leaving the actual treatment decisions in the hands of the doctors provides the patient with a real ability to address at the most basic level what they would object to regarding treatment of their body, as well as avoiding issues of ambiguity if the directions are written by someone with little medical knowledge.

Therefore, Alzheimer’s patients should give clear and specific instructions, make their advance directive with informed advice from their doctor, and if possible write it down because “there are obvious practical advantages in having advance directives in writing to ensure as far as possible that the consumer's wishes are understood and followed.” It is recommended that the content contains values and quality of life preferences rather than dictating specific treatment refusals. However, it could be best for some patients to create an advance directive containing both values and specific treatment refusals. For example, the living will could indicate the patient would like a certain quality of life, but definitely does not want one specific treatment.

Doctors should endeavour to remain objective when deciding to implement advance directives, and focus on the four legal requirements for a valid advance directive mentioned in the definition section above. Ron Paterson suggests that if a doctor is unable to carry out the wishes expressed in an advance directive for ethical or moral reasons, responsibility for care could be transferred to another provider. Medical professionals should remember that to not carry out an

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54 Paterson, above n 35.
55 Paterson, above n 35.
advance directive is to deny someone their rights to bodily autonomy and self-determination.

Perhaps the tendency to err on the side of treatment rather than follow a living will is also a response to the “lack of legislative clarity and inaccessible law” about advance directives.\textsuperscript{56} It may seem much harder to take on the responsibility for stopping treatment than simply initiating or continuing the cascade of treatment. If the law, and professional guidelines, were clearer on the ways doctors should approach and respond to advance directives, it would be much easier for doctors to follow the expressed preferences. Additionally, guidelines surrounding advance directives would be very helpful to those facing the daunting task of creating a living will. If Alzheimer’s patients were informed about the best ways to extend their autonomy and how their preferences should be expressed, it is more likely the directions they leave will be followed.

5. Issues with the validity of an advance directive

In New Zealand there are few formal requirements regarding the legal validity of an advance directive, and the ways a patient can make an advance directive are diverse. However, doctors must be careful when the advance directive is delivered by a friend or family member; they should determine if the wishes legitimately came from the patient.\textsuperscript{57} Care must also be taken where the wishes of an Alzheimer’s patient were expressed informally.\textsuperscript{58} Remarks about preferences for cessation of treatment without serious consideration of consequences are often made by competent people, but these are unlikely to be held as valid.

\begin{footnotes}
\textsuperscript{56} McMullan, above n 9, at 360.
\textsuperscript{57} Willmott, above n 47, at 563.
\textsuperscript{58} Skegg and Paterson, above n 11, at 547-548.
\end{footnotes}
This is particularly due to the change in view many have when they lose capacity but find they still value their life, or discover that the quality of life they want to refuse treatment for is still worth living.

Peter Skegg argues that once someone has become severely incapacitated their views or oral remarks, which previously would not be valid, are more significant because they have an understanding of the quality of life experienced while in their circumstances.\textsuperscript{59} This view arguably extends to those suffering the initial stages of Alzheimer’s as long as they are still sufficiently competent. These patients will be confronted with what it is like to live with Alzheimer’s and perhaps will have enough understanding of the degenerative process to have their views given more weight.

A health practitioner cannot contradict an advance directive unless the validity of the document is in question.\textsuperscript{60} It may be invalid if it does not represent the most recent preferences of the patient, if it is too vague or if the patient was misinformed. In the context of a quadriplegic refusing artificial feeding, which would result in death, the Supreme Court of Western Australia held that for an advance directive to be valid, a patient must be fully informed of the consequences of any refusal of treatment decisions.\textsuperscript{61} Any kind of misinformation or inadequate discussion with health professionals could result in a patient’s living will being invalid.

The advance directive can also be held to be invalid if there has been a change in the patient’s circumstances unanticipated at the time of

\textsuperscript{59} At 548.
\textsuperscript{60} Wareham, McCallin and Diesfield, above n 8, at 354.
advance directive creation.\(^62\) This can be seen in the case of \(HE \text{ v } A\) Hospital NHS Trust where a patient had signed an advance directive indicating refusal of any blood transfusions because she was a Jehovah’s Witness.\(^63\) There was, however, evidence that since the creation of the advance directive she had rejected the faith and become a Muslim. This was enough to indicate a change in the patient’s circumstances to invalidate the advance directive. This concept of changed circumstances could be extremely broad and has the potential to be used inappropriately as an excuse for not enforcing an advance directive.

In \(HE\), Munby J also observed that if the validity of an advance directive is called into question in a situation where “irreparable damage to the patient’s health is to be anticipated,” then it is in the public interest for the health providers to seek a court’s declaration to determine whether treatment in opposition to the advance directive would be lawful.\(^64\) Because it is often the life of a patient at stake, the court will need to establish “the continuing validity and applicability of the advance directive ... by convincing and inherently reliable evidence.”\(^65\) On this approach, a doctor is justified in continuing to provide treatment until a decision is reached.\(^66\)

To stop these issues preventing implementation of an advance directive, a specific time for renewal or revocation should be indicated at the time of its creation so that patients can always be sure their directions stay valid and represent their current values and ideals for

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\(^{62}\) Skegg and Paterson, above n 11, at 233.

\(^{63}\) HE v A Hospital NHS Trust, above n 3.

\(^{64}\) At [53].

\(^{65}\) At [24].

medical treatment.\textsuperscript{67} This supports the argument that an advance directive should only be valid if it was “made fairly recently, and ... applies to the consumer’s current condition.”\textsuperscript{68}

It is possible to look to the family or carers of an Alzheimer’s patient who have spent time with them after the advance directive’s creation in order to help interpret the wishes expressed in the advance directive or update preferences.\textsuperscript{69} The opinions of family or friends should, however, “rarely if ever be regarded as a sufficient reason (“lawful excuse”) for ceasing treatment that would otherwise have been provided.”\textsuperscript{70} In particular, care should be taken to ensure a living will is not invalidated due to undue influence in its creation. The Australian case of \textit{Hunter and New England Health Area Service v A} stressed that if the advance directive is not an independent exercise of the person’s will, it will not be valid.\textsuperscript{71}

There can also be issues of validity if the capacity of the patient at the time of creation of the advance directive is in question.\textsuperscript{72} In \textit{Hunter}, it was determined that a patient’s preferences for treatment should be respected unless there is evidence to rebut the presumption of capacity. It is therefore important for Alzheimer’s patients to consult their medical professional and ensure they have the requisite capacity to make a valid advance directive.

\begin{itemize}
\item[\textsuperscript{67}] Wareham, McCallin and Diesfield, above n 8, at 355.
\item[\textsuperscript{68}] At 352.
\item[\textsuperscript{69}] Paterson, above n 35.
\item[\textsuperscript{70}] Skegg and Paterson, above n 11, at 548.
\item[\textsuperscript{71}] \textit{Hunter and New England Area Health Service v A}, above n 66.
\item[\textsuperscript{72}] Willmott, above n 47, at 563.
\end{itemize}
In contrast, an advance directive is not invalid if it seems irrational or foolish to the treating health professionals. As long as all other requirements for validity are present, doctors must keep in mind that they do not have to find the living will reasonable to implement it. The United Kingdom addresses this issue in recent legislation, stating that “a person is not to be treated as unable to make a decision merely because he makes an unwise decision.”\(^73\) In the English case *Re E*, even though the advance directive was ultimately considered invalid due to incompetence at the time of creation, the seemingly irrational living will was not “less real” for it; it had the possibility of being enforced.\(^74\) It also does affect validity where the advance directive is based on “religious, social or moral grounds.”\(^75\)

Along the same line of reasoning an advance directive will still be valid in the absence of terminal illness, or if the person is not in a persistent vegetative state.\(^76\) Although these situations might be seen as typical cases for advance directive use, there is no requirement for a certain level of illness and it is up to the competent Alzheimer’s patient to determine the quality of life at which they consider it appropriate to refuse medical treatment.

### C. The Possibility of Legislative Change

The problems discussed show that the law in New Zealand on advance directives needs updating. Current legislation merely indicates that consumers have a right to create an advance directive “in accordance

\(^73\) Mental Capacity Act, s 1(4).

\(^74\) *Re E (Medical Treatment: Anorexia)* [2012] EWHC 1639 (COP) at [127].

\(^75\) *Hunter and New England Area Health Service v A*, above n 66, at 98.

\(^76\) *H Ltd v J* [2010] SASC 176.
with the common law.” As well as enshrining the common law in statute like this, guidelines should be set out for determining the capacity of those wishing to make advance directives. Guidelines on a legally binding form for living wills should also be created. This might be in the shape of a written document signed by a witness, as required in the United Kingdom’s Mental Capacity Act. A signed document could give health professionals confidence that the advance directive is authentic, valid and should be followed. A more formal advance directive also leaves less opportunity for abuse or fraud. Additionally, a legislative framework should inhibit medical practitioners from ignoring valid advance directives.

Ron Paterson opposed formal requirements for the creation of advance directives on the basis that “such an approach would unduly hinder the future development and recognition of advance directives.” Particularly important is ensuring that no limitation or restriction is placed on a patient’s ability to exercise their rights.

Lindy Willmott uses the consequences of recent Australian legislation to show how statutory regimes specifying the way advance directives should be made have “eroded rather than promoted the principle of autonomy.” She claims that regulating the circumstances in which an advance directive will operate undermines the right to bodily autonomy, and therefore legislation intending to facilitate the use of advance directives should not contain inflexible restrictions as to form or

77 Code of Patient’s Rights, Right 7(5).
78 Mental Capacity Act, s 25(6).
79 Malpas, above n 12, at 288.
80 Willmott, above n 47, at 564.
81 Paterson, above n 35.
82 Willmott, above n 47, at 556.
operation. “Given that the common law was shaped by the principle of autonomy ... it should follow that the legislation also safeguards and promotes the autonomy of competent individuals” to refuse medical treatment. The aim of formality requirements is to promote autonomy and ensure that a patient’s views are not misrepresented or unduly influenced. Therefore the effect of legislation should not be in opposition to these ideals.

It is suggested that New Zealand compromises between these principles of sanctity of life and self-determination by leaving the possibility of oral advance directives open, while still giving health professionals and consumers more guidance. Ensuring that formal requirements are not too onerous means that those in situations where a patient cannot write an advance directive or has limited time are still left with a way to extend their right to autonomy beyond loss of competence. Low-level requirements as to form and operation should cater to these consumers, while also solving issues of validity or non-compliance.

D. Conclusion

This article has demonstrated that New Zealand is doing its healthcare consumers and medical practitioners a disservice by having minimal guidance and legislation on advance directives. It would be useful for all involved to have more direction in the legislation surrounding advance directives. This does not necessarily mean that advance directives need to require a particular form to be legally binding. Instead, Parliament should set out the best requirements for determining capacity for those

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83 At 557.
84 At 577.
with cognitive impairment like Alzheimer’s disease, and give guidance as to how these living wills are to be treated by healthcare professionals. Advance directives will then be followed more often, have fewer validity issues, and the prevalence of use should increase to the benefit of both patients and carers. New legislation should look similar to the United Kingdom’s Mental Capacity Act 2005. The best case scenario for an Alzheimer’s patient would be to write a detailed and informed advance directive after initial diagnosis and while still competent. The patient should obtain definite confirmation of capacity in conjunction with a health practitioner to ensure the latter’s awareness of the decisions the patient is making and knowledge of the consequences of these decisions. Obtaining legal advice throughout these processes will ensure that undue influence and invalidity are avoided.
THE PRACTITIONER KNOWS BEST?
ASSESSMENT OF PATIENT CAPACITY AND
RESPONSES TO REFUSAL OF TREATMENT IN
EMERGENCY HEALTHCARE

PHILIP ARNOLD *

Introduction

This article seeks to address two key questions. First, how is patient competency to consent or refuse medical treatment assessed in a pre-hospital or emergency scenario? Secondly, what is the appropriate legal response in a pre-hospital or emergency scenario to a finding of incompetency, or to a competent patient who declines medical treatment? Though the second question touches on the two distinct concepts of incompetent patients, and competent patients who decline medical treatment, this article addresses them as one. Both are primarily focused on determining what options are available to a healthcare provider when faced with a patient who is unable to consent or who is refusing treatment that the provider believes is in the patient’s best interest.

* LLB (Hons)/BA (in progress), The University of Auckland. I wish to acknowledge Associate Professor Joanna Manning for her support of this article when in its formative stages, and Luke Sizer for his helpful review. I also wish to thank the many clinicians whom I spoke to about this article; their opinions were beneficial and I hope this article proves salutary for other healthcare professionals.
The rationale for this article is basic: research compiled by Carol Peters in 2009 showed “poor overall knowledge of some key areas of the law relating to consent to medical treatment”, including a “defensive risk management” style that looked to deter potential complaints rather than focus on the “patient’s best interests”.¹ Peters’ study followed research in the United Kingdom that concluded: “emergency healthcare workers do not have adequate knowledge about how to assess capacity and treat people who either refuse treatment or lack capacity”.² The results were especially dismal for ambulance officers and paramedics, with none of the 23 ambulance staff assessed being able to identify the stages in testing capacity. Comparatively, 10 per cent of nurses and 67 per cent of doctors were judged as correct in their knowledge regarding capacity to consent or refuse treatment.³

But the need for this research is perhaps best illustrated by a 2008 article in the Otago Daily Times in which a senior operations manager for a New Zealand ambulance service stated that a tattoo stating “Do not resuscitate” would not stop him from saving a life. “I would hesitate for a second but I would still do my job”⁴ There are powerful tensions between the instinct that many healthcare providers have to preserve life, and the principle of patient autonomy that is so entrenched in New Zealand’s healthcare law. Although not necessarily

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¹ Carol Peters “Consenting to medical treatment: legal requirements vs. medical practice. Are healthcare providers exposing themselves to potential legal action?” (2009) 122(1300) NZMJ 50 at 50, 58.
³ At 392.
⁴ Hamish McNeilly “Grandmother’s chest tattoo makes wishes clear” Otago Daily Times (online ed, New Zealand, 12 December 2008).
incorrect, the statement displays a remarkable divergence between the healthcare provider’s understanding of entitlement to provide medical treatment, and the consumer’s prima facie right to decline medical treatment.

What is the New Zealand position on this matter? This article will traverse the existing statutory tests in New Zealand, the common law both in New Zealand and other Commonwealth countries and current industry guidelines for assessing capacity. The article will also critically analyse whether current guidelines in New Zealand and elsewhere are “safe” from a legal risk management perspective, and whether they encourage compliance with a patient’s best interests. The rationale for this aspect of the article is that – as John Devereux noted in the Australian context – “[t]he existing tests … lack the precision needed to provide clear guidance to medical practitioners”.5 After considering this, the article probes the defence of necessity, considers the distinction between treatment of competent and incompetent patients and briefly discusses the unique cases of suicidal and child patients.

A. Terminology

This article uses two sets of terms interchangeably. “Consumer” and “patient” is one set. No distinction is intended to be drawn between these terms and both can be found in New Zealand legislation. Secondly, I use the terms “capacity” and “competence” interchangeably. As Scott Kim notes, it is important to clarify that these terms have the same meaning despite it being “widely taught that

“capacity” is a clinical concept, whereas “competence” is a legal one.⁶ As Peter Skegg states, capacity to consent to medical treatment means legal capacity to give legally effective consent, and “not merely the ability to express or otherwise indicate what could be taken as consent”.⁷

Determination of capacity is a legal question. Although it is an issue healthcare professionals ordinarily determine, it is sometimes subject to the determination of court. Where the determination is not a question for the court, it may also have implications under legislation such as the Mental Health (Compulsory Assessment and Treatment) Act 1992. Moreover, the determination of capacity is critical because of the role it has as an element of informed consent. Right 7(1) of the Code of Health and Disability Services Consumers’ Rights (“the Code”) provides that services may only be provided to a consumer if that consumer makes an informed choice and gives informed consent.⁸ A consumer who lacks the legal ability to decide on specific questions relating to their medical treatment cannot therefore give informed consent.

Where a patient has diminished competence, the consumer “retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence”.⁹ Where, therefore, a determination is made that a consumer is incompetent to

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⁷ PDG Skegg “Presuming Competence to Consent: Could Anything be Sillier?” (2011) 30 UQLJ 165 at 166.
⁸ Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996, sch, cl 2 Right 7(1).
⁹ At Right 7(2).
refuse or consent to medical treatment, any treatment the consumer receives will be without informed consent and in breach of Right 7(1). While the provisions relating to informed consent and reasonable actions in Right 7(4) and clause 3 of the Code may provide a defence or justification for this breach, at least under the Health and Disability Commissioner Act 1994, it nonetheless remains a breach of the consumer’s autonomy.

B. Statutory Indicators

1. Protection of Personal and Property Rights Act 1988 (“PPPRA”)

The PPPRA offers some direction for determining competency. It provides a “mechanism for the giving of consent or the authorisation for medical treatment on persons incapable of consenting for themselves”, and is concerned both with those who are incompetent and those who have something more than complete incapacity but are “not fully able to manage their own affairs”.

Section 5 of the PPPRA states:

every person shall be presumed, until the contrary is proved, to have the capacity –

(a) to understand the nature, and to foresee the consequences, of decisions in respect of

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11 Protection of Personal and Property Rights Act 1988, Long Title.
matters relating to his or her personal care and welfare; and

(b) to communicate decisions in respect of those matters.

This section also provides a statutory assumption of the ability of every person to:

1. understand the nature of decisions;
2. foresee the consequences of decisions; and
3. communicate those decisions.

Additionally, s 5 affirms the presumption of competency found in Right 7(2) of the Code. It is unclear to what standard it must be proved that a patient lacks capacity – that is, how high the s 5 hurdle is – although it is likely that the civil standard of balance of probabilities applies.\(^\underline{12}\)

Section 6(1) of the PPPRA makes it clear that a court can interfere with a person’s decisional autonomy if they:

(a) [lack], wholly or partly, the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare; or
(b) [have] the capacity to understand the nature, and to foresee the consequences, of decisions…but wholly [lack] the capacity to communicate decisions in respect of such matters.

This section elucidates the distinction between a finding that the patient lacks capacity, and an ability to interfere with their autonomy. Here the assessment is in relation to the personal care and welfare of the patient, whereas in emergency healthcare the assessment would be in relation to the treatment decision.

\(^{12}\) This is the standard applied in Canada. See PH v Eastern Regional Integrated Health Authority (2010) NLTD 34 (NLSCTD) at [33]-[34].
Section 93B of the PPPRA adds some important caveats to the presumption of competency. First, it stipulates that a person must not be presumed to lack the competency just because a person exercising ordinary prudence would not make the same decision in the same circumstances.\textsuperscript{13} Secondly, it clarifies that a person must not be presumed to lack the competence to make a decision just because the person is subject to compulsory treatment or has special patient status under the Mental Health (Compulsory Assessment and Treatment) Act 1992. These caveats encapsulate the fundamental tenets that a person is not incompetent purely because the provider disagrees with their choice, and that a person cannot be assumed incompetent because they suffer from a mental illness requiring compulsory treatment.\textsuperscript{14}

2. \textbf{Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT)A)}

While the MH(CAT)A is specifically intended to deal with mentally disordered persons – and therefore needs to be distinguished from the test that might be applied to those suffering from incompetence not arising from mental disorder – it offers an indication of where

\textsuperscript{13} See also s 6(3) of the PPPRA. In stipulating this the PPPRA ushered the common law into statute, since it is well established that a patient may make a decision for rational, irrational reasons or for no reason at all: \textit{Re T (Adult: refusal of medical treatment)} [1993] Fam 95 at 113; [1992] 3 WLR 782; [1992] 4 All ER 649; [1992] 2 FLR 458.

Parliament has seen to fit to intrude on a person’s autonomy and compel medical treatment. It can help us think of circumstances and characteristics that might limit or negate a person’s capacity to make their own treatment decisions.

Section 2 of the MH(CAT)A defines mental disorder as:

an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it –

(a) poses a serious danger to the health or safety of that person or of others; or
(b) seriously diminishes the capacity of that person to take care of himself or herself.

This definition illustrates that delusions, disorders of mood or perception, volition or cognition are characteristics that potentially indicate a loss of capacity. Where found, the patient may be forced to undergo treatment (that is, the decision is taken away from them because of their inability to properly make a choice either way). Furthermore, the second prong of s 2 shows that where a patient has a mental disorder this is not itself sufficient to intrude on a person’s autonomy; there must also be a serious danger to the health or safety of that person or another. This usefully raises the limits that apply in the treatment of incompetent patients, and is interesting in light of the restrictions accompanying the doctrine of necessity, which is considered later.

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15 It is apt to note, however, that “[b]eing mentally disordered and competent are not mutually exclusive, although the presence of both factors simultaneously is no doubt uncommon”: Re S [1992] 1 NZLR 363 (HC) at 374.
A look at Re K helpfully reveals some principles evoked by the MH(CAT)A which are relevant to our discussion of what is an appropriate legal response to a finding of incompetency. On an application to extend a compulsory treatment order, the Court was at pains to note that while “Mrs K’s condition clearly comes within the statutory definition of “mental disorder”, her right of self-determination could not “simply be brushed aside on the basis that she ought to accept treatment that is good for her and will preserve her quality of life”. On the facts, Mrs K was compelled to undergo treatment for her chronic paranoid schizophrenia because she was at times “deprived of the power to make any reasoned or rational choice”, and therefore unable to care for herself. The material words in this judgment might be considered to be “any”, “reasoned” and “choice”, which together indicate the concern the MH(CAT)A has with intervening only when a person lacks the capacity to reach a decision, whether that be beneficial or harmful. This judgment usefully illustrates how Parliament, when it has turned its mind to persons who are unable to make decisions for themselves, has not been prepared to interfere with the sanctity of decisional autonomy unless a person cannot reach any reasoned choice. This signposts the principles that must also apply to consumers who are incompetent for reasons not covered by the MH(CAT)A.

Certainly, although the treatment permissible under the MH(CAT)A is limited to treatment for the mental disorder itself, the criteria the Act provides highlight the basic principle that in assessing appropriate legal responses to incapacity, both the internal reasoning processes (whether

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16 Re K [2003] NZFLR 318 at 325.
17 At 327.
the person is deluded or disordered) and the outcome (whether that or other persons are at risk) should be considered.\textsuperscript{18}

3. Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996

Though it regulates the presumption of competency in Right 7(2), the Code adds surprisingly little about how providers should assess competency. It stipulates in Right 7 that a consumer with diminished competency may still retain some capacity to consent, and that where a consumer is not competent to make an informed choice the provider may in certain circumstances provide services. Furthermore, the Code preserves the consumer’s right to refuse services and to withdraw consent to services, in Right 7(7). This right appears to correlate to s 11 of the New Zealand Bill of Rights Act 1990, which affirms the right of “everyone to refuse to undergo any medical treatment”. Rights litigation now confirms that “everyone” in s 11 means “every person who is competent to consent”.\textsuperscript{19}

Because the Code operates as a high level tool which presumes practitioners and other healthcare providers are capable of assessing competency without statutory direction, it is of limited use in answering the first question this article seeks to address. However, the Code will become important when examining appropriate legal responses to incompetent patients.

\textsuperscript{18} Jeffery, above n 10, at [1.4.3].
\textsuperscript{19} Re S, above n 15, at 374.
C. Case Law

Case law concerning the assessment of capacity is expansive. The starting point must be the judgment of Lord Donaldson MR in *Re T.*20 In this case the principle was established that “the patient’s right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent”.21

The first substantive test for assessing capacity was provided in 1994 in *Re C.* In it Thorpe J postulated three stages in assessing whether a person is a competent decision-maker:

1. comprehending and retaining treatment information;
2. believing it; and
3. weighing it in the balance to arrive at a choice.22

Three years later, in *Re MB*, Butler-Sloss LJ applied the test in *Re C*, less the requirement of “believing” the information.23 She further explained the concepts of irrationality, comprehension and weighing information in the balance.24

In 2002 in *Re B*, Butler-Sloss P repeated the test she applied in *Re MB*.25 She further commented that any doubt about the mental capacity of a patient should be resolved by doctors within the hospital or by other normal medical procedures, and that doctors ought not to be guided by

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20 Above n 13, at 102.
21 At 113.
22 *Re C (adult: refusal of medical treatment)* [1994] 1 WLR 290 (Fam) at 292.
24 At 175.
25 *Re B (Consent to Treatment: Capacity)* [2002] EWHC 429 (Fam) at 459.
their emotional reaction to a patient’s decision when assessing his or her mental capacity to make the decision.\textsuperscript{26}

A year later, the Supreme Court of Canada provided a similar test in the landmark case \textit{Starson v Swayze}.\textsuperscript{27} The Court established that “the presumption of capacity can be displaced only by evidence that a patient lacks the requisite elements of capacity”.\textsuperscript{28} Its test bears marked resemblance to that laid out in \textit{Re MB} since it requires a person to understand (or comprehend) the information and then to appreciate (similar to having to weigh) the information to make a treatment decision.

New Zealand case law has generally followed the approach taken by the United Kingdom and Canada. In 2004 Miller J held that the threshold question was whether the statutory presumption of competence has been rebutted.\textsuperscript{29} He held that four factors are of primary importance in determining whether a person has capacity to make the relevant decision:

1. ability to communicate a choice;
2. understanding of relevant information;
3. appreciation of the situation and its consequences; and
4. manipulation of information – in other words, the person’s ability to follow a logical sequence of thought in order to reach a decision.

\textsuperscript{26} At 474.
\textsuperscript{27} \textit{Starson v Swayze} 2003 SCC 32, [2003] 1 SCR 722.
\textsuperscript{28} At 42-43.
\textsuperscript{29} \textit{KR v MR} [2004] 2 NZLR 847 (HC) at [50]. This was a determination of competency under the PPPRA.
Miller J further held, citing *Re G* in support, that these abilities had to be “so limited ... that any choice between such alternatives or options ... cannot responsibly be recognised as effective.”

D. Academic Criticism

1. New Zealand

Academic material considering a patient’s legal capacity to consent to or refuse treatment constitutes a considerable portion of the writing on medical law. The starting point for any discussion of medical law in New Zealand must be Skegg and Paterson’s *Medical Law in New Zealand*. It summarises New Zealand’s test of capacity as requiring the person to have ability to:

1. understand and retain what the treatment involves;
2. process this information; and
3. reach a decision.

By comparison, Sue Johnson and others simply adopt the approach taken in the United Kingdom, the test created in *Re C*. Skegg and Paterson instead appear to amalgamate case law from the United Kingdom, Canada and New Zealand. There is an inconsistency here inasmuch as the element of “belief” is absent from the amalgamated account. Certainly, that element was significant enough that Butler-

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Sloss LJ chose to omit it from her characterisation of the test for capacity in *Re MB*. The tests therefore appear to depart from each other, and could foreseeably be applied to reach different conclusions with regard to the same set of facts.

2. **Australia**

Australian law is no clearer. In *Australian Medical Law*, Devereux states “competency operates as a “gatekeeper”…[telling us] which bioethical principle, respect for autonomy or beneficence, should take precedence in any particular patient’s case”.

Devereux proposes a functional approach to competency based upon how well the patient can achieve certain tasks and decisions. Within this approach he highlights five different sub-approaches:

1. evidence of choice;
2. reasonable outcome of choice;
3. choice based on rational reasons;
4. the ability to understand; and
5. actual understanding.

It is the last test of actual understanding that applies in Australia. In *Re: O* the Australian Family Court was faced with an application by a 16-year-old boy with Asperger’s syndrome and Gender Identity Disorder to undergo special procedures in relation to a gender change. Applying the actual understanding test, Dessau J noted O was competent to consent and had the ability to:

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33 Devereux, above n 5, at 197.
34 At 198.
35 At 199.
36 *Re: O (Special Medical Procedure)* [2010] FamCA 1153.
37 At [77]-[99].
(1) understand the nature and purpose of the proposed treatment;
(2) make an informed decision about the proposed treatment;
(3) understand explanations given to him by the professionals; and
(4) understand the options available to him.

Re O thereby usefully indicates indicia for assessing capacity in Australia. While not discussing the issue in any detail, Re O is part of the category of cases which Devereux considers to show that “the patient need only understand “in broad terms” the nature of any procedure” to be said to have actual understanding.\(^3\)

Importantly, Devereux considers a distinction can be made between three meanings of “understanding”. The first may be described as “understanding how”, the second as understanding “that” and the final as understanding “what”.\(^4\) Understanding “that” is the sense of understanding relevant to an assessment of competency because the patient must be able to make sense of what he or she is told, believe the information and apply that information to their own treatment choices.\(^5\) This analysis of the test of capacity is similar to that in Re C, although it retains the now-dropped element of belief.

### 3. Canada

The tests for capacity in some Canadian provinces are far clearer than in New Zealand or Australia. Legislative guidance has been provided in Alberta and Manitoba. In Alberta a person is competent to make treatment decisions if the person is “able to understand the subject

\(^3\) At 200.

\(^4\) At 199.

\(^5\) At 199-200 (emphasis added).
matter relating to the decisions and to appreciate the consequences of making the decisions”. In Manitoba the patient must understand “his condition, the nature and purpose of the treatment, and the relative risks and benefits of undergoing, or not undergoing the treatment”.41

Although these legislative measures go some way in defining the test for capacity, Sneiderman, Irvine and Osborne note “there is no definitive objective test that measures a patient’s decision making capacity”.42 Nonetheless, they posit that the primary test of competence in Canada is: understanding information and the foreseeable consequences of the proposed treatment.43 This test was fully affirmed by the Supreme Court of Canada in Starson v Swayne.44 McLachlin CJ’s dissent adds flesh to this two-stage test by saying “the primary means of ascertaining capacity or ability ... [is] ... what an individual in fact says and does.”45

Canadian jurisprudence was significantly developed in PH v Eastern Regional Integrated Health Authority,46 into the following elements:

1. Understanding the information, that is, being able to process and retain the information; and
2. Understanding the information, that is, being capable of recognising that he or she is affected by a condition;
3. Being able to weigh and appreciate the foreseeable consequences of the treatment decision.

41 Barney Sneiderman, John Irvine, Philip Osborne and Randy M Zettle Canadian Medical Law: An Introduction for Physicians, Nurses, and Other Health Care Professionals (2nd ed, Carswell, Ontario, 1995) at 264.
42 At 382.
43 At 34.
44 Starson, above n 27.
45 At 14-15.
46 PH, above n 12.
These three elements are synonymous with the tests put forward by Skegg, Johnson and others, and Devereux. The \( PH \) test raises the same three elements as does Skegg. Although it does not discuss “belief”, it is materially similar to the Johnson and Devereux tests by requiring the patient to have the ability to recognise they suffer from a condition. This is perhaps a requirement additional to the test enunciated by Skegg but might also be caught by his requirement that a patient must have the ability to process the information. In this way, there is a substantial degree of similarity across the three common law jurisdictions.

4. England

In their cogent analysis of the test for capacity in the United Kingdom, Kennedy and Grubb draw attention to the “functional test” advocated in the Law Commission’s 1995 report, *Mental Incapacity*.\(^{47}\) The Commission stated:\(^{48}\)

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\text{... the new definition of incapacity should emphasise its decision-specific nature. A diagnostic threshold of “mental disability” should be included, except in cases of inability to communicate. \textit{We recommend} that legislation should provide that a person is without capacity if at the material time he or she is:}
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1. unable by reason of mental disability to make a decision on the matter in question; or
2. unable to communicate a decision on that matter because he or she is unconscious or for any other reason'.
This strongly resembles the notion of mental disorder in the MH(CAT)A, and s 6 of the PPPRA, referring to a person who is unable to communicate. In the Mental Capacity Act 2005 Code of Practice, the Department for Constitutional Affairs noted that the Act sets out a two-stage test of capacity: 49

(1) Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

(2) Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

(a) A person is unable to make a decision if they cannot:

(i) Understand information about the decision to be made;

(ii) Retain that information in their mind;

(iii) Use or weigh that information as part of the decision-making process, or

(iv) Communicate their decision (by talking, using sign language or any other means).

The second stage of this test is of course similar to the Canadian test of actual understanding. Indeed, Kennedy and Grubb note that where judges have discussed “understanding” they have asked whether the “patient does in fact understand what is involved”, rather than “is capable generally of understanding”. 50

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49 Department for Constitutional Affairs Mental Capacity Act 2005 Code of Practice (TSO, Norwich, 2007) at 45.

50 Kennedy and Grubb, above n 50, at 615 (emphasis added).
E. Industry Guidelines

Assessing clinical guidelines across the British Columbia Ambulance Service (“BCAS”), Ireland Pre-Hospital Emergency Care Council (“PHECC”), St John New Zealand and the London Ambulance Service (“LAS”), it becomes apparent that capacity is assessed differently at the coal-face of healthcare than in legal jurisprudence. For instance, BCAS guidelines state: “mental status involves awareness (or level of consciousness), cognition (or thinking) and attention. A typical altered patient [that is, a patient with a reduced mental status] may be sleepy, not making sense or unable to follow commands. Patients may also be excited, repetitively asking questions or belligerent”.\textsuperscript{51} The procedures are, however, silent on the issues of patient capacity and consent while at the same time directing that “patients with altered mental status and no discernable treatable cause require expeditious transport to hospital”.\textsuperscript{52}

The danger with this direction is that it can lead emergency healthcare workers to think that expeditious transport may be justifiable if it is in the patient’s best interests, and is therefore compellable. Indeed, the Goal of Care for agitated patients is “Recognition of altered mental status; look for reversible causes, and provide safe transportation”.\textsuperscript{53} This fails to recognise the legal principle that capacity concerns whether the patient is capable of understanding (or actually understands), rather than whether they have an “altered mental status”.

\textsuperscript{51} British Columbia Ambulance Service “Adult Treatment Guidelines” (Emergency and Health Services Commission, British Columbia, 2012) at 1 (original emphasis).

\textsuperscript{52} At 1.

\textsuperscript{53} At 3.
A different approach is taken by PHECC. PHECC has different guidelines according to a practitioner’s authority to practice (that is, their ability to provide specific treatments such as morphine). While identifying and managing life-threatening conditions, patient Care Principles ensure adequate ventilation and oxygenation, and provide appropriate pain relief. There is, however, no principle regarding informed consent. PHECC guidelines do appear cognisant of the law and warn that “practitioners may not compel a patient to accompany them or prevent a patient from leaving an ambulance vehicle”.

Additionally, the Guidelines provide the following test for evaluating capacity:

1. Patient verbalises/communicates understanding of clinical situation?
2. Patient verbalises/communicates appreciation of applicable risk?
3. Patient verbalises/communicates ability to make alternative plan of care?
4. If no to any of the above consider Patient Incapacity.

While these questions identify understanding and appreciation as components of capacity, the third question appears anomalous. What is meant by an alternative plan of care is unclear, and there is a risk it could lead practitioners to believe that where a patient does not deal with or change their circumstances (for example, by seeing a GP), the patient lacks capacity. In this way, the third question may cause a patient to be considered incompetent simply because they appear to

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55 At 52.
56 At 52.
suffer from a delusion or condition for which they competently refuse treatment and refuse to communicate an alternative plan of care.

Despite this, the PHECC guidelines provide a commendable model for ensuring patients can make an informed choice. It encourages practitioners to request police help where there is a “potential to harm self or others”, to “reassure patient and explain what is happening at all times”, to “offer to treat and or transport the patient”, “inform the patient of potential consequences of treatment refusal”, “advise alternative care options” or “await arrival of doctor or [police]” where the patient lacks capacity and is refusing. These Guidelines are likely to result in effective communication and information-giving under Rights 5 and 6 of the Code. In particular they ensure an explanation of the person’s condition is given, including an explanation of expected risks, side effects and benefits of each treatment option.

St John New Zealand has Comprehensive Clinical Practice Guidelines which successfully identify the link between competency and consent, and notice the right of “competent patients…to decline treatment, including resuscitation in the event of cardiac arrest”.

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57 At 52.
58 St John New Zealand “Clinical Practice Guidelines 2011-2013” (St John New Zealand, 2011). The Guidelines state that when treatment is provided by a student or trainee, ‘the patient (if competent) is asked to consent to have treatment provided by a student or trainee’ at 10 (emphasis added).
59 At 43.
The Guidelines provide the following test for competency: ⁶⁰

- A competent patient has the right to refuse treatment. Every patient is presumed to be competent to make decisions unless there are reasonable grounds to believe otherwise;
- Patients can be deemed competent to make decisions if they meet all of the following criteria:
  a) They appear to understand information given to them and can recall this when asked and
  b) They appear to understand the implications of their decisions and can recall these when asked and
  c) They communicate on these issues consistently and
  d) They are over 16 years of age and
  e) They have not attempted, or expressed thoughts of self harm
- If all of these criteria are not met, competency is in question and personnel must act in the best interest of the patient. ⁶¹
- Always act in the best interest of a patient who is not competent to make decisions. ⁶²
- The risks of treatment and/or transport against their will must be balanced against the risks of their illness or injury.

These Guidelines go a significant way in ensuring that patient competency is assessed and respected. They accord with the major rights under the Code, including the right to effective communication and the right to be fully informed. Recognising the fact that emergency healthcare practitioners have little time, scarce resources and a lack of specialised skill to declare a patient incompetent, the Guidelines are reasonably geared towards providing the practitioner with possible indicators of incompetency rather than an exhaustive test. As practitioners lack the three to five hours it might take for a specialist to

⁶⁰ At 131.
⁶¹ At 128.
⁶² At 83.
undertake a full competency assessment, this is a practical and pragmatic approach.

However, certain elements of the test provided in these Guidelines signal conclusions that are not necessarily legally correct. First, stating that if all the criteria provided are not met competency is in question and the personnel must act in the best interest of the patient is a legal misnomer, for several reasons. If the competency of the patient is in question, this is not the same as a declaration that the patient is incompetent to make a specific treatment decision. Further, a provider will only be justified in acting in the best interest of a patient who is actually not competent to make a specific treatment decision. Staff who instead act in the best interest of a patient whose competency is in question may be in breach of Right 7(2) of the Code’s presumption of competency. That said, where the provider has a reasonably held belief that the consumer is incompetent, any action taken may be defensible under Clause 3 of the Code.

Secondly, while acknowledging that personnel must act in the best interests of a consumer who is not competent to make an informed choice, the test omits the legal obligations under Right 7(4)(b) and (c) of the Code. These state that, in addition to the best interests rule, a provider must take “reasonable steps to ascertain the views of the consumer” and can only provide treatment where “having regard to those views, the provider believes … that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent”. Where the consumer’s views cannot reasonably be ascertained, the provider must “take into account the views of other suitable persons”.63 By omitting these elements the

63 Code of Health and Disability Services Consumers’ Rights, above n 8, Right 7(4)(c)(ii).
Competency and Consent in Emergency Healthcare

Guidelines fail to ensure paramedics are acting legally when providing treatment to patients who are incompetent to make a specific treatment decision.

Thirdly, despite a positive affirmation in the Guidelines that competence must be presumed, the actual test does not follow this assumption. Rather, it reverses the starting point by stating that “patients can be deemed to be competent to make decisions if they meet all of the following criteria”. While acknowledging that in a time-pressured emergency environment it may be more practical to provide indicators of competency than incompetency (which are limitless), the test ought to be framed in the negative: a patient may be incompetent if they cannot meet any of the following criteria.

Fourthly, the test states that a patient must be able to communicate their understanding consistently. Although inability to make a decision is a potential indicator of incompetence there is no legal requirement to communicate on an issue consistently. Certainly, ambivalence in making a treatment decision “may be relevant if, and only if, the ambivalence genuinely strikes at the root of the mental capacity of the patient”. Moreover, some American case law signals that a change of mind may not demonstrate incompetence. However, if a person cannot communicate on issues consistently enough to make a choice at all (given enough time to do so), this may indicate a lack of capacity.

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64 St John Guidelines, above n 61, at 83.
67 See PPPRA, s 94(2)(a)(i).
Other elements of St John’s test require clarification in order to enhance consistency of application among ambulance practitioners. For example, while understanding the information, understanding the implications of their decision, and the ability to recall the information are listed as indicia of competence, the Guidelines fail to expand on the definitions of each. As noted in PH v Eastern Regional Health Authority, “understanding” is a complex term that entails being able to process the information and believing that he or she is affected by a condition.68 Furthermore, the ability to “recall the information” requires further definition as it is unclear how long and how much information must be recalled. The answer to this question will no doubt change depending on the facts and the gravity of the choice being made.

The Guidelines also appear to endorse an all or nothing approach. They talk about “competent” and “not competent” patients. A distinction can be drawn between deeming a patient competent to make decisions and competent to make a particular decision. Indeed, the question regarding competency is “decision-specific: does the patient possess the mental capacity to decide upon the particular treatment at issue?”69 Kennedy and Grubb echo this sentiment.70 Broadly deeming a patient competent or incompetent risks breaching Right 7(3) by failing to acknowledge that a consumer may be entitled to make some decisions, if not others.

The LAS has a detailed “Policy for Consent to Examination or Treatment” document which contains guidance for all staff who provide care to patients. This policy is the most comprehensive of any material described in this article, and defines capacity as: “not an

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68 PH, above n 12, at 13.
69 Sneiderman, above n 42, at 382.
70 Kennedy and Grubb, above n 50, at 613.
absolute concept. Different degrees of capacity are required for different decisions, with the level of competence required increasing with the complexity of the decision”.  

It reiterates the two-stage test laid out in the Mental Capacity Act 2005 but usefully provides the following additional questions:

(1) First Stage
   (a) Is there any evidence that the patient has ‘an impairment of, or a disturbance in the functioning of, the mind or brain’?

(2) Second Stage
   (a) Do you feel the patient is able to communicate a decision effectively?
   (b) Has the patient been given sufficient information, in a way they can understand, to inform them of the decision they now need to make about treatment?
   (c) Do you feel that the patient is able to understand the principal risks and benefits of what is proposed?
   (d) Does the patient, therefore, understand the reasonably foreseeable consequences of receiving, or not receiving, the proposed treatment?
   (e) Can the patient retain the information for long enough to make a valid decision?
   (f) Is the patient free from external pressure or coercion?

An obvious limitation is that this test mimics the Mental Capacity Act 2005, which has no application in New Zealand. However, the test appears to ask the same four questions as Miller J did in KR v MR. Regarding this last point, it is the question “can the patient retain the

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71 London Ambulance Services NHS Trust “Policy for Consent to Examination or Treatment” (Medical Directorate, 2010) at 5.
72 At 6-7.
information for long enough to make a valid decision?” which inquires whether the person can manipulate the information.73

I would suggest that the LAS test therefore inquires into the same indicia of capacity as New Zealand courts have applied, and for this reason should be viewed as an excellent example of how to clarify industry procedures. It is worth noting that the process of assessing capacity in London is generally more comprehensive and legalistic than in New Zealand; the LAS has specific “assessment of capacity” forms which practitioners must complete if faced with an incompetent patient.

The LAS question regarding coercion is no doubt geared toward the dictum of Staughton LJ in Re T, who noted that the three reasons consent may be inoperative include undue influence, a lack of adequate and accurate information or incapacity.74 Although these issues do not appear in New Zealand cases as strongly as they do in the United Kingdom, it is clear that New Zealand consumers also have a right to be free from exploitation or undue influence.75

The “checklist approach” may provide greater guidance in the following three case studies.

Case A: Consider the situation of a middle-aged woman whose flatmate called an ambulance after becoming concerned that the woman had been consuming large amounts of alcohol for several days. The woman, whose house is ordinarily immaculate, does not appear to have left her couch even for toileting and the floor is

73 KR v MR, above n 29, at [51].
74 Re T (Adult: Refusal of Treatment), above n 13, at 121-122.
75 Code of Health and Disability Services Consumers’ Rights, above n 8, at Right 2.
covered with empty bottles. She is not initially aware as to date, day or time, but does become orientated to these after some time. She consistently refuses any treatment or examination, does not express thoughts of self-harm and repeats back the information she is given. She is not committing any crime, does not pose a public nuisance and does not appear to have an immediately life threatening condition.

This case is perhaps the most difficult. Against the indicia of competency provided in the St John guidelines the woman might be found competent, despite being intoxicated. She is eventually orientated as to basic facts and can recall the information and implications of her decision when asked. She therefore has a basic ability to retain information, and to understand it. Her potential lack of capacity appears largely to lie in her inability to apply the information to herself and process it, although this is not a requirement of the St John test. In practice, this woman was forcibly taken to hospital (in her best interests and at the request of her flatmate) by police, although the legal justification for this is unclear.

Case B: Consider the situation of a middle-aged man with acutely low blood pressure, but who is alert and orientated and consistent in his refusal of transport. He is only able to maintain consciousness while lying down, and collapses on standing.

A checklist approach that asks whether this patient understands the information, the risks and benefits of treatment and can weigh and apply the information would here be beneficial. The patient would be found incompetent to refuse treatment because his attempt to walk illustrates a lack of understanding of his condition. Once unconscious, he is incompetent to make a treatment decision and the practitioner might justifiably act in reliance on the fact that the situation is now wholly different from when he was refusing.
Case C: Consider the situation of a 16-year-old boy who, having consumed magic mushrooms, is incontinent and unable to make a definitive decision whether to accept transport to hospital. This is the only presently available intervention, and is necessary for continued monitoring of the patient. His mother advocates but does not insist on transport to hospital.

This case is clear-cut since the patient is unable to communicate consistently. This would render him incompetent by the St John guidelines, indicating that he lacks the ability to refuse treatment. The same conclusion would be reached on an LAS checklist approach since the patient is unable to communicate a decision effectively; it must be said that where a patient cannot reach a decision at all, he fails the capacity statement on this part.

F. What Action Can Be Taken Without a Patient’s Informed Consent?

1. If the patient is competent

It is a fundamental tenet of medical law, encapsulated in Right 7(7) of the Code, that a competent adult patient has the autonomy to refuse to consent or to withdraw consent to any medical treatment, even where such will result in the inevitable death of the person who is refusing consent. The situation for children differs and will be discussed later.

Thus, it is not possible to compel a consumer to receive treatment that they have competently refused, even where the provider believes it to be in their best interest. As is noted in the Code of Practice for the

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Mental Capacity Act 2005, “ultimate responsibility for working out best interests lies with the decision-maker”. 77 Where a consumer makes a treatment decision they are competent to make but which is unwise, the provider is best to reiterate the consequences of that decision, ensure that sufficient information has been provided in a way that the consumer can understand, and to involve family, friends and other treatment providers where appropriate and where the patient has given consent to do so.

Respect for self-determination and the autonomy of a competent patient is heavily protected. In New Zealand, s 11 of the New Zealand Bill of Rights Act 1990 preserves the right of every person to refuse to undergo any medical treatment. The only restriction to this broad right is that “everyone” must be read as meaning “every person who is competent to consent”. 78

The courts have shown fierce reluctance to intervene with a patient’s autonomy. This is true even where a person may be unable, at times, to preserve his or her ordinary standards of property and personal cleanliness, with detrimental effects to her health. 79 In the United Kingdom and Canada, the sanctity of decisional autonomy has been respected with the result that a patient suffering from an irreversible condition was granted an injunction ordering the discontinuance of a life-sustaining ventilator, 80 and a prisoner determined to starve himself to death was allowed to do so. 81 Moreover, it seems “this right to refuse treatment also extends to situations that will imperil the health and life

77 Code of Practice, above n 52, at 88.
78 Re S, above n 15, at 374.
79 Re K, above n 16, at 324.
80 Nancy B v Hotel-Dieu de Quebec (1992) 86 DLR (4th) 385 (Que SC).
of an unborn child”, where the courts appear to favour the autonomy of the competent mother.\textsuperscript{82}

Perhaps the only limit the courts have placed on competent refusals of lifesaving treatment is to increase the level of capacity required. Thus, doctors should consider “whether [there is] capacity commensurate with the gravity of the decision being made”.\textsuperscript{83}

2. If the patient is incompetent

(1) Where there is a valid advance directive or anticipatory refusal

Where a patient is incompetent the practitioner must obey any valid advance directive or other anticipatory refusal of treatment.\textsuperscript{84} Treatment not anticipated by, or falling outside the scope of, the advance directive is subject to the same rules that apply when there is no advance directive.\textsuperscript{85}

(2) Where there is a proxy

Where a patient is incompetent to make a specific treatment decision there may be scope under Right 7(4) of the Code to provide treatment if no person entitled to consent on behalf of the consumer is available and all other relevant criteria have been met.

\textsuperscript{82} Skegg, above n 80, at 231. See also \textit{St George’s Healthcare}, above n 14.

\textsuperscript{83} \textit{Re T}, above n 13, at 113.

\textsuperscript{84} See the Code of Health and Disability Services Consumers’ Rights, above n 8, Right 7(5).

\textsuperscript{85} [Editor’s Footnote: see also the excellent article by Emma Sherratt at (2013) 3 NZLSJ 1.]
Who may be entitled to consent on behalf of a consumer? Examples include “a parent giving consent on behalf of a child, or a welfare guardian”\textsuperscript{86} and a person with Enduring Power of Attorney, although the latter cannot refuse standard lifesaving treatment.\textsuperscript{87}

(3) Where there is no proxy

Contrary to popular belief, there is no general right whereby a spouse or near relative has the ability to give consent on behalf of an adult.\textsuperscript{88} This was confirmed in the United Kingdom in both \textit{Re F} and \textit{Re T}.\textsuperscript{89} In a 2007 decision by the Health and Disability Commissioner (“HDC”), it was said that because neither Mrs B nor Ms C (the daughters of Mrs A) were “entitled to consent to the use of restraint on Mrs A’s behalf”, it was misleading to ask Mrs A’s family to complete consent forms regarding the use of cot-sides.\textsuperscript{90}

Nonetheless, “[p]revention of a lawsuit is the practical consideration behind securing the consent of an incompetent patient’s relative”,\textsuperscript{91} and the HDC has found that in certain circumstances a failure to consult family constituted a breach of Right 7(4)(c)(ii) of the Code.\textsuperscript{92} Thus, best

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\textsuperscript{86} & Health and Disability Commissioner “A Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers’ Rights – A Resource for Public Consultation” (Health and Disability Commissioner, Wellington, 2004) at 43. \\
\textsuperscript{87} & Protection of Personal and Property Rights Act 1988, s 18(1)(c). \\
\textsuperscript{88} & Kennedy and Grubb, above n 50, at 823. \\
\textsuperscript{89} & See Jeffery, above n 10, at [1.2.1]. \\
\textsuperscript{90} & Deputy Health and Disability Commissioner \textit{Decision 07HDC17744} (Health and Disability Commissioner, Wellington, 2009) at 26. \\
\textsuperscript{91} & Rozovsky, above n 70, at 466. \\
\textsuperscript{92} & Health and Disability Commissioner \textit{Opinion 97HDC7679} (Health and Disability Commissioner, Wellington, 2000) at 6. \\
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practice is to consult with the patient’s family and seek “their guidance and approval … more [as] a courtesy extended to the family than a legal requirement”.93

If it is determined that no person entitled to consent on the consumer’s behalf is available, Right 7(4) effectively implements a double-barreled test that applies both a “best interests” and a “substituted judgment” test. As noted by the HDC, when assessing a patient’s best interests, the provider must look at the consumer’s “needs, interests and quality of life from a wider holistic view point, as required by Right 4(4) of the Code”.94 In determining best interests, a “consensus building approach” is best practice.95 This aims to ensure that what the patient considers to be his or her best interests is applied, since it “aims to draw on the family and treating team’s knowledge and understanding of the patient’s personal values”.96 In doing so, this approach meets the obligation to take reasonable steps to ascertain the views of the consumer under Right 7(4)(c)(ii). If the views of the consumer are in conflict with what the healthcare provider determines as being in the patient’s best interests there is no authority for the provider to then act according to his or her belief of those interests. To do so would be a breach of Right 7(4)(c)(i) by providing treatment the consumer would refuse if competent.

The substituted judgment test is “a controversial concept, not the least because of the inherent difficulties of attempting to assess what an incompetent patient would have decided were he competent”.97

93 Sneiderman, above n 42, at 28.
94 Resource for Public Consultation, above n 90, at 43.
95 Devereux, above n 5, at 892.
96 At 892.
97 Kennedy and Grubb, above n 50, at 832.
Primarily, it ought to be used as an aid to assess what is in the patient’s best interests since a patient is ordinarily the best arbiter of his or her own interests. Moreover, by seeking the views of the patient there is substantial attention given to “his moral worth”, and “if the person recovered … he would be most likely to ratify a decision that attempted to ascertain and do that which from the circumstances it appears that he would have done”.\(^98\)

### 3. Emergency situations

A provider is not excused from the Right 7(4) test simply because of time constraints. The provider must still act in the patient’s best interests and make reasonable attempts to ascertain the patient's views, although what is reasonable in an emergency scenario will no doubt be assessed against a much lower threshold than in other circumstances.

The “emergency room rule” is that a provider will be justified in providing treatment where such is limited to what is strictly necessary in the circumstances, until further consent can be obtained.\(^99\) Any reasonable action taken in an emergency is likely to be covered by cl 3 of the Code,\(^100\) and “there health practitioners and others will often come within the scope of a common law justification when … they intervene in an emergency in an attempt to save the life of an unconscious [or incompetent] victim”.\(^101\)

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\(^{98}\) At 835.


\(^{100}\) Clause 3(1) reads: “A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code”.

\(^{101}\) Skegg, above n 80, at 245.
There are two basic requirements for the common law justification of necessity:

1. A necessity to act when it is not practicable to communicate with the assisted person; and
2. The action taken must be such as a reasonable person would in all circumstances take, in the best interests of the patient.¹⁰²

The fundamental limitation is that, in an emergency, the doctrine of necessity will not justify action over or above what was strictly required in the circumstances. Thus, the healthcare provider must take the least intrusive and fewest interventions as possible in seeking only to “preserve his life and health”.¹⁰³ Lord Goff of Chievey did, however, make it clear that the doctrine may extend beyond the bare minimum where the patient is permanently or semi-permanently incompetent.¹⁰⁴

Rozovsky illustrates necessity’s applicability with cases of unconscious patients,¹⁰⁵ patients with heart attacks, strokes or bee sting reactions in progress,¹⁰⁶ and patients incapacitated by sudden illness, intoxication, or shock or trauma.¹⁰⁷

What about the incompetent patient who is alert, conscious, and refusing? This situation is common among patients who are hypoglycaemic or have sustained a traumatic brain injury. Such patients are often combative, though are no doubt incompetent. Does the

¹⁰² Devereux, above n 5, at 776.
¹⁰³ Sneiderman, above n 42, at 28.
¹⁰⁴ Re F v West Berkshire Health Authority [1990] 2 AC 1 (HL) at 26.
¹⁰⁵ Rozovsky, above n 70, at 33.
¹⁰⁶ At 105.
¹⁰⁷ At 106-107.
emergency rule enable a healthcare provider to pharmacologically relax or paralyse this patient in order to provide treatment? It is likely that where a patient poses a risk to themselves or others, restraint can be applied in these forms.108 This is also the position in the United Kingdom where it has been noted that “treatment … may be given if [the incapacitated patient] is uncooperative; if it is in his best interests to receive such treatment in spite of resistance”.109

Conundrums arise where a patient of apparently sound mind requires but refuses emergency treatment. There is substantial inconsistency in determining the response of healthcare providers to patients in this scenario. On one hand, it appears that because of the statutory presumption of competence a patient who, in an emergency, voices a refusal to consent to treatment or examination should have that direction respected until the patient can be proven incompetent.

I believe this approach is incorrect. The primary rationale for this belief is that “the law, when in doubt, opts for life rather than no life, and treatment rather than no treatment”.110 Indeed, “if immediate priority is given to the patient’s autonomy through acting according to [their] wishes, there is a risk of depriving her of potential benefits in the future”,111 and it is clear that in considering each emergency case “a doctor should err on the side of preserving life” before acting upon a decision which has come about in circumstances where the consumer

108 Skegg, above n 80, at 245. See also s 48 Crimes Act 1961 “Self-defence and defence of another”.
111 Re B, above n 25, at [70].
has had little time to make a reasoned decision.\textsuperscript{112} It might also be said that a patient who makes a decision in an emergency that will or could have life-ending ramifications should not have that decision honoured until they have been given sufficient information so that their decision could be considered informed. Although Lord Donaldson made it clear in \textit{Re T} that informed refusal is a controversial concept, it is true that a patient should know in “broad terms … appropriately full information”.\textsuperscript{113} Certainly, the amount of information that can be imparted in an emergency situation is limited, but as the Supreme Court of Western Australia noted in \textit{Brightwater v Rossiter} full provision of information as to consequences of any decision should be given where “perfectly feasible”.\textsuperscript{114} Considering the public interest in preserving life, there are good grounds to advance the proposition that if a patient is unable to, or has not, received full information about their condition and treatment options, it is reasonable to refrain from acting on a decision that might lead to irreparable harm or death.

Moreover, the United Kingdom Court of Appeal has noted that “where delay [in assessment] may itself cause serious damage to the patient’s health or put her life at risk then formulaic compliance with these guidelines [of assessing capacity] would be inappropriate”.\textsuperscript{115} This has been echoed by Butler-Sloss P: “while the question of capacity is being resolved, the patient must, of course, be cared for in accordance with the judgment of the doctors as to the patient’s best interests”.\textsuperscript{116}

\textsuperscript{112} Francis and Johnston, above n 113, at 170.
\textsuperscript{113} Above n 13, at 115.
\textsuperscript{114} \textit{Brightwater Care Group (Inc) v Rossiter} [2009] WASC 229, (2009) 40 WAR 84, at [30].
\textsuperscript{115} Skegg, above n 7, at 173.
\textsuperscript{116} \textit{Re B}, above n 25, at [100].
The following examples provide support for the notion that life-saving treatment should be provided until capacity can be properly assessed: “consider the victim of a traumatic accident who decides soon after learning that she is quadriplegic … that her respirator be disconnected. That kind of hasty decision cannot be accepted because the patient must have time to come to terms with her situation … [if] she remains adamant, then her choice must be honoured”.117 This example adopts the rationale of the Court in Re M where the decision of a 15-year-old girl to refuse a heart transplant in circumstances that came on suddenly and moved rapidly was not accepted because the girl lacked time and maturity to consider her options.118

4. Suicide attempts

Snap decisions to refuse consent to medical treatment frequently come after suicide attempts or from patients suffering depression. These patients are likely to be treated as part of a special category, with some legal commentators arguing that “in an emergency room setting, (apparent) suicide attempters should not be presumed competent”.119

A patient has the right to refuse treatment, even where this leads to the patient’s death.120 A refusal of lifesaving measures is not necessarily suicide, and I am solely concerned with clear instances of suicide or suicidal intent. In the main, if the patient has intentionally brought about their medical crisis, for example by a self-inflicted shooting,

118 Re M (Child: Refusal of Medical Treatment) [2000] 52 BMLR 124 (Fam).
119 Skegg, above n 7, at 187.
120 See Skegg, above n 80.
underdose or overdose, it is highly probable that suicidal intent was a driving factor.\textsuperscript{121}

Returning to the presumption against suicide attempters’ competency, I consider this approach is correct for two reasons. First, there is a statutory framework and public interest in preventing suicide. Section 41 of the Crimes Act 1961 provides a justification to use reasonable force in preventing the commission of suicide or serious injury to any person. This would appear to cover attempts to prevent death after the attempt. Moreover, the state holds an interest in preserving life, which should enable practitioners to provide treatment in the case of suicide attempts.\textsuperscript{122}

Secondly, suicide attempts are often cries for help rather than genuine attempts.\textsuperscript{123} The case of Kerrie Wooltorton who in 2007 drank several glasses of antifreeze in a suicide attempt and presented at hospital with a note refusing treatment illustrated clearly the irreversible and risk-averse approach taken by some practitioners to suicidal patients.\textsuperscript{124} As one commentator has noted, “most people who present in a manner similar to that of Kerrie Wooltorton will not have made a considered decision to die that carries forward their agency. For most, the attempt

\textsuperscript{121} See Raphael Leo “Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians” (1999) 1(5) Prim Care Companion J Clin Psychiatry 131 at 137.

\textsuperscript{122} Kennedy and Grubb, above n 50, at 923.

\textsuperscript{123} Keenan “Consent”, above n 99, at 109.

\textsuperscript{124} S Callaghan and CJ Ryan “Refusing Medical Treatment After Attempted Suicide: Rethinking Capacity and Coercive Treatment in Light of the Kerrie Wooltorton Case” (2011) 18 JLM 811. Kerrie Woolworton was allowed to die, and healthcare professionals acted in compliance with her note.
will be an impulsive one”.125 Indeed, “in the case of adults, it seems the great majority suffer from serious mental disorders – and, much more often than not, will subsequently be glad that their lives have been saved.”126 Psychiatrist Raphael Leo writes that “severe suicide attempts along with suicidal ideas, intent, or plans constitute prima facie evidence for a psychiatric disorder and the lack of capacity to make reasoned decisions regarding interventions”.127 Leo usefully further argues “it is desirable to delay decision making until after the depression, or the psychiatric condition underlying the suicidal ideation, is successfully treated”.128 The strength of this argument is compounded by the fact that suicidal patients or those suffering from major affective disorders can “retain the cognitive capacity to understand … yet fail to appreciate” the benefits of medication.129 Extrapolating this, it would appear that the same patient would not be in a position to reliably appreciate or apply to her or himself the consequences of her or his treatment decision. Although a consumer’s choice must be respected, it should not be necessary to allow a seriously depressed patient to cross the Rubicon from life to death in an effort to respect their decisional autonomy, when that decision may have been made without full ability to appreciate the salient facts.

From a practical perspective, courts will likely resist condemning those who provide life-saving treatment after a suicide attempt, even where the patient has refused. Policy reasons in favour of presuming suicidal

125 At 819.
126 Skegg, above n 7, at 182.
127 Leo, above n 123, at 137.
128 At 137.
patients to be incompetent and proceeding in accordance with the best interests of the patient are strong. The likelihood that such a patient suffers from an underlying mental health condition which renders them incompetent to make life-ending decisions, coupled with the high chance that they are subject to fluctuating lucidity, are elements that point towards a reasonable assumption of incompetence. In addition, suicidal ideas and behaviour are often marked by “acute distress and ambivalence” indicating that clinicians ought to be cautious about the patient’s decisional capacity.\textsuperscript{130}

Two issues should be flagged. First, if it is ascertained that the patient is competent and refusing treatment, this must be honoured. I note, however, the controversy over whether it is possible to make a “rational” decision to commit suicide.\textsuperscript{131} Secondly, it must be remembered that the best interests test still applies. It may not be in the best interests of the patient to provide life-sustaining treatment, and there is no mandate to save life that is unique to instances of attempted suicide. Indeed, in the case of a consumer with numerous co-morbidities, poor quality of life, terminal illness, chronic pain, the probability of an anoxic brain or a short life expectancy prior to the suicide, withholding treatment may still be legally permissible.

Ultimately, practitioners are under a duty to provide the necessaries of life to those in their care. They may be in breach of this duty by failing to provide treatment to a suicidal patient who is incompetent.\textsuperscript{132}

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\textsuperscript{130} Navneet Kapur and others “Advance directives and suicidal behaviour” (2010) 341 BMJ 587.
\textsuperscript{132} Crimes Act 1961, s 151.
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Therefore, “where [an] incompetent patient refuse[s] life-prolonging treatment, there would be a duty not to respect that patient’s wishes … if that was in the patient’s best interests”\(^\text{133}\). In respect of those who attempt to commit suicide, I can only warn that blanket application of the presumption of competency to suicidal patients may deprive those who are most at risk of their right to timely treatment. Situations can be imagined where it might even deprive these people of their right to life. There are good grounds to promote a change in the statutory presumption of competency so that those who attempt to take their lives are treated by healthcare professionals without the specter of unlawful treatment standing in the way of what may otherwise be their legal, ethical and professional duty to act.\(^\text{134}\)

G. Children

Under the Care of Children Act 2004 a consent or refusal to consent to medical or surgical treatment, if given by a child of or over the age of 16, has effect as if the child were of full age.\(^\text{135}\) Commentators agree that this Act does not prevent children under the age of 16 years being able to give valid consent. Indeed, the HDC has noted that “the common law concerning consent by minors … to medical treatment is well established as a “competency based” assessment: *Gillick v West Norfolk*

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\(^{133}\) Kennedy and Grubb, above n 50, at 922.

\(^{134}\) Importantly, the removal of the presumption of competency from suicide attempters would leave open the question regarding the efficacy of advance directives refusing life-saving treatment. Whether an advance directive might apply as it did in Kerrie Wooltorton’s situation is a question that deserves more attention that can be given here. For a good overview of this topic, see: Navneet Kapur and others, above n 132.

\(^{135}\) Care of Children Act 2004, s 36(1).
In that HDC decision, a 14-year-old boy was enabled to consent to a tetanus immunisation without the practitioner needing to seek consent from his mother.

According to *Gillick* a child, regardless of his age, is able to provide consent if he is “of sufficient maturity and understanding to take a decision of the seriousness of that in question”. In Canada, this has become known as the “mature minor rule”, whereby a minor “who can fully understand and appreciate the nature and consequences of a proposed medical procedure can give legally valid consent to treatment”. The test of competency is thus the same test as for an adult.

Where the child (in New Zealand, under the age of 18) is found to be incompetent to make a particular treatment decision, it falls to their parent or other legal guardian to provide proxy consent in their best interests. Importantly, the proxy must be competent and “the scope of parental rights is reflective of parental duties towards children … every child has the right not to be deprived of life”. There is a range of instances in which a healthcare provider may be justified to act in the incompetent child’s best interests without parental consent: emergency,

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136 Health and Disability Commissioner *Decision 01HDC02915* (Health and Disability Commissioner, Wellington, 2002) at 5.
137 Francis and Johnston, above n 113, at 34. See also, *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112 (HL).
138 Downie, above n 141, at 212.
139 Care of Children Act 2004, s 8 (“child”).
parental neglect (where the parent is not acting in the child’s best interests), abandonment of the child and inability to find the parent.\textsuperscript{141}

There has been controversy around whether a child’s right to refuse treatment is as absolute as a child’s right to give informed consent. A New Zealand commentator has noted that even a competent child may have a decision that could result in death or severe disability overridden.\textsuperscript{142} Although the United Kingdom Court of Appeal has developed the rule that the refusal of the child patient, of whatever age, will not prevail in law against the consent of a person with parental responsibility,\textsuperscript{143} there are no cases in New Zealand in which this position has been adopted. Rather, the HDC has indicated that “\textit{Gillick} should be followed for a number of reasons, including the importance of "nature" minors being able to seek or refuse health services without fear of parental involvement”.\textsuperscript{144}

This has, in turn, found broad support. Notably, the Ministry of Health stated in a 1998 publication that a parent could not overrule their competent child’s refusal,\textsuperscript{145} while Fiona Miller recently wrote that “the

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\item \textsuperscript{141} Kathryn McLean “Children and Competence to Consent: \textit{Gillick} Guiding Medical Treatment in New Zealand” (2000) 31 VUWLR 551 at 556.
\item \textsuperscript{142} Keenan “Consent Issues”, above n 30, at 141.
\item \textsuperscript{143} Francis and Johnston, above n 113, at 33.
\item \textsuperscript{145} Ministry of Health Consent in Child and Youth Health: Information for Practitioners (December 1998) at 13.
\end{itemize}
child should have the right to consent to, or to refuse treatment, if the child is assessed as being competent”.146

Instances where the United Kingdom Court of Appeal has overridden the decision of a child are still worth considering, however, since they indicate circumstances where a creative court could blur the line between assessing competency and rationality. They include Re L, where Lord Donaldson MR found a 14-year-old was incompetent to refuse a blood transfusion because she did not actually understand what it entailed.147 And in Re W the same Court of Appeal found that W, a minor, was competent but overrode her refusal because “it is a feature of anorexia nervosa that … it creates a compulsion to refuse treatment”.148

In essence, New Zealand courts are quiet on the issue of children and their capacity to consent. It appears that children who are competent to do so are able to make decisions to the level of their competency. This is recognised by Right 7(3) and firmly established by Gillick. Where a provider believes a decision by a minor or the minor’s guardian to refuse treatment will seriously threaten the health or life of the minor, the provider “should not hesitate” to save the child’s life.149

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146 Fiona Miller “Wake up COCA! Give children the right to consent to medical treatment” (2011) 7 NZFLJ 85 at 88. See also Lucy Thomson “Whose right to choose? A competent child’s right to consent to and refuse medical treatment in New Zealand” (2001) 8(1) Canterbury Law Review 145; Tim Grimwood “Gillick and the Consent of Minors: Contraceptive Advice and Treatment in New Zealand” (2009) 40 VUWLR 743.

147 Re L (Medical Treatment: Gillick Competence) [1998] 2 FLR 810 (CA).

148 Re W (A minor) (Medical Treatment) [1992] 4 All ER 627 (CA).

149 Skegg, above n 80, at 246.
H. Time for Change: Concluding Remarks

Capacity is a difficult thing to measure. The search for a conclusive test really is the search for the “holy grail”.\textsuperscript{150} However, the way healthcare providers assess capacity can improve markedly through clearer guidance in clinical procedures. Practitioners who genuinely apply the tests set out in \textit{Re C}, Right 7(4) and their clinical guidelines should not be afraid of liability where their actions were reasonable in the circumstances.

Although a competent adult patient has an absolute right to refuse even life-saving medical intervention, in an emergency practitioners who have reason to doubt a consumer’s competence should provide life-saving treatment while taking all reasonable efforts to determine the competency status. This is particularly true where there is a strong indication of incapacity as in the case of a minor, a patient who has attempted suicide, or a patient who has recently undergone significant trauma. The New Zealand position would benefit from clearer statutory guidance and more discussion on this matter, rather than the current concoction of common law which is both confusing and inaccessible to most healthcare professionals. The Code could be amended. More radically, a rule should be enacted that permits treatment, to protect the life of or to prevent irreparable harm to a consumer, where: the patient’s competency is in doubt; the treatment is in the patient’s best interests; and a capacity assessment cannot reasonably be carried out without causing harm to the patient.

This would usefully do away with the problem healthcare providers face: the need to make a capacity assessment based on limited

\textsuperscript{150} Sneiderman, above n 42, at 382.
information and in a narrow time frame. It provides a brighter line, protects the public interest in the preservation of life and brings into statute what may only otherwise be found in the doctrine of necessity. Numerous issues exist with this rule – it would be necessary to couple it with the requirement that treatment provided must be strictly necessary, and a capacity assessment be undertaken without unreasonable delay – but perhaps fewer than exist in the current law.

As substantial a part of the solution may be found in education, however. There is need for universities and healthcare employers to broaden the legal elements of their teaching, and for regulatory bodies to issue clearer and uniform guidance on the assessment of and appropriate responses to issues of capacity. This way, even if New Zealand law remains in the throes of legal uncertainty, practitioners who comply with their regulatory guidance may well be able to invoke a Clause 3 defence to breaches of the Code.

Ultimately, an emergency healthcare provider who acts without negligence in their assessment of a patient’s capacity, will not be in breach of any legal or ethical duties in their attempts to gain informed consent, to ascertain the patient’s personal views and best interests and to keep the patient reasonably informed. Courts must recognise the disadvantageous position emergency healthcare practitioners find themselves in, and pay homage to the public good performed by their efforts to save lives where competency is in doubt.

ASSESSMENT AND TREATMENT OF CHILDREN UNDER THE MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992

REBEKAH MAPSON*

Introduction

Mental illness in young people is a serious issue worldwide, but is a particular concern in New Zealand, which has the dubious distinction of having the highest youth suicide rate for 15-to-24-year-olds (17.7 deaths per 100,000 people) of all OECD countries1. Te Rau Hinengaro,2 New Zealand’s first mental health survey, highlighted that 16-to-24-year-olds had the highest prevalence of any mental health disorder and that half of the most commonly occurring mental health disorders have begun by the age of 18.3 Despite these findings, available mental health services are often considered inadequate for children and young people, a situation attributed to the “adultocentrism”4 of the existent services and lack of appropriately trained staff for child mental health.

* LLB/BA/MusB(Hons) (in progress), University of Otago.
3 Sylvia Bell and Warren Brookbanks Mental Health Law in New Zealand (2nd ed, Brookers, Wellington, 2005), at 127.
4 At 127.
health intervention.\textsuperscript{5} This article discusses the issue of compulsory treatment of mental disorder in children under the Mental Health (Compulsory Assessment and Treatment) Act 1992, and this legislation’s compatibility with the values of the United Nations Convention on the Rights of the Child, in particular Article 12(1) and (2),\textsuperscript{6} Article 13\textsuperscript{7} and the Code of Health and Disability Services Consumers’ Rights Regulation 1996.\textsuperscript{8} It will consider the historical, international and policy context in which the legislation developed, and its effectiveness in balancing the “wellbeing and best interests” of children, with the need to treat psychiatric illness.

\textsuperscript{5} P Royce “Focus on psychiatry in New Zealand” (2002) 180 The British Journal of Psychiatry, at 468-470.

\textsuperscript{6} Article 12 provides: “(1) children’s views shall be given due weight in accordance with the age and maturity of the child, and (2) that children shall be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law”. New Zealand legislation has moved away from the concept of “age and maturity” and has instead adopted the idea in the Care of Children Act 2004 that “any views the child expresses must be taken into account”. However, it is the concept of giving children a voice in situations affecting them that is important.

\textsuperscript{7} Article 13 provides that children shall have the right to seek, receive and impart information and ideas of all kinds.

\textsuperscript{8} See particularly the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights Regulation 1996, Right 7.
A Conception of Childhood Mental Health

What is meant by the term “child” has changed over time within different historical contexts and for centuries children were considered to be little different from objects owned by the adult male of the family. The modern conception is linked to the psychological understanding of the human race which began to develop in the emerging field of psychology. Influential authors such as psychologist Jean Piaget (1986-1980) and Lev Vygotsky (1896-1934) advanced the notion of childhood as a separate stage in human development and acknowledged the status of children as distinct from adults particularly in regards to cognitive, physical and emotional immaturity. As a result, in the nineteenth and twentieth centuries, changing social perceptions of children led to legislation that sought to protect their welfare. In the United States, for example, laws were passed establishing juvenile courts and a Federal Children’s Bureau, while the United Kingdom passed the Guardianship of Infants Act 1886, and New Zealand passed the Child Welfare Act 1925, the Guardianship Act 1968, and the Children, Young Persons and Their Families Act 1989. New Zealand also ratified the United Nations Convention on the Rights of the Child in 1993 committing to the international community that it will develop

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9 See Y Hebert and WJ Hartley Personalised Learning and Changing Conceptions of Childhood and Youth (Schooling for tomorrow, Personalised Education, OECD, Paris, 2006).
12 Sondheimer and Jensen, above n 10.
all actions and policies in light of the best interests of the child.\textsuperscript{13} One such way to do so was through the enactment of the Care of Children Act 2004, the purpose of which is to promote children’s welfare and best interests and facilitate their development by helping to ensure appropriate arrangements are in place for their guardianship and care and to recognise certain rights of children.\textsuperscript{14} Similarly, New Zealand has passed legislation including the Health and Disability Commissioner Act 1994 (resulting in the Code of Health and Disability Services Consumers’ Rights Regulation 1996) and the New Zealand Bill of Rights Act 1990 codifying a set of rights pertaining to all New Zealanders, irrespective of age.

Notwithstanding the development of child-focused legislation, New Zealand continues to assess children’s abilities to understand and consent to medical treatment against an adult standard of law, the Mental Health (Compulsory Assessment and Treatment) Act 1992. A recent survey revealed that no country in the world has a clearly defined mental health policy pertaining uniquely to children and adolescents.\textsuperscript{15} Yet 34 countries were found to have identifiable mental health policies which may have beneficial impact on children and adolescents. This relative lack of policies is unfortunate, since research has shown that an explicit policy for child and adolescent mental health can improve the

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  \item \textsuperscript{14} Care of Children Act 2004, s 3.
\end{itemize}
quality and accessibility of services and promote the rights and mental health of all children and adolescents within a country.\textsuperscript{16}

**B. Development of Mental Health Legislation in New Zealand**

Following a number of inquiries conducted by the New Zealand Mental Health Commission, it was recognised that early intervention is important in ensuring that “mental illness” is not a lifelong disruption.\textsuperscript{17} This resulted in a number of documents, including: *New Futures: A Strategic Framework for Specialist Mental Health Services for Children and Young People in New Zealand*,\textsuperscript{18} *Better Times: Contributing to the Mental Health of Children and Young People*,\textsuperscript{19} *Te Tāhuhu - improving mental health 2005-2015: The second New Zealand mental health and addiction plan*,\textsuperscript{20} and *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015*.\textsuperscript{21} All highlighted how young people’s mental health requirements needed to be addressed. In an attempt to ameliorate the issue of youth mental health, the original


draft of the Mental Health Bill (which preceded the Mental Health (Compulsory Assessment and Treatment) Act 1992) included a definition that would have applied to children under the age of 17. Children and young people would have been considered mentally disordered if their behaviour indicated “an abnormal state of mind characterised by delusions or by disorders of mood or perception or volition or cognition or by disturbance of conduct or behaviour of such a degree that it poses a serious danger to the health or safety of that person or others or mental or emotional development of that person” (emphasis added). The need for the italicised limb showed the difficulty of defining youth mental illness, and recognised that mental illness in young people does not manifest itself in the same way as it does in adults. For example, studies on human development and mental illness indicate that children and young people are less likely to verbalise their problems and are more prone to act out delusions.22

However, the additional limb raised concerns that the law might be used as a means of social control, rather than increasing legal protection to children. This concern has been reflected on an international platform where the efficacy of adolescent institutionalisation in “therapeutic” boarding schools, youth boot camps, and other similar programmes has been questioned and strongly criticised.23 As described by one United States psychologist, “most of these kids get into the system because they are troubling to someone else, not because they are

22 Peter Boshier “Early Mental Health Intervention with Young People — Is the Mental Health Act a Help or a Hindrance” (paper presented at Capital Coast District Health Board Conference, Wellington, 2009).

troubled”. As a result, the additional limb of the definition was removed, and the Mental Health (Compulsory Assessment and Treatment) Act 1992 applies to all people, irrespective of age. However, in recognition of the vulnerability of children, s 4 provides that the Act cannot be invoked by a “person's... delinquent behaviour,” while additional constraints specific to children are imposed in s 8 including the right to reassessment at 17, consent provisions and an injunction on brain surgery for people under the age of 17.

C. Assessment Provisions

The Mental Health (Compulsory Assessment and Treatment) Act 1992 applies if a person meets the s 2 definition of “mental disorder”, which means:

- an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—
  - (a) poses a serious danger to the health or safety of that person or of others; or
  - (b) seriously diminishes the capacity of that person to take care of himself or herself.

In terms of assessment of children under the age of 17, the Act requires that “wherever practicable” the first examination should be carried out by a psychiatrist with expertise in child psychiatry. This requirement is intended to prevent misdiagnosis of young people who may simply be displaying challenging behaviour characteristic of some adolescents.

25 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 86.
rather than the “abnormal state of mind” required for treatment under the Act. However, in 1996 the Mason committee noted that child psychiatrists are currently one of New Zealand’s scarcest medical professional.\textsuperscript{26} As a result, this intended safeguard may be undermined because assessment can be carried out by any other medical practitioner approved by the Director of Mental Health Services.\textsuperscript{27}

Case law has helped to shape the interpretation of s 2 by stating that a diagnosis of mental illness does not itself satisfy the requirements for a compulsory treatment order. \textit{Re PJ}\textsuperscript{28} (SRT 28/93) establishes that the definition is not concerned with diagnostic labels. Furthermore, in \textit{Re RT}\textsuperscript{29} 12/4/96, SRT13/96 it was stated, “Parliament has deliberately eschewed reference to major mental disorders as understood in the psychiatric community … [but] has set the parameters for establishing the existence … of a mental disorder according to the presence or absence of observable symptomological indices”. A child may be given a psychiatric diagnosis (for example, schizophrenia), but this in itself is not necessarily enough to satisfy the s 2 definition of “mental disorder”; rather the symptoms of the illness will be identified to establish the need for a Compulsory Treatment Order.

Another way in which children might be disadvantaged under the adult test of mental disorder is the requirement that a mentally disordered person must have diminished capacity for self-care. In \textit{Re C} 278/8/00,

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\item \textsuperscript{26}KH Mason \textit{Inquiry under s 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley} (Ministry of Health, Wellington, 1996).
\item \textsuperscript{27}Bell and Brookbanks, above n 3.
\item \textsuperscript{28}Re PJ (SRT 28/93).
\item \textsuperscript{29}Re RT, 12/4/96, SRT13/96.
\end{itemize}
Thorburn J proposed a mixed subjective/objective test for assessing diminished capacity for self-care stating that “[t]he Court should objectively assess what an ordinary person would find acceptable as a minimum standard of effective self care for a person of the patient’s circumstances and background”.

However, whether this is applicable to children is debatable as all children have a “diminished capacity for self care” based on legal status, development and age, and therefore more easily satisfy the definition of mental disorder. On the other hand, the Act could be said to be implementing the requirements of the United Nations Convention on the Rights of the Child to protect the best interests and wellbeing of a child. Research has shown that children and adolescents seldom decide for themselves when to seek out health services for physical or emotional problems. Therefore, one way in which the Act recognises the different situation of children is by assuming that a child has a lower level of capacity for self-care, and accepting that it is the role of the parent to seek medical care.

Once an assessment has been undertaken, if a psychiatrist considers there are reasonable grounds for believing that a child is mentally disordered, a Compulsory Treatment Order may be enacted. A Compulsory Treatment Order requires a patient “to accept such treatment for mental disorder as the responsible clinician shall direct” during the first month of the Order and thereafter if a psychiatrist appointed by a Review Tribunal considers treatment is in the patient’s best interests. Should this situation arise, a child’s caregiver is entitled

30  Re C 278/8/00, Judge Thorburn DC Auckland CAT132/99.
31  “Better Times: Contributing to the Mental Health of Children and Young People”, above n 19.
32  Mental Health (Compulsory Assessment and Treatment) Act 1992, s 59(1).
under ss 19(6) and 20(3) to be present throughout any hearing except as the Judge may otherwise order, and may be heard by the court when an application for a Compulsory Treatment Order is considered. The explicit indication in the Mental Health (Compulsory Assessment and Treatment) Act 1992 that a young person’s caregiver must be informed and consulted on assessment and treatment decisions of the young person is one way the Act attempts to afford young people additional protections in regards to treatment for mental health problems.

This assessment process places the caregiver in a difficult position and may compromise their ability to effectively advocate for the child, a serious issue when children are considered incapable of advocating for themselves. The formality and paternalism of a judicial hearing to order and enforce a Compulsory Treatment Order might result in resentment from both the caregiver and the child, leading to a breakdown in their relationship. Similarly, the caregiver might have feelings of disempowerment, an inadequate understanding or misperception of diagnosis and treatment, and so might feel responsible for the illness. This could lead to increased chances of non-compliance with medication and medical visits, further compromising the health of the child.

On the other hand, too much involvement by a misinformed caregiver may hinder a child’s recovery. In Journeys of Despair, Journeys of Hope: Young Adults Talk About Severe Mental Distress, Mental Health Services and Recovery the mental health experiences of children were documented

33 Boshier, above n 22.
34 Heather Barnett and Hilary Lapsey Journeys of Despair, Journeys of Hope: Young Adults Talk About Severe Mental Distress, Mental Health Services and Recovery. (Mental Health Commission, Wellington: Mental Health Commission, 2006).
throughout the course of their mental health treatment. In the chapter “Going Downhill” several participants described how “family … continued to be an ongoing source of distress, and declining mental health was attributed to continuing to live in an insecure, unsafe and unpredictable family environment.”

One way this issue might be ameliorated would be to appoint a specialist lawyer for the child to assist in advocacy at judicial hearings, but also to be available to hear the views of the child and their caregiver, explain the assessment and treatment processes at each stage and reinforce the rights of each party. Part 8 of the Act outlines special provisions relating to protection of children’s rights which requires that if necessary a personal representative other than a family member will be appointed to ensure that that child’s rights are protected.

D. Consent Provisions

Another major issue that has arisen through the enactment and application of the Mental Health (Compulsory Assessment and Treatment) Act 1992 is the potential removal of the right to consent to medical treatment for mental disorder. Seeking informed consent is part of a healthcare provider’s “pivotal ethical duty to uphold and enhance their patient’s autonomy” by respecting the patient’s ability to make an informed decision, even if in the end the patient involved decides not

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35 At 25.
36 This is in line with Principle 2 of the United Nations Principles for the Protection of Persons with Mental Illness: “Special care should be given within the purposes of the Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.”
to accept recommended treatment. Consent is therefore a fundamental ethical concept in the provision of healthcare services.

There are a number of statutory provisions and regulations that protect the right to consent. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights Regulation 1996 provides that all New Zealanders, irrespective of age, are entitled to make “an informed choice and give informed consent”.

However, it also states that “nothing in this Code shall require a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by any enactment”, suggesting that the right to consent may be overridden in situations where the Mental Health (Compulsory Assessment and Treatment) Act 1992 applies.

Similarly s 11 of the New Zealand Bill Of Rights Act 1990 states that everyone has the right to refuse medical treatment. However this is in contention with s 59(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992. In In re MP 20/8/97, SRT64/96 the prevailing view was that the limit on the right to refuse treatment for a mental disorder was demonstrably justifiable under s 5 of the New Zealand Bill of Rights Act. The right to refuse treatment is therefore overridden.

This has a number of implications for children. Not only is childhood a life stage in which capacity to make informed decisions is changing and developing, and for which the law is less than explicit, but there is also a comparative lack of case law on which to base guidance about

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children’s capacity and rights to consent or refuse to give consent to

treatment. Generally the right to provide or withhold consent for
medical treatment is afforded to a child’s primary caregiver, and their
views might conflict with the views of the child, whether in the best
interests of the child or not. However, this right can be overridden
where an application for a Compulsory Treatment Order is approved,
transferring the parental duty to protect the best interests and well-being
of the child to the state. This “hints of paternalism”, leading to a feeling
of disenfranchisement\(^{39}\) and could potentially lead to issues of gate-
keeping by parents that compromise the health of the child.

The Act does attempt to protect some consent and procedural rights of
young people with mental disorders by allowing people over the age of
16 years to have a voice in their treatment.\(^{40}\) Section 87 states that
“notwithstanding anything in s 36 of the Care of Children Act 2004 or
any other enactment or rule of law to the contrary, in respect of a
patient who has attained the age of 16 years, the consent of a parent or
guardian to any assessment or treatment for mental disorder shall not
be sufficient consent for the purposes of this Act”. Consequently, a
young person may refuse consent to any form of treatment for a mental
disorder except when undergoing assessment pursuant to s 11 or s 13
or during the first month of a Compulsory Treatment Order. In such
circumstances they are entitled to a “second opinion” on the treatment
from an independent psychiatrist appointed for that purpose by the
Mental Health Review Tribunal, as if they were of full age. By giving
young people over the age of 16 the ability to consent, situations
involving the informal admission of young people by the substituted
consent of their parents and guardians are avoided. This affords young

\(^{39}\) Boshier, above n 22, at 6.

\(^{40}\) Mental Health (Compulsory Assessment and Treatment) Act 1992, s 87.
people the best possible balance between protection and liberty.\textsuperscript{41} It also acts to preserve the principles of the United Nations Convention on the Rights of the Child to recognise children as autonomous beings and protect civil, social and health rights of children.

While the Act only makes provisions for children over the age of 16 to have a say in their treatment, at common law a child under the age of 16 years may give valid and effective consent if he or she has a sufficient understanding of the significance of the proposed treatment. This was outlined in the House of Lords decision in \textit{Gillick v West Norfolk and Wisbech Area Health Authority}\textsuperscript{42} where Lord Scarman stated “the parental right to determine whether or not their minor child below the age of 16 will have the medical treatment terminates if, and when, a child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed”. The \textit{Gillick} competency test can be seen reflected in the Code of Health and Disability Services Consumers’ Rights Regulation 1996, which creates a presumption of competence and recognises the right of a consumer with diminished competence to retain the right of informed consent to a level appropriate to that competence.

When a child is not \textit{Gillick} competent the law generally favours a parent’s right to decide for their child.\textsuperscript{43} With this in mind it is important to note that s 6 of the Care Of Children Act 2004 and art 12(1) of the United Nations Convention on the Rights of the Child and Right 7(4)(b) of the Code of Health and Disability Services Consumers’

\textsuperscript{41} “Consent in Child and Youth Health: Information for Practitioners”, above n 37.

\textsuperscript{42} \textit{Gillick v West Norfolk and Wisbech Area Health Authority} [1986] 1 AC 112.

Rights Regulation 1996 emphasise the importance of the “views of the child” irrespective of their Gillick competency. Despite this clear legislative intent, recent research suggests many Family Court professionals have not “substantially altered their practices from the prior provisions in section 23 of the Guardianship Act 1968” which states that “the Court shall ascertain the wishes of the child, if the child is able to express them, and shall … take account of them to such extent as the Court thinks fit, having regard to the age and maturity of the child” (emphasis added). Children’s views therefore continue to be discounted based on age and maturity. In situations involving a Community Treatment Order it could be argued that a mentally ill child is or may not be capable of expressing coherent and informed views on their treatment. However, the Care Of Children Act 2004 states that “any views the child expresses (either directly or through a representative) must be taken into account” (emphasis added). In order to address this issue, it has been suggested that court professionals be required to undertake additional training when working on cases involving children and families. This could perhaps be extended to include training in child development or psychology and specialist advocacy skills for dealing with young people. It is also important to note there is a requirement to inform the child about the treatment (that is, risks and side effects), a right that is not displaced where a parent or guardian gives consent to treatment. This is in line with art 13 of the United Nations Convention on the Rights of the

45 Care of Children Act 2004, s 6(2)(b).
46 Robinson and Henaghan, above n 44, at 39.
Child, which states that children are entitled to receive information of all kinds.47

E. Recommendations for Improving Current Mental Health Law

“The interventions of the law into children’s lives, whether to protect or to punish, need to be made with attention to their emerging and changing abilities and needs”48. This passage recognises that just as the law is developing, so too is our understanding of a child’s social, mental and cultural development. Despite some flaws, the Mental Health (Compulsory Assessment and Treatment) Act 1992 is positive for children in a number of ways: it enables early intervention to occur when there is evidence of mental disorder; it recognises the rights of young vulnerable patients and of the need for consent to be sought where treatment is ongoing; and it recognises the need to advise those closest to young patients, with a degree of precision as to the perceived nature of the mental illness and its best treatment.49 The law could be improved by providing specialised education and training to medical and legal professionals involved with child welfare, and by acknowledging that childhood mental illness often manifests differently to mental illness in adults.

There remains, however, one particularly concerning issue with the Mental Health (Compulsory Assessment and Treatment) Act 1992.

49 Boshier, above n 22.
Despite all the evidence advocating for child-specific policy and law, the Act continues to apply to all New Zealanders, irrespective of age.\textsuperscript{50} The power of the Act to impose strict state and medical control over both a child and their caregiver may place that child at a greater disadvantage to their adult counterparts, as children are already in a vulnerable position due to age and emotional development. This issue might be mitigated if there was a guarantee that a childhood mental health specialist would always be available to provide assessment where mental disorder is suspected.\textsuperscript{51} Unfortunately evidence of a lack of trained professionals in this area, as well as limited resources, means this is not always a reality.\textsuperscript{52} The New Zealand Government has an obligation under the United Nations Convention on the Rights of the Child to consider a child’s best interests when implementing policy, and could do so by allocating greater funding and resources to the area of adolescent mental health and mental health research. This would strengthen strategies for early identification and intervention for children at risk and provide for crisis and long-term intervention strategies for those with more serious conditions.\textsuperscript{53} Furthermore, making such investments into child wellbeing would ultimately translate into long-term social, academic and economic benefits for New Zealand society.\textsuperscript{54}

\textsuperscript{50} Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.
\textsuperscript{51} Therefore ensuring that symptoms are attributable to a mental disorder or illness, rather than a behavioural issue.
\textsuperscript{52} Mason, above n 26.
F. Conclusion

Growing evidence indicates an approach to mental health that incorporates promotion, prevention and early intervention can have far-reaching benefits by improving mental health across the community as well as reducing the prevalence and burden of mental health problems and mental disorders in the long-term.\textsuperscript{55} This provides strong evidence that New Zealand’s mental healthcare system, like much of the world, would benefit from development and implementation of child-specific mental health law and policy. By taking into account psychological and sociological developmental theory, the provisions of the Care of Children Act 2004 and the obligation to uphold the principles of the United Nations Convention on the Rights of the Child, as well as the knowledge and expertise of child mental health specialists, New Zealand would not only strengthen current mental health laws but would provide the best possible outcomes for children and adolescents with mental illness.

\textsuperscript{55} Mental Health Commission Early Intervention and Prevention in New Zealand (1997).
PRIVACY AND PATIENT RIGHTS: DOES NEW
ZEALAND NEED A RIGHT TO
INFORMATIONAL PRIVACY IN THE CODE OF
HEALTH AND DISABILITY SERVICES
CONSUMERS’ RIGHTS?

SAMANTHA BEATTIE *

Introduction

In his 2009 Review of the Code of Health and Disability Services Consumers’ Rights (“the Code”), the incumbent Health and Disability Commissioner (“HDC”), Ron Paterson, argued the restricted definition of privacy in the Code should be removed. He believed the HDC should have jurisdiction to hear all privacy complaints. The present state of the law enables the HDC to hear complaints relating only to breaches of spatial privacy whilst issues relating to information privacy are dealt with by the Privacy Commissioner (“PC”) under the Privacy Act, and the Health Information Privacy Code (“HIPC”). Paterson’s key concern was that the split complaints system was detrimental to healthcare consumers’ ability to seek redress when their privacy was

* LLB/BA (University of Auckland). I would like to thank Ron Patterson, Joanna Manning and Stephen Penk for inspiring my passion for health care and privacy law through their elective courses. I would also like to thank Lillian Beattie for the many hours she has spent proof reading and editing this work.
breached. Given there is a comprehensive set of statutory rules in relation to health privacy, as well as common law causes of action, there does not appear to be a lack of remedial avenues for patients who have suffered. Perhaps then the issue is more one of lack of consumer ease than lack of consumer opportunity.

Aside from considering the effect on consumers, the broader consequences of including a right to privacy in the Code should also be contemplated. It is notable that the legislature has been reluctant to enact a general right to privacy in any area of the law. Perhaps then to include a right to privacy in the Code would undermine Parliament's seemingly deliberate omissions. Any inclusion of a broad right to privacy could create further trouble as there is a wide range of statutory provisions granting express permission for privacy and confidentiality to be breached. A right to privacy may make it harder to justify such breaches. Finally, the Code differs from both the common law and legislation in that no harm needs to be suffered in order to make a claim. While this may be positive at times, it could also have some undesirable effects. For example, it could expose the HDC to an increase in frivolous assertions, or cause the Office to be considered a backdoor way for claimants, who would ordinarily be unsuccessful, to triumph. This article will examine the question of whether an unrestricted right to privacy should be included in the Code. In weighing up the effects for consumers with the implications that it could have for the two Offices and the law in a broader context, I find that the balance falls on the side of not inserting an all-encompassing right to privacy in the Code.
A. Summary of the 2009 Review of the Code of Health and Disability Services Consumers’ Rights

Currently the Code provides a right to privacy.¹ Right 1(2) states a consumer has “the right to have his or her privacy respected”² and thus many consumers may believe the HDC has jurisdiction to hear an array of privacy complaints. This right is, however, extremely constrained. Both the Code³ and the Health and Disability Commissioner Act 1994 provide that only privacy issues other than those dealt with under the Privacy Act or HIPC are covered.⁴ This essentially denotes that only matters of spatial privacy, such as providing patients with adequate facilities to get changed in, and not information privacy, that is disclosure of private or confidential information, are covered by the Code.⁵ Dialogues regarding the Code make many references to confidentiality, and thus both privacy and confidentiality will be considered concurrently throughout this article.

Ron Paterson, during his evaluation of the Code in 2008 and 2009, strongly advocated for this right to privacy to be expanded. He noted in the HDC Consultation Document there was some scope for the HDC to deal with informational privacy claims via a liberal interpretation of Right 4(2) regarding legal, professional and ethical standards, or if the privacy issue was only a minor part of the broader complaint. However,

¹ The Code is a Schedule to the Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996.
² At cl 2.
³ At cl 4.
⁴ Health and Disability Commissioner Act 1994, s 20(1)(c).
this was not particularly practical and thwarted the deliberately narrow definition of privacy in the HDC legislation. Paterson also found other issues arising from the narrow definition. He argued splitting claims between the HDC and the PC was detrimental to the complainant as the issue could not be seen in its entirety. The division also resulted in repetition of process, and incurred unnecessary time and expense. Furthermore practitioners in breach of their ethical duty of confidentiality could not be held liable under the Code and thus by the Director of Proceedings’ process before the Health Practitioners Disciplinary Tribunal. As a solution to these concerns he proposed the definition of privacy in the Code and Act be removed to allow the HDC to hear information privacy claims. He did not recommend the removal of the PC’s jurisdiction, but rather that the two Offices have joint jurisdiction so privacy claims could be dealt with by the more appropriate agency. Paterson alluded to the fact that the HDC currently shared jurisdiction with the Chief Human Rights Commissioner (CHRC) in regard to the right to be free from discrimination and this had proved effective.

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8. At 14.
11. Paterson, above n 6, at 47.
12. At 47.
B. Why are Privacy and Confidentiality So Important in the Medical Context?

Paterson advocates an inclusion of a general right to privacy because “the right to privacy is integral to the quality of health and disability services and the rights of health and disability service consumers.” Confidentiality is a concept long recognised in medical practice. This is perhaps due to its appearance in the Hippocratic Oath circa 500 BC, one of the first ethical codes in medicine. The inclusion of confidentiality can be justified by appealing to philosophical reasoning. From a teleological or consequentialist point of view, it is thought that if private information is kept confidential then patients are more likely to disclose everything that a doctor needs to know in order to make an accurate diagnosis and provide the right treatment. If they are fearful that personal, and at times embarrassing, information will be shared then they will be discouraged from seeking care. A deontological perspective advocates for confidentiality on the basis that it sustains patient autonomy and fosters one’s dignity and freedom.

In the New Zealand context, the deontological perspective is of particular importance. The whole rationale behind codifying patient rights developed out of the reforms in the healthcare system following

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13 Paterson, above n 7, at 13-14.
14 Peter de Cruz Comparative Health Care Law (Cavendish, London, 2000) at 47.
16 At 315.
the Cervical Cancer Inquiry and the Cartwright report in the 1980s.\textsuperscript{17} This investigation revealed experimental research on patients was occurring without patient consent.\textsuperscript{18} Having such atrocities brought to light fostered demands for patient autonomy and a need for the traditional paternalistic approach of healthcare professionals to change.\textsuperscript{19} Thus while respecting patient privacy had always been central to medicine in order for practitioners to perform their job to the best of their ability, it is now also recognised as a key means of upholding patient dignity and independence. In principle, then, privacy is extremely important.

C. For and Against an Unrestricted Right to Privacy

1. Current Remedies for Breaches of Consumer Privacy and Confidence

The first question in deciding whether there should be a right to privacy included in the Code is whether the remedies currently available to patients are adequate in helping address claims.

(I) The code

The process the HDC Office must take is set out under the Health and Disability Commissioner Act.\textsuperscript{20} If, after an initial assessment,\textsuperscript{21} the claim

\begin{enumerate}
\item Paterson, above n 17.
\item Health and Disability Commissioner Act 1994.
\item Section 33.
\end{enumerate}
is passed on to the HDC, the HDC has a range of options before them,\(^{22}\) including the power to investigate.\(^{23}\) The consequences of an investigation where there is a breach finding will usually result in the practitioner being asked to apologise to the claimant or to review their practice so that a similar event does not reoccur.\(^{24}\) If the breach is sufficiently serious the decision can be forwarded to the Director of Proceedings\(^{25}\) who can then refer the matter to the relevant disciplinary tribunal,\(^{26}\) or to the Human Rights Review Tribunal\(^{27}\) where damages are sometimes awarded to the aggrieved claimant.

The Code does contain a right to privacy and, if the breach covers spatial privacy, it can provide an effective avenue for redress. Opinion 96HDC2314 was a situation where a woman was not given the opportunity to remove her clothing behind a screen. This was found to be a breach of Right 1(2) and an apology from the doctor to the patient was demanded.\(^{28}\)

There are instances where the HDC will deal with information privacy rights via a broad interpretation of the Code. This can be achieved using Right 4(2): the right to have services provided that comply with the various relevant standards, including legal and ethical standards.\(^{29}\)

The HIPC is a legal standard dealing with health information

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\(^{22}\) Sections 34-40.

\(^{23}\) Section 40.

\(^{24}\) Section 45(2)(a).

\(^{25}\) Section 45(2)(f).

\(^{26}\) Section 45(2)(f)(i).

\(^{27}\) Section 45(2)(f)(ii).

\(^{28}\) Health and Disability Commissioner Report on Opinion - Case 96HDC2314 (8 December 1997).

\(^{29}\) Above n 1, at cl 2.
disclosure,\textsuperscript{30} and there are a number of ethical codes, such as the New Zealand Medical Association’s Code of Ethics which include in its principles respect for a patient’s private information.\textsuperscript{31} In Opinion 01HDC03691 the HDC found a doctor liable for breaching Right 4(2) due to his unethical treatment of patient information. Dr B disclosed to Dr A that his patient had gonorrhoea. When the patient’s wife visited Dr A, Dr A was aware of the circumstances and proceeded to act in a paternalistic matter to protect the wife from the truth. Dr B disclosed the private information to Dr A before trying to persuade his patient to make the disclosure himself. This was considered both a breach of HIPC Rule 11 and the doctor’s ethical duties. Both doctors were ordered to apologise, review their practice and the matter was sent to the Director of Proceedings.\textsuperscript{32} This avenue is extremely rare however and when there is an obvious information privacy issue, complaints will be sent to the PC.

Using the Code is a quick, cost-effective way to solve complaints. However, despite some discretion, it is not the best place for consumers with grievances stemming from information privacy breaches to go for resolution. The problem is that the existence of an organisation which deals specifically with the rights of health and disability consumers, and includes in its Code a right to privacy, may cause a number of patients to try this avenue of redress first.

\textsuperscript{30} Health Information Privacy Code 1994, r 11.
\textsuperscript{32} Health and Disability Commissioner \textit{Report on Opinion – Case 01HDC03691} (2002).
(2) The HIPC

When a complaint reaches the PC they may take action if there has been a breach of the HIPC and if this breach has caused, or may cause, some form of harm, whether it be loss, injury, adverse effects on rights or interests, or damage to feelings or dignity. Thus the threshold for finding a breach is higher than under the Code. The PC has an advisory role. If a breach is found, the PC can make recommendations or, if the complaint is sufficiently serious, refer the issue to the Director of Human Rights Proceedings, who then has the option to issue proceedings before the Human Rights Review Tribunal. The Tribunal has authority to award remedies including damages and costs.

Issues regarding health information disclosure are dealt with under Rule 11 of the HIPC whereby health information must not be disclosed unless it fits within one of the exceptions listed. Both the Privacy Act and the HIPC are generally silent as to the status of these rules. While some of the literature has discussed the HIPC as establishing rights, there is in fact no codified right to privacy regarding disclosure. The PC takes issues relating to disclosure of medical information very

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35 At 239.
36 Above n 30, r11(1).
38 Only Information Privacy Principle 6 is considered to be enforceable as a right under s 11 of the Privacy Act 1993.
seriously however and has stated that “professional confidence should only be breached in the most exceptional circumstances”.\(^{39}\)

As with the Code, the HIPC is an inexpensive and fast way to deal with privacy breaches. However, the fact of a higher threshold for a breach finding may mean claimants who have had their privacy breached, but do not suffer any significant harm as a result, will not have their objections considered. Also as non-disclosure of private information is not a right, a privacy claim will be given less weight when competing rights, such as the public’s right to know, come into play.\(^{40}\) Nor is there a mechanism in place to have the provider placed before the disciplinary committee and thus the consequences of breaching privacy for a practitioner may not be as serious.

\section*{(3) Common law}

Aside from a few exceptional circumstances, breaches of the privacy rules under the Privacy Act cannot be heard in the courts.\(^{41}\) The implementation of these rules however does not remove a consumer’s ability to take civil action.\(^{42}\) Therefore the common law works alongside the statutory provisions to provide another forum for disgruntled patients to air their concerns about privacy breaches.\(^{43}\) Depending on the circumstances, an action can be brought in equity or in tort. Despite some overlap between the two actions, in New Zealand breach of

\begin{itemize}
\item \(^{39}\) Case note 2049 [1996] NZPrivCmr 7.
\item \(^{40}\) Brooker v Police [2007] NZSC 30, [2007] 3 NZLR 91 at [210].
\item \(^{41}\) Dalzeil and Johnson, above n 34, at 239.
\item \(^{42}\) Ron Paterson “Health Care Law” (1996) 3 NZ L Rev 286 at 287.
\item \(^{43}\) John Dawson “Common Law Principles Concerning Confidentiality, Privacy and Disclosure” in PDG Skegg and Ron Paterson (eds) Medical Law in New Zealand (Brookers, Wellington, 2006) 325 at 325.
\end{itemize}
confidence and the tort of unwarranted disclosure of private facts remain separate causes of action.\(^{44}\)

### (a) Breach of confidence

Lord Keith in *AG v Guardian Newspapers (No 2)* has stated “[a relationship of confidentiality] can also arise as a necessary or traditional incident of a relationship between the confidant and the confider, such as priest and penitent, doctor and patient”.\(^{45}\) This is also the position in New Zealand where in *Duncan v Medical Practitioners Disciplinary Committee* a GP was found guilty of professional misconduct for a breach of confidence.\(^{46}\) The GP warned his patient’s passengers and the police that his patient had just undergone a triple coronary artery bypass graft operation and thus he felt it was unsafe for the man to be driving. It was noted that while sometimes public interest may justify a breach of confidence, it should be ensured that disclosure is made only to the relevant authority.\(^{47}\)

A breach of confidence can be established when the information disclosed has the “necessary quality of confidence about it”, is imparted in “circumstances importing an obligation of confidence”, and when there is an “unauthorised use of that information.”\(^{48}\) It is likely most patients will consider their information is confidential when it is provided for a special purpose, such as to get treatment, with the

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\(^{44}\) *Hosking v Runting* [2005] 1 NZLR 1 (CA) at [45].

\(^{45}\) *Attorney General v Guardian Newspapers (No 2)* [1988] 2 WLR 805 (CA) at 867.

\(^{46}\) *Preliminary Proceedings Committee of the Medical Council of New Zealand v Duncan* [1986] 1 NZLR 513 (CA).

\(^{47}\) At 518.

\(^{48}\) *Coco v AN Clark (Engineers) Ltd* [1969] RPC 41 (Ch) at 47.
recognition that it will not be disclosed without consent, and when the information is not already within the public arena.\(^49\) Furthermore it must be shown that economic or emotional harm has been sustained due to the breach.\(^50\) The remedies available are delivery of personal documents, account of profits, injunction to prevent a potential or continuing breach and damages.\(^51\)

**(b) The tort of unwarranted disclosure of private facts**

In most instances of a provider-patient relationship breach of confidence will be the preferable route to take. However, the tort of unwarranted disclosure of private facts may provide a claimant with another cause of action. In *P v D* the plaintiff sought an injunction to prevent the publication of information regarding treatment received at a psychiatric hospital. While they stated such information could only have been obtained due to a breach of confidence, there was not enough evidence to prove this and so they proceeded on the basis that publication would breach their privacy.\(^52\) To establish a breach of privacy, there must be public disclosure of private facts that would be highly offensive and objectionable to the reasonable person.\(^53\) As with breach of confidence, harm must be suffered.\(^54\) The remedies available to a successful plaintiff are damages and injunction preventing the publication of the objectionable material.\(^55\)

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\(^49\) Dawson, above n 43, at 328.
\(^50\) At 329.
\(^51\) At 329.
\(^52\) *P v D & Independent New Auckland Ltd [2000] 2 NZLR 591 (HC)*.
\(^53\) *Hosking v Runting*, above n 44, at [259].
\(^54\) Dawson, above n 43, at 333.
\(^55\) At 333.
Both these common law avenues are more time-consuming and expensive than using the statutory regimes. This is especially true for the plaintiff if the defendant can adequately defend disclosure. In *R v Matthews* a patient told his doctor he had been sexually involved with a child. The Court held that while the doctor did have a duty of confidence to his patient, his duty to tell the police about the incident so as to prevent imminent and serious threat of harm outweighed it.\(^56\) If a claimant is successful, however, the remedies may be greater.

### (4) Are the remedies adequate?

In reviewing the available remedies for breaches of privacy, it would appear all bases are covered. The Code allows an avenue of redress when a consumer feels their spatial privacy has been interfered with. The HIPC and two common law causes of action can provide remedies when confidential or private information is, or is going to be, shared without legitimate justification. The key issue in terms of having an avenue for complaint is perhaps that the threshold for finding a breach is higher in the HIPC and common law compared with the Code.

In 2005 Helen A Malcom conducted a study where patients discussed their perceptions of privacy in shared hospital rooms.\(^57\) One of the findings was that while patients were satisfied that their spatial privacy was respected by means of screens or curtains, they found that their personal medical information could be overheard by, and thus disclosed to, others in the room; this frequently made them uncomfortable.\(^58\) The correct place to complain in this instance would be to the PC as there

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\(^56\) *R v Matthews* CA370/03, 8 March 2004.

\(^57\) Helen A Malcom “Does Privacy Matter? Former Patients Discuss their Perceptions of Privacy in Shared Hospital Rooms” (2005) 12 Nurs Ethics 156.

\(^58\) At 160.
has been disclosure to others and without justification or their consent. It seems though that as no sufficient harm had been suffered it is unlikely they would receive a remedy.

Some participants stated that in certain instances the discomfort could escalate to severe stress, especially if the illness being discussed was serious. This would likely be covered by the HIPC. If the Code were to cover informational privacy the HDC would be at liberty to find a breach, as a right simply needs to have been interfered with. To include a right to privacy in the Code would therefore cater to those who have had their informational privacy breached but have not suffered sufficient harm so as to be provided with redress under the HIPC.

D. The Purpose of the Code

The second point to consider is how the restricted definition of privacy fits in with the purpose of the HDC Act and Code. As set out in the Act the objective is to “promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights.” This reflects the importance of the patient’s perspective.

A split system hinders rather than achieves this purpose. In the Code the rights conferred on consumers impose parallel duties on healthcare

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59 At 160.
60 Above n 4, s 45(1)(a).
61 Section 6.
The fact that information privacy is excluded from the Code seems to imply there is no obligation under the Code for providers to respect consumer’s informational privacy. This may not be clear to consumers, especially as there is often considerable ignorance as to the relevant legislation. Arguably many patients without comprehensive understanding of statutory interpretation will simply look at the rights provided in the Code. They will make their complaint without looking to Clause 4 that states the right to privacy is subject to Parts VII, VIII and X of the Privacy Act. Even if a consumer was to consider Clause 4, to then have to negotiate their way around the Privacy Act further encumbers their ability to easily express their grievances.

Australia has faced similar issues in that there are a “patchwork of laws” designed to protect health consumer privacy. The Federal Privacy Commissioner has noted that having multiple pieces of legislation covering similar issues “may result in consumers not knowing where they should go to resolve issues about the privacy of their health information.” Indeed, in New Zealand, 154 claims to the HDC in 2011 had to be referred to other agencies. No doubt a number of these claims were in relation to breaches of confidentiality or privacy. Consequently, several discontented consumers would have had a longer wait than they would have thought necessary to resolve their issues.

62 Above n 1, cl 1.
63 Malcom, above n 57, at 158.
64 Above n 1, cl 4.
66 McInnes, above n 65.
67 Health and Disability Commissioner Learning from complaints: Annual Report for the year ended 30 June 2011(3 October 2011) at 8.
Paterson believes having a “one-stop shop” approach would be significantly more convenient for patients.\(^{68}\) The Nursing Council of New Zealand agrees, and further argues it would “[allow] for low level resolution or disciplinary action to be taken where appropriate.”\(^ {69}\) Such action would help foster a culture whereby healthcare practitioners consider the patient’s perspective before acting.

The PC on the other hand remains opposed to the inclusion of an unrestricted right to privacy in the Code. Her key concern is that compressing the HIPC into a single right in the Code would result in greater misunderstanding by consumers.\(^ {70}\) Certainly this has again been an issue faced in Australia whereby having multiple pieces of legislation and agencies to provide remedies to deal with privacy claims has resulted in inconsistencies as to how privacy issues are dealt with.\(^ {71}\) The Federation of Women’s Health Council Aotearoa has anticipated that discrepancies may start to appear, stating they would rather have information privacy dealt with under the jurisdiction of the PC “as relevant understanding and expertise has been developed within that office.”\(^ {72}\)

To combat this problem a removal of the restricted definition of privacy in the Code could be replaced by inclusion of a more complex set of clarifications to encompass the various exceptions to the entitlement to have healthcare information kept private and

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\(^{68}\) Paterson, above n 7, at 14.

\(^{69}\) At 13.

\(^{70}\) At 13.

\(^{71}\) McInnes, above n 65, at 87.

\(^{72}\) Paterson, above n 7, at 13.
confidential. However, given the accessible way in which the Code is written, complex clauses would be detrimental to the Code’s standing as a consumer-friendly system.

Including an unrestricted right to privacy could significantly increase the HDC’s workload. In 2011 the HDC received 1,405 complaints. The PC received 968, of which 185 related to the HIPC. It would thus appear unnecessary to disperse the privacy claims between the two agencies, as the PC does not receive as many complaints as the HDC. Increasing the HDC’s workload could further delay claims from being resolved in a fast and efficient manner.

The arguments in favour of upholding the status quo are compelling. However, most qualms are countered by the fact that Paterson wishes the two jurisdictions to coordinate and work together. He remarks that often privacy claims brought to the HDC contain issues about other aspects of the Code and thus it makes sense for the HDC to hear the complaint in its totality in order to combat broader issues, especially in relation to the quality of services. In terms of extra workload, the HDC would not be taking all the PC’s HIPC complaints and thus the work would be fairly distributed.

E. Privacy Expressed as a Right

The Code is a code of rights. A right in law holds significant weight. Despite public perception that privacy is a fundamental human right, 76

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73 Health and Disability Commissioner, above n 67, at 7.
75 Paterson, above n 6, at 47.
76 Malcom, above n 57, at 157.
in New Zealand the legislature appears to have been careful not to include a right to privacy in any domestic legislation. Most notably, there is no right to privacy in the New Zealand Bill of Rights Act 1990. Indeed in that Act’s White Paper there was debate surrounding this issue. In the end it was decided the scope and development of privacy was too uncertain for inclusion.\textsuperscript{77} In the HIPC there is no absolute right to privacy as an individual does not have a general right to veto disclosure of their health information.\textsuperscript{78} Perhaps this lack of status is because, while considerable importance is placed on maintaining patient confidentiality, the justifications for disclosure in certain situations are seen as more important. Such justifications for disclosing health information under the HIPC include when there is an imminent and serious threat to public safety,\textsuperscript{79} and when the information is needed in court or tribunal proceedings.\textsuperscript{80}

If privacy is not given the status of a right then it is less significant, and is able to be more easily outweighed by other interests that are rights or freedoms.\textsuperscript{81} Additionally, there are several other pieces of legislation that make provision for the disclosure of information without consent.\textsuperscript{82} To include a right to privacy in the Code could thus undermine the structures of current legislation. Furthermore, privacy claims may more readily be made to the HDC over the PC as the stronger language may lead to it being seen as the more successful

\begin{flushleft}
\textsuperscript{78} Above n 30, r 11(2).
\textsuperscript{79} Rule 11(2)(d)(i).
\textsuperscript{80} Rule 11(2)(i)(i)-(ii).
\textsuperscript{81} Brooker v Police, above n 40, at [210].
\textsuperscript{82} See generally: Health Act 1956, s 22C; Tuberculosis Act 1948, s 3; Venereal Diseases Regulations 1982, r 7.
\end{flushleft}
route. This could have the effect of both undermining the Office of the PC and seeing a dramatic increase in complaints to the HDC as consumers may believe such a right overrules other statutory provisions.

Giving privacy the status of a right could also be seen as focusing too much on patient autonomy and having a chilling effect on beneficial dialogue between healthcare professionals. Ross Boswell accepts patient information brings with it obligations of confidentiality. However, such obligations are seen by providers as a duty to contain the information within the medical community.

The legal perspective is stricter. Informal discussions about unique cases are seen as acceptable in the healthcare provider arena, but under the HIPC are discouraged. Only discussions that provide a direct benefit to the patient are permissible. Boswell believes the law as it stands is already overly strict and can be detrimental both to the patient and to the education of other medical professionals. To include an unrestricted right to privacy in the Code could thus be seen as further preventing practitioners from being able to disclose patient information to one another for instructive reasons. If patients became aware of such discussions the practitioner may find themselves subject to a complaint, despite having the patient’s, and wider community’s, best interests at heart.

While removing the restricted definition in the Code may appear to advance the status of privacy, there are a number of limitations provided in the Code. The first is the wording of the right. The right to

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83 Ross Boswell “Privacy Issues and Medical Practice” (Speech to the Privacy Issues Forum, Wellington, 30 March 2006).
84 Boswell, above n 83.
privacy falls under the broader right of the right to respect, and Paterson’s amendment is worded as “the right to have services provided in a manner that respects the privacy of the individual.”

Thus, the right to privacy is clearly a qualified one; it is only to be in relation to the provision of healthcare services. A provider is not in breach of the Code if they take all reasonable actions in the circumstances to give effect to the patient’s rights and their duties. While the burden is on the provider to prove this, it gives them an opportunity to demonstrate they were justified in disclosing the private information. The Code also makes reference to other enactments, stating that nothing in the Code shall prevent a provider from performing their duties or obligations imposed by other enactments. This will prevent other legislation from taking a subordinate position to the Code. In relation to a right to privacy not being included in the New Zealand Bill of Rights Act, an existing right is not restricted simply by its exclusion from the Act. Nor have a number of the other rights in the Code been included in the New Zealand Bill of Rights Act, and this has not proved to be an issue.

The inclusion of privacy as a right in the Code would not undermine other legislation. The Code is clear it is subordinate to other rights and obligations, imposed by law, on providers. Such apprehension stems from the fact that privacy as a right has been the subject of much discussion at both the parliamentary and judicial level. However, that the right is qualified and contextualised should immediately clarify any concerns.

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85 Paterson, above n 7, at 4.
86 Above n 1, cl 3.
87 At cl 5.
88 New Zealand Bill of Rights Act 1990, s 28.
The biggest problem with including a right to privacy is that it would be inconsistent with the HIPC, which does not discuss its rules as rights. Given that a right has greater weight, it could undermine the PC’s role. It should be noted that Paterson has used the example of joint jurisdiction with the CHRC as an example of where partnership has worked well.\footnote{Paterson, above n 6, at 47.} However, there is already a well-recognised right to be free from discrimination affirmed in the relevant legislation and thus there is no inconsistency.\footnote{New Zealand Bill of Rights Act 1990, s 19.} Furthermore, it could place too great a burden on practitioners. Defining privacy as a right therefore needs further consideration.

**F. No Need for Harm**

The final issue to consider more deeply is how a lack of harm is needed in order for there to be a successful breach finding under the Code. A lack of harm may result in the HDC being exposed to an increase in trivial claims. Patients, in seeing that harm does not need to be suffered, may make complaints to the HDC simply because they believe they are entitled to preferential treatment.

This is, however, unlikely to cause many problems as the HDC has the power to take no action if a complaint is trivial or vexatious.\footnote{Above n 4, s 38.} Clause 3 of the Code also provides a defence for practitioners if their actions were reasonable in the circumstances.\footnote{Above n 1, cl 3(1).} Thus a patient in a public hospital who does not get their own private room for a consultation may find there is no breach if there are resource constraints and the
doctor took care to discuss their condition with them in such a way that could not be overheard by others.93

Alternatively, the exclusion of harm could prove to be valuable to the reasonable patient in a number of cases. The earlier example from Malcom’s study is one such instance. The patients did not necessarily suffer harm as defined by the Privacy Act, and thus there would be no actionable claim.94 The HDC, however, upon finding a breach, would be able to request the doctors of this hospital review their practice and that some guidelines be put in place, such as ensuring they spoke in low voices and stood as close as possible to the patient. Patients value these simple actions.95

However, the lack of a need to prove harm could be seen as undermining the PC’s Office. In Case Note 35361, the PC found the doctor had unjustifiably breached his patient’s privacy by discussing the patient’s injury with his employer without consent. However, the harm suffered by the patient was not considered to result from the privacy breach.96 In such a case, had the complaint gone to the HDC and there was an unrestricted right to privacy, a breach would certainly have been found.

Comparing this issue again to the joint jurisdiction the HDC has with the CHRC, discrimination can be seen as inherently causing harm in that it adversely affects one’s rights. It would be difficult to find an instance of discrimination that did not cause harm and therefore this has not been a problem. In regard to the PC, however, this is a serious

93 Malcom, above n 57, at 159-160.
94 At 160.
95 At 161.
issue that needs to be taken into consideration if there was to be joint jurisdiction. Indeed, this was a problem in Australia whereby inconsistent legislation means the same issues are treated differently under different schemes. Such discrepancies lead to patient confusion and damage the institutions’ reputations.

G. Conclusion

Initially it makes sense for the HDC to be able to hear claims regarding information privacy. Privacy and confidentiality are key aspects of the doctor/patient relationship. The exclusion of a right to privacy in the Code, which is designed to promote patient rights and place obligations on practitioners, seems counter-intuitive. While there are plenty of avenues an aggrieved claimant can take if they feel their privacy has been breached, the common law options can be slow, expensive and incur great stress. Furthermore, such options are primarily reserved for only the most serious breaches and may not provide less aggrieved consumers the opportunity they seek. Thus for the majority of complainants, the PC and HDC are the suitable avenues. Between the two jurisdictions, aspects of patient privacy seem to be suitably covered.

Having split jurisdictions, however, seems to contradict the purpose of the HDC Act: to promote patient rights and facilitate their resolution in the event of a breach. Patients with little knowledge of statutory interpretation may appeal to the HDC without realising their complaint should be placed with the PC. Such unawareness creates lack of consumer ease and unnecessary duplication of process. Concern has been expressed that simplifying the HIPC into one right in the Code would cause greater confusion and there could be an increase in the

97 McInnes, above n 65, at 87.
HDC workload. Such arguments are negated by the fact that Paterson has advocated for joint jurisdiction and a collaborative partnership.

The two key issues remaining therefore are that the Code is one of rights whereas the HIPC is simply a set of rules, and secondly that there is no need to prove harm under the Code. In regard to using the term “rights”, it has been found this is not so much of an issue in the broader context of law, as the right in the Code is clearly qualified by referring only to health and disability services. However, to use the language of rights could have two detrimental effects. It may undermine the PC’s Office as claimants may feel they could have greater success under the Code with its stronger language. Secondly, it may have a chilling effect on practitioners who wish to discuss cases, especially for educational purposes. While this would not be the intention of the HDC, public perception can be very powerful and, as Western society is frequently considered a rights-based one, such rhetoric could be detrimental.

That the Code does not require harm is also a marked difference that needs serious consideration. While there are many instances where a lack of need to prove harm is beneficial to patients and could help providers improve their services, it could also be seen as undermining the PC’s role. The HDC could find itself in the position of finding breaches where the PC would not. This inconsistency could be damaging to the credibility of both Offices. Finally in regard to these two problems, while Paterson has referred to the success of having joint jurisdiction with the CHRC, there is already an affirmed right to be free from discrimination in the legislation, and discrimination is seen as inherently harmful. Thus neither of these issues has caused a problem for the two agencies.
Having an unrestricted right to privacy in the Code could be desirable for many reasons. Unfortunately having two codes that are inconsistent risks causing problems. Perhaps the HIPC could be amended so that the language of rights is used. Indeed, the general public already appears to consider the HIPC and Privacy Act confers rights upon individuals.

The question of whether to remove the need for harm in regard to Rule 11 of the HIPC, or to include it in Rule 1(2) of the HDC Act is more problematic. To either add harm into the HIPIC or remove it from the Code would have the effect of creating inconsistency within the Codes themselves. Thus it is most practicable to have the two jurisdictions remain separate and for the law to stay as it is. The proposed overhaul of the Privacy Act provides an opportunity to address such discrepancies and consider amending the law to allow for a joint jurisdiction that is truly complementary.
GEOENGINEERING IN INTERNATIONAL LAW AND POLICY: NEW CHALLENGES FOR ENVIRONMENTAL LAW

Natalie Jones *

Introduction

Anthropogenic climate change will likely pose grave risks to society during the course of this century. An increase in average global temperature of between 1.1 and 6.4 degrees Celsius from the year 2000 to 2100 is predicted.¹ Effects of climate change include a decrease in sea ice and glacier cover, accelerated sea level rise, more frequent extreme weather events such as heat waves, cyclones and droughts, and irreversible impacts on biodiversity including species extinction; significantly, these effects are already becoming evident.²

As efforts to limit greenhouse gas emissions stagnate, geoengineering techniques, which aim to manipulate the environment, are rising to the forefront of climate policy debate. Although historically geoengineering has been regarded as somewhat of a fringe topic, barely appearing in the 2007 report of the Intergovernmental Panel on Climate Change

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Geoengineering raises novel issues of law and policy that pose challenges for the established scheme of international environmental law. This article tackles these issues in four parts. First, a basic scientific understanding of the various schemes is provided. Then, the legal and policy challenges involved are outlined, before examining the current legal framework surrounding geoengineering. Finally, the future of geoengineering in policy and law is discussed.

A. The Science of Geoengineering

The term “geoengineering”, or “climate engineering”, refers to “the deliberate large-scale manipulation of the planetary environment to

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3 B Metz, OR Davidson, PR Bosch, R Dave, and LA Meyer (eds) Contribution of Working Group III to the Fourth Assessment Report of the Intergovernmental Panel on Climate Change (Cambridge University Press, Cambridge, 2007) at [11.2.2], which referred to geoengineering as being “largely speculative and unproven.”

4 House of Commons Science and Technology Committee The Regulation of Geoengineering (Fifth Report of Session 2009-10, March 2010).

counteract anthropogenic climate change.” Instead of conventional carbon emissions reduction techniques, geoengineering aims to alter the climate in a more direct, intentional and specific way. Scientists, engineers and entrepreneurs have proposed many different methods of geoengineering. Although there are some broad similarities between them, it is difficult to make generalisations in terms of policy issues; there are marked differences in terms of each method, its cost, the degree of international cooperation required for deployment of the scheme, and the degrees of risk and uncertainty involved. Due to the degree of scientific complexity involved, only a basic outline can be given here, but it is sufficient for this article’s purposes.

A basic categorisation of geoengineering into two main types can be made:

(1) Carbon dioxide removal. In these methods, carbon is removed from the atmosphere or captured and sequestered before it is released into the atmosphere.

(2) Solar radiation management. This involves the limitation of the amount of solar radiation (sunlight) striking the Earth.

Several methods of geoengineering which fall into one or the other of these categories will now be examined.

1. Ocean iron fertilisation

An example of a carbon dioxide removal proposal is iron fertilisation. This method would introduce iron to nutrient-deficient areas of the upper ocean, triggering the growth of phytoplankton blooms which are essentially large clusters of phytoplankton, in that area. Phytoplankton

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are carbon-rich, and when they die at least 20 to 30 per cent of their biomass sinks and becomes suspended in deep currents. This means that carbon is thus effectively isolated from the atmosphere for centuries.\(^7\)

There are, however, several disadvantages and sources of uncertainty involved in iron fertilisation. For it to work, centuries of sustained activity on a large geographical scale would most likely be required, which is rather impractical given the uncertainties and fluctuations of human society.\(^8\) In addition, the potential and effectiveness of iron fertilisation depends strongly upon choice of location, and the variables that determine effectiveness have not been isolated. It is unclear how long the carbon would be isolated for, and how much of the phytoplankton would be isolated. Furthermore, field trials have not yielded particularly positive results: predominantly, the phytoplankton blooms were quickly devoured by zooplankton, krill, and fish.\(^9\) Moreover, there are considerable side effects of iron fertilisation on ocean ecosystems, including increased ocean acidification,\(^10\) and the production of toxic algae.\(^11\) This method could potentially lead to an increase in the release of methane and nitrous oxide – worsening

\(^7\) R Rayfuse and others “Ocean Fertilisation and Climate Change” (2008) 23 IJMCL 1.
\(^9\) Rayfuse and others, above n 7, at 9.
climate change.\textsuperscript{12} It is as yet unclear how these side effects could be mitigated.

There are several other carbon removal methods involving the oceans, including sub-seabed sequestration of carbon dioxide,\textsuperscript{13} injection of carbon dioxide (CO\textsubscript{2}) directly into the water column\textsuperscript{14} and weathering techniques to increase the alkalinity of the oceans and therefore enhance the solubility pump.\textsuperscript{15}

2. Carbon capture and sequestration

Another idea is to capture and sequester CO\textsubscript{2} emitted from coal-fired power plants. Options for places to store the CO\textsubscript{2} long-term include: depleted oil and gas formations, coal seams that are unsuitable for mining, and non-potable saline aquifers.\textsuperscript{16} A limitation of this method is that so far it has only been tested on coal-fired power plants – to be effective, it needs to be applied to the many other industrial activities that emit CO\textsubscript{2}.

The obvious risk in carbon capture methods is a CO\textsubscript{2} leak, which could be fatal to those in the surrounding area. It is also unclear how well it

\begin{flushleft}
\textsuperscript{12} M Lawrence “Side-effects of ocean iron fertilization” (2002) 297 Science 1993.

\textsuperscript{13} A Weeks “Sub Seabed Carbon Dioxide Sequestration as a Climate Mitigation Option” (2007) 12 Ocean & Coastal LJ 245.

\textsuperscript{14} Rayfuse, above n 7, at 3.

\textsuperscript{15} L Harvey “Mitigating the atmospheric CO\textsubscript{2} increase and ocean acidification by adding limestone powder to upwelling regions” (2008) 113 J Geophys Res 113.

\end{flushleft}
can be contained, and remain captured.\textsuperscript{17} There is also the probable limit of CO\textsubscript{2} that can be stored. Nor does carbon capture address the ultimate problem: emission of CO\textsubscript{2}. More real-world testing is needed: without this, it is impossible to know the answers to these key questions.

3. Reforestation

Reforestation is a popular option for CO\textsubscript{2} removal. Forests are a huge carbon sink; scientists estimate that if all deforested land were converted back to forests, atmospheric CO\textsubscript{2} would be reduced by 40 to 70 ppm. However, creating new forests is only the first step. A sustainable forest takes time to establish, and for reforestation to create a viable carbon sink forests must have proper protection and stewardship to prevent future deforestation or degradation that can lead to carbon emissions.\textsuperscript{18} Biodiversity, species and ecosystems relevant to the native environment must be considered when planting.

Reforestation is likely the safest and least uncertain geoengineering method. One important caveat is that not all land is equal when it comes to reforestation. Tropical regions are in general much more suitable than the mid-latitudes for reforestation initiatives.\textsuperscript{19} This is because of another significant effect that forests can have: a decrease in albedo, or the reflectivity of the earth, due to the dark colour of forest canopies. A decrease in albedo generally leads to an increase in temperature because more solar energy is absorbed into the earth.

\begin{itemize}
\item \textsuperscript{17} M Latham “The BP Deepwater Horizon” (2001) 36 Wm Mary Env L & Pol’y Rev 31 at 44.
\item \textsuperscript{18} JG Canadell and others “Managing Forests for Climate Change Mitigation” (2008) 320 Science 1456 at 1456.
\item \textsuperscript{19} At 1457.
\end{itemize}
However, the albedo effects vary by region: forests which substitute for snow-covered ground in boreal areas will ultimately decrease albedo, whereas in tropical regions more forests would result in increasing cloud formation, causing albedo to increase. Thus, reforestation is most effective in tropical areas.

4. Stratospheric aerosols

Sulfate particles, or aerosols, when injected into the stratosphere cause dimming as they scatter and absorb incoming sunlight. This leads to global cooling. These effects have already been studied via naturally occurring processes such as the emission of ash during the 1991 Mt Pinatubo eruption. In the 15 months following that incident the average global temperature measurably cooled, by about 0.6 degrees Celsius. Studies suggest that a source 15 to 30 times that of the current non-volcanic sources of sulfur to the stratosphere would be required to balance warming associated with a doubling of CO₂; a concerted global effort would be required.

Side effects of aerosol use include adverse consequences for the hydrological cycle potentially leading to drought, and further ozone depletion, although concerns about increased acid rain are demonstrably unfounded. A practical issue is the short atmospheric

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23 Rasch, above n 21, at 4031.
24 At 4032.
lifetime (one to two years) of aerosols; continuous deployment would be needed to maintain cooling. Conversely, aerosols cannot be removed from the atmosphere once they have been released, which means that their effects need to be comprehensively studied if they are to be released on a wide scale. A positive effect suggested by some studies, however, is that more diffuse radiation allows plants to photosynthesise more effectively, increasing their carbon sink capacity.

5. Cloud whitening

Spraying a fine seawater mist into low-level marine clouds causes them to reflect more sunlight and thus increases the Earth’s albedo. One proposal would deploy this method using a fleet of around 1,500 unmanned ships, and it estimates this technique would be sufficient to reverse the warming effect of a doubling of CO$_2$.

Advantages of this method are: it uses natural and renewable resources, it is considerably cheaper than many other proposals, and it utilises already existing technologies. The major risk involved is that regional weather patterns could be disrupted in unpredictable ways. A critical drawback of this scheme, and indeed all solar radiation management schemes is that they only address the warming problem, and not any of the other problems associated with increased CO$_2$ concentrations such as increased ocean acidification.

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28. At 3985.
6. Conclusions

It is clear that generalised thinking about geoengineering only yields limited conclusions. The methods vary widely: some are undeveloped or have proven negative side effects (such as iron fertilisation), while others (such as cloud whitening and aerosol injection) are comparatively well developed and plausible. No scheme is free of side effects.

There are also some commonalities. First, it is clear that for the successful deployment of any of these options some kind of international agreement would be needed, either because of the inherent trans-boundary effects or because of the practical need for geoengineering to be implemented around the globe. In addition, though the degree of risk varies between schemes there is an inherent measure of uncertainty involved: scientists acknowledge that although climate models are improving, the complexity and chaotic nature of the system means total confidence in any given scheme is impossible.\(^{29}\) It should be noted, however, that although uncertainty can never be fully eliminated, it can be significantly reduced in many cases by further research and testing. Indeed, for all schemes more development is needed to create a viable proposal. Finally, another inherent disadvantage of all geoengineering techniques, when compared to the alternative approach of emissions reduction, is that if deployment stops (in the cases of iron fertilisation, cloud whitening, or aerosols), or if carbon escapes from sequestration, rapid warming is likely to ensue, which would have unprecedented catastrophic effects on the climate.\(^{30}\)

\(^{29}\) Robock, above n 25, at 17.
\(^{30}\) Lenton, above n 8, at 2595.
B. A Policy Basis for Geoengineering … And Some Issues to be Resolved

1. An argument for geoengineering

There is a strong argument for the development of viable geoengineering proposals. Scientifically, the problem of anthropogenic climate change is well-documented and agreed upon. Increasing CO\textsubscript{2} emissions lead to a rising global average temperature, which causes adverse consequences such as melting sea ice, rising sea levels, more frequent extreme weather events like drought\textsuperscript{31} and wildfire,\textsuperscript{32} increased ocean acidification,\textsuperscript{33} and large-scale extinctions.\textsuperscript{34} The scientific community is largely in agreement that climate change is occurring and will continue to occur, with only limited disputes arising as to the extent of the change and its regional consequences.\textsuperscript{35}

International efforts to limit greenhouse gas emissions have thus far failed due to political, socio-economic and technological inertia, and the evidence suggests this trend will continue.\textsuperscript{36} Even if the political will to limit emissions emerges there is a fast-closing window of opportunity

\textsuperscript{31} C Schar and others “The Role of Increasing Variability in European Summer Heatwaves” (2004) 427 Nature 332 at 335.
\textsuperscript{32} T Brown and others “Assessing Climate Change and Fire Danger” (2008) 89 Bull Am Meteorological Society 788.
\textsuperscript{34} Hansen and others “Global Temperature Change” (2006) 103 Proc Nat’l Acad Sci US 14288 at 14292.
\textsuperscript{35} See IPCC, above n 1, at 5.
\textsuperscript{36} As documented in C Redgwell “Geoengineering the Climate” (2011) 5 CCLR 178 at 178-179.
to avoid a significant temperature increase.\textsuperscript{37} In addition, climate change could be far more rapid and severe than we can predict, due to net positive feedbacks in the carbon cycle such as the release of CO\textsubscript{2} from the decomposition of peatlands, wetlands and permafrost,\textsuperscript{38} the release of CH\textsubscript{4} from marine gas hydrates\textsuperscript{39} and reduced albedo from melting of ice and snow.\textsuperscript{40}

Therefore, the basic argument is that knowledge of geoengineering techniques, and plans to put those techniques into action, are needed in the (unfortunately likely) event that emissions reduction strategies fail.

\section{A stop-gap measure}

However, scientists and policymakers agree that geoengineering should be a temporary, stop-gap measure only.\textsuperscript{41} This is imperative for three reasons. First, many methods (such as cloud whitening and stratospheric aerosols) only counter warming, not other effects of increased CO\textsubscript{2} concentration, which themselves can have devastating effects on the environment. Secondly, none of the proposals outlined above can be sustained indefinitely, meaning that when they end it is important the climate does not simply return to its non-altered state of carbon overabundance. Finally, in addition to climate change other

\begin{itemize}
  \item See S Kallbekken and N Rive “Why Delaying Emission Reductions is a Gamble” (2007) 82 Climatic Change 27.
  \item See Royal Society, above n 6.
\end{itemize}
problems remain and need to be addressed as part of a long-term solution, such as the depletion of resources, environmental pollution and ecosystem destruction. Put simply, even taking the possibility of geoengineering into account, human society cannot simply continue as normal: emissions reduction efforts must continue.

A common argument against geoengineering is that there is a high risk of it being viewed as a viable alternative to emissions reduction, rather than merely a supplement. This would mean states and individuals feel no imperative to make the long-term lifestyle changes necessary to address climate change. A2

Several counterarguments can be made. First, the prospect of actual implementation of geoengineering programs may well generate the political will necessary to implement more aggressive mitigation policies, rather than deploy a radical geoengineering proposal. Moreover, even if geoengineering would undermine mitigation, it may well become the only realistic option to deal with climate change: it would at least hold the temperature constant while buying time for the development of alternative technologies, and more gradual and less costly emissions limitations and adaptation measures. It is clearly “dangerously myopic” to discount geoengineering as a climate policy option altogether.

3. The need for further research

It is equally clear that geoengineering proposals are largely speculative, with perhaps the exception of reforestation even the most developed schemes require significantly more research and testing before implementation. This supports the point already made that

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A2 Robock, above n 25, at 17.

geoengineering should only ever be a Plan B, a supplement to emissions reduction measures to be used as a last resort.

The precautionary principle, applied to geoengineering, states that in the face of risk and uncertainty geoengineering experiments and deployment must be treated with caution.\textsuperscript{44} This is clearly justifiable. It should be noted, however, that there are inherent difficulties in applying this principle since “it forbids all courses of action, including regulation. Taken seriously, it is paralyzing, banning the very steps that it simultaneously requires.”\textsuperscript{45} It must be kept in mind the precautionary principle can be argued both ways: it requires us to take any step possible to avoid the dangerous and uncertain consequences of anthropogenic climate change. The precautionary principle must not scare us off geoengineering altogether.

In fact, further research must occur – having made the \textit{negative} point that geoengineering schemes should not be deployed until there is sufficient research, the \textit{positive} point is just as important. It is vital for law and policy to support geoengineering research and testing within the bounds of proper caution. Some level of regulation is necessary. The mere idea of geoengineering as having radical side effects and being highly likely to cause unintended consequences must not deter further research and development in order to overcome current scientific barriers.

If real-world testing does not occur, Davis puts forward a worst-case scenario: desperate countries faced with large-scale famine, economic

\begin{footnotesize}
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\item \textsuperscript{44} JR Nash “Standing and the Precautionary Principle” (2008) 108 Colum L Rev 494 at 498.
\item \textsuperscript{45} C Sunstein “Irreversible and Catastrophic” (2006) 91 Cornell L Rev 841 at 850.
\end{itemize}
\end{footnotesize}
depression or war might well unilaterally decide to deploy a crash geoengineering project. In the absence of scientific information the project would probably be ineffective or actively counterproductive. Even if it was partially successful in mitigating climate change, the side effects might not be ameliorable without prior research. Hence there is a vital need to engage in real-world experimentation. Further to this, a range of different proposals must be seriously looked into so as to diversify future options. It is clear that law is needed – but the challenge will be to build a legal regime through which the risks can be managed, but without inhibiting or stifling research.

C. Governance Challenges

A range of issues exists. First, questions of global equity arise. Deployment of geoengineering on any significant scale will undoubtedly have trans-boundary effects, which may be positive or negative. The existing global playing field is wildly uneven both in terms of political power and wealth, and in relation to regional and local variations in potential vulnerability to the effects of climate change. Indeed, there are only a few countries that have technical capacity to engage in geoengineering, and many geoengineering techniques, such as iron fertilisation or cloud whitening, could potentially be carried out unilaterally by individual states or even companies or wealthy individuals. This raises questions of who would have the authority to undertake geoengineering in ways that might be advantageous to some but not others. Bronsen points out geoengineering offers a perfect excuse for industrialised countries to “evade historical responsibility

46 Davis, above n 43, at 906.
rather than reducing emissions.”47 Geoengineering has a huge potential to disproportionately affect countries that generally lack political power and technological know-how. Furthermore, some states are likely to benefit from climate change due to, for instance, changing rainfall patterns or longer crop growing seasons – how are their interests to be represented in any regime?48 Any system needs to be developed with global equity considerations at its core.

The issue of multinational companies is similarly fraught, as the profit motive makes it difficult for a company to have the global good at heart. As Robock puts it, geoengineering could pose issues “analogous to those raised by pharmaceutical companies and energy conglomerates whose products ostensibly serve the public, but who often value shareholder profits over the public good.”49 The global climate is too important to entrust to private hands. Thus, it is important for geoengineering development to be publicly regulated and transparent in research, rather than solely privately controlled.

The final issue arises in relation to a more general lack of scientific knowledge. For instance, it is difficult to know exactly how much geoengineering would be required to “offset” anthropogenic climate change. Moreover, we do not know Earth’s “ideal” mean temperature. This issue can be somewhat reduced by ongoing research. We can see that a legal framework should be constructed to maximise the potential benefits and minimise the risks of geoengineering. However, these

49 Robock, above n 25, at 17.
complex policy issues raise challenges that must be addressed in any such regime.

D. Current Regulation

The current legal picture is diverse, fragmented, and relatively sparse; it reflects how recently geoengineering has burst into global awareness and how little is understood. There is no single treaty or institution governing geoengineering; rather, there are a multitude of instruments that could be construed so as to apply to geoengineering. It is uncertain how far these existing rules can be adapted to regulate geoengineering actors and activities. Indeed, in some cases it is unlikely that the possibility of geoengineering to counter climate change was contemplated at the time of drafting. Nonetheless, some are potentially applicable to all geoengineering, whereas others can only apply to particular schemes.

1. **1977 Convention on the Prohibition of Military or Any Other Hostile Use of Environmental Modification Techniques (the 1977 Convention)**\(^{50}\)

The 1977 Convention prohibits military or other hostile uses of “environmental modification techniques”, which art II defines broadly as “any technique for changing – through the deliberate manipulation of natural processes – the dynamics, composition or structure of the Earth”, having widespread, long-lasting or severe effects (art I). However, peaceful use of such techniques consistent with other

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\(^{50}\) Convention on the Prohibition of Military or Any Other Hostile Use of Environmental Modification Techniques 1108 UNTS 151 (opened for signature 18 May 1977, entered into force 5 October 1978).
applicable rules of international law is expressly permitted (art III). Geoengineering would appear to fall under these provisions.

The principal importance of this convention lies in its prohibition upon hostile uses of climate modification. However, it is institutionally weak, for instance offering no regulation around when “peaceful use” of environmental modification techniques might be allowed. Moreover, its approach is essentially prohibitory. These factors make it ill suited for adaptation as a geoengineering regulatory instrument.51


This convention applies to disposal of waste material in any area of the water column (arts III (1), (3)). The definition of dumping does not include placement of matter for a purpose other than mere disposal, as long as it is not contrary to the aims of the Convention (art III(1)(b)ii). On the face of it the convention would probably not cover iron fertilisation, and opinions are divided as to whether it would prohibit experimental injection of CO₂ into the water column.53

Later amendments have introduced provisions specifically relevant to geoengineering. Under a 1996 Protocol, which has limited participation,

51 Redgwell, above n 36, at 183.
direct injection of CO$_2$ into the water column is prohibited. However, amendments permitting storage of CO$_2$ under the seabed were adopted on 2 November 2006. Guidelines in respect of sub-seabed sequestration would require parties to issue a permit for the sequestration subject to stringent conditions being fulfilled (s 9), including rigorous studies and geological assessments of the proposed site (ss 3, 4, 6).

In 1997, the Scientific Bodies to the Convention issued a “statement of concern” in response to field trials of iron fertilisation. They noted its potential to have negative impacts on the marine environment and human health, stated that “knowledge about the effectiveness and potential environmental impacts … currently is insufficient to justify large-scale operations,” and stated that the London Convention is competent to address the issue of iron fertilisation, urging states to use “utmost caution”. This statement was highly significant in that it specifically recognised iron fertilisation as a method of geoengineering, and promoted caution among member states. It is clear that the Scientific Bodies recognised the current uncertainty and risks of iron

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58 International Maritime Organization Report of the Twenty-Ninth Consultative Meeting and the Second Meeting of the Contracting Parties LC 29/17 (Dec 14, 2007) at [4.23.1]-[4.23.5].
fertilisation. As such, it is undoubtedly a step forward in terms of sheer recognition of the issues. However, the Scientific Bodies essentially took a precautionary approach, without encouraging further research. Moreover, it should be noted this is only a soft law statement, rather than a rule binding on the parties to the Convention. Nevertheless, it is a valuable development.

3. **1992 Convention on Biological Diversity (the CBD)**

Under this Convention, parties must introduce environmental impact assessment procedures for proposed projects that are likely to have significant adverse effects on biodiversity in order to avoid or minimise such effects (art 14). Parties also have a duty to cooperate in the conservation and sustainable use of biological diversity beyond national jurisdiction, directly or through competent international organisations (art 5). Methods of geoengineering that affect biodiversity, such as iron fertilisation and reforestation, would fall under these broad provisions.

Although the parties debated adopting a moratorium on ocean fertilisation activities, they ultimately (and rightly) followed the London Convention approach. Parties are urged to ensure ocean fertilisation activities do not occur until there is an adequate scientific basis and a “global transparent and effective control and regulatory mechanism is in place for these activities”. An exception is made for small-scale research within “coastal waters” for scientific purposes only.

Further to this theme, a 2010 report under the CBD called on

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61 Ninth Meeting of the Conference of the Parties to the Convention on Biological Diversity, Decision IX/16 (2008).
parties to ensure “that no climate-related geo-engineering activities take place until there is an adequate scientific basis on which to justify such activities and appropriate consideration of the associated risks for the environment and biodiversity and associated social, economic and cultural impacts,” with the exception of small scale research studies conducted in a controlled setting. The sheer lack of scientific knowledge and uncertainty surrounding iron fertilisation was clearly a key influence behind this report.

These developments, along with the London Convention, may indicate an emerging norm discouraging geoengineering or at least geoengineering by iron fertilisation. This is an essentially precautionary approach, although the recognition of the need for small-scale, controlled research is a significant development. It is also only weakly precautionary in that there are no specific sanctions upon a state which does choose to undertake large-scale iron fertilisation.

4. 1985 Convention for the Protection of the Ozone Layer

Under this convention there is an obligation to protect the environment against adverse effects resulting from human activities that modify, or are likely to modify, the ozone layer (art 1). It has a well-developed compliance procedure established pursuant to the 1987 Montreal Protocol. This convention therefore has a limited effect. Although

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64 Montreal Protocol on Substances that Deplete the Ozone Layer 1522 UNTS 3 (opened for signature 16 September 1987, entered into force 01 January 1989).
aerosol injection could potentially breach this obligation, as it has adverse effects on the ozone layer, no other geoengineering techniques discussed would be affected.


UNCLOS has several implications for ocean iron fertilisation and other marine methods of geoengineering. Parties have general obligations to protect and preserve the marine environment (art 192), and to take individual or joint steps to prevent, reduce and control the pollution of the marine environment from any source (art 194). In addition, there is an obligation not to transfer, directly or indirectly, damage or hazards from one area to another (art 195). States’ parties must assess as far as practicable the potential effect of planned activities under their control which may cause substantial pollution or significant and harmful changes to the marine environment and to publish reports of their results (arts 204 and 206). Iron fertilisation schemes could potentially fall under each of these provisions.

The provisions that would require research into planned geoengineering activities are of particular interest. Based on the London Convention, the CBD and UNCLOS, it is arguable that a precautionary norm has developed around iron fertilisation. In varying degrees under these agreements states’ parties are urged to be cautious in developing and deploying iron fertilisation.

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Under UNCLOS there is also a duty to cooperate on a global and regional basis in the protection of the marine environment, for the purpose of formulating rules, standards and recommended practices for protection, as well as promoting studies, undertaking scientific research programmes and encouraging the exchange of information (art 197). This could have significant implications for the development of marine geoengineering policy, but it would be better if this duty also existed in relation to other forms of geoengineering. Nevertheless, this is an important provision that shows international recognition of the need to cooperate in research around, and protection of, the marine environment. It recognises the marine environment is a shared resource at the centre of global dynamics.

Marine scientific research is a freedom of the high seas (arts 87(1)(f), 256, 257), and some argue that marine geoengineering activities should likewise constitute a freedom of the high seas. This is accurate to the extent of geoengineering research activities. Even so, high seas freedoms must be exercised with due regard for the interests of other states (art 86) and in accordance with other provisions of the convention (for example, art 240), and marine scientific research must be undertaken for the benefit of mankind (art 140). These articles are highly applicable to marine geoengineering research.

UNCLOS could potentially also apply to aerosol injection, if such injection took place from ships or if it had an impact on the marine environment. In addition, launch of aerosols from foreign-flagged vessels in the 12-mile territorial sea would not be permitted without the express consent of the coastal state, because such activity does not constitute “innocent passage” (art 9).

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66 Scott, above n 48, at 7.
6. Regional Agreements

Some regional agreements could have limited application to geoengineering. For instance, the 1979 Convention on Long-range Transboundary Air Pollution for Europe and North America\(^{67}\) regulates sulfur emissions and has evolved a compliance mechanism to address breaches of its provisions. It aims to address acidification from sulfur deposits created mainly by industrial sources. Nonetheless, it could have implications for geoengineering to the extent that geoengineering processes contributed to exceeding fixed national sulfur emissions ceilings: aerosols are sulfate particles.\(^{68}\)

Another example is the 1986 Noumea Dumping Protocol to the 1986 Noumea Convention.\(^{69}\) The dumping of CO\(_2\) in high seas areas by a party would be subject to the issue of a general permit from the party to its flag vessel (art 6). This would in effect require parties to introduce an environmental impact assessment process before issuing a permit for an ocean geoengineering scheme.\(^{70}\)

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\(^{68}\) Redgwell, above n 36, at 185.


\(^{70}\) Warner, above n 53, at 114.
E. Options for the Legal Future

It can be seen there are a plethora of potentially applicable instruments. International law hardly presents a blank slate. However, there is an alarming lack of principled regulation, which poses potential threats to marine and land-based ecosystems and the climate in general. In particular, the current law does not adequately address the necessity of further research and real-world testing, although the provisions in relation to iron fertilisation discussed above present a hopeful backdrop. Nor does it address the need for an agreement between as many countries as possible, and in particular with powerful countries, or the supplementary nature of geoengineering.

An international regime to regulate and manage geoengineering is desirable – perhaps necessary – to adequately tackle the problem of climate change. The deployment of some options, such as reforestation, would not require an international consensus in terms of safety. However, an international instrument would still be greatly helpful in relation to the effectiveness of such methods: reforestation is more likely to be effective if pursued in more states. Several options for the legal future will be considered below.

1. A multilateral geoengineering treaty

Some advocate for a global overarching instrument which would “provide both the catalyst and the forum for examining geoengineering options at the international level,”71 setting out common principles of application to both research and deployment activities. This instrument would need to include tools such as environmental impact assessment, monitoring, cooperation and liability, and would

71 Scott, above n 48, at 8.
also need to establish appropriate institutions that are to provide advice on science and engineering matters, take policy decisions on which technologies should be developed and how information should be shared, and resolve disputes. Scott advocates for this instrument to be developed as a protocol to the 1992 UN Convention on Climate Change, since geoengineering needs to be seen in the context of other measures including emissions reductions and adaptation.\(^7\) Geoengineering fits well into this context. It would not be appropriate, conversely, for the instrument to be developed under UNCLOS, as the issue of geoengineering is far larger than the law of the sea.

It is important this instrument not only incorporates the interests of those states well-equipped to carry out geoengineering research and deployment, but also vulnerable states that would be adversely affected by geoengineering or climate change in general. A broad state membership is important, and global equity concerns must be at the heart of any such international instrument.

2. **An international research body**

To be effective, the treaty would have to create an institutional structure for a centre for research, development and deployment of geoengineering technology. A multilateral research program would make the use of geoengineering feasible scientifically by determining which options best offset global mean temperature increases with minimal side effects. A range of geoengineering schemes should be investigated with an eye to precisely ascertaining their effects, fully investigating and countering all possible side effects, and making the scheme technically and economically possible. Outdoor testing, although crucial, should be highly controlled and on as small a scale as

\(^7\) Scott, above n 48.
reasonably possible, and should be preceded by notice and consultation with other countries that could conceivably be affected.\textsuperscript{73}

International collaboration on geoengineering research is vital not only scientifically but to develop norms of cooperative transparency which would build mutual confidence and trust, ameliorate political tensions and lend political legitimacy to the project. Mechanisms for the provision and acquisition of information about parties’ capabilities, planning, intentions and decision-making processes would be desirable.\textsuperscript{74}

This would also set the stage for development of more norms and decisions surrounding the actual deployment of geoengineering, if any.

3. **A norm discouraging geoengineering?**

Others advocate for a norm discouraging geoengineering altogether, and this is severely problematic. This view could preclude the use of geoengineering as even a last resort in the event of catastrophic climate change, or could result in the equally catastrophic use of a poorly researched geoengineering scheme.\textsuperscript{75} Although geoengineering should be approached with extreme caution, it should not be actively discouraged as geoengineering research is key to mitigating climate change. The provisions in the London Convention, the CBD and UNCLOS may be taken as a guide to an advisable level of caution.

\textsuperscript{73} Davis, above n 43, at 944.
\textsuperscript{74} At 941.
\textsuperscript{75} At 936-937.
4. Soft law

Some see a multilateral treaty as “neither likely nor desirable”: unlikely because the appetite for law making in the climate change context is low and undesirable because a “one size fits all” approach cannot be taken beyond the identification of key guiding principles or concerns of general application. Redgwell thinks a more realistic step forward would be adoption of guiding principles for geoengineering governance, which could be embedded in soft law and used by the key geoengineering stakeholders to guide decision-making on geoengineering research in particular. Another advantage of a soft law approach is that the lack of binding provisions could make powerful, technologically advanced states more likely to cooperate.

I disagree. It is true that climate change law has been slow to progress. Of course, it is not inconceivable that geoengineering regulation would suffer the same global collective inertia. However, one only has to look at the speed at which the parties to the London Convention and Protocol issued a “statement of concern” to see that the will and impetus for geoengineering regulation very much exists. And, unlike carbon mitigation efforts, geoengineering development would involve small, achievable steps and would not run against the flow of international economics.

It is also fair to say that no single approach can be taken to all methods of geoengineering. An integrated and concerted approach to research and the development of geoengineering policy can be taken. Indeed, such an overarching approach is necessary to deal with all the interrelated and overlapping effects of various types of geoengineering.

76 Redgwell, above n 36, at 188.
77 At 188.
Although soft law guidelines could be a good starting point, and indeed could usefully be incorporated into a treaty, ultimately something more is needed, in the form of an international agreement.

F. Conclusion

Geoengineering cannot be society’s Plan A to mitigate the effects of anthropogenic climate change. However, if conventional efforts to counter climate change fail, we will need an insurance policy. Currently several methods of geoengineering have been proposed or tested; none, however, are presently viable and all are troubled by uncertainty as to both effectiveness and potential for negative side effects.

It is vital that viable forms of geoengineering are developed. For this to occur, we need real-world research and experimentation to occur. Thus, international law must remain open to research, and indeed must actively promote and facilitate it, while maintaining caution around actual deployment of geoengineering. A multilateral effort is clearly needed, due to the inherently trans-boundary effects of geoengineering, global equity concerns, and the difficulties and costs of effective large-scale implementation.

The current law proves inadequate to effectively regulate geoengineering. Although several existing instruments could be applied to geoengineering, and it is arguable that a precautionary principle is developing in relation to iron fertilisation, the law is ultimately piecemeal and insufficient. A precautionary principle alone is not enough; positive support for geoengineering research and policy development is needed.
An overarching international framework to provide a centre for geoengineering research and policy is recommended. A multilateral treaty, possibly as a protocol to the 1992 UN Convention on Climate Change, would be ideal as the structural basis for such an organisation. Although at this point it is only possible to speak in aspirational terms, the increasing level of awareness, debate and discussion surrounding geoengineering gives hope for these aspirations to become a reality.
THE SHERMAN ACT 1890: BEHIND THE DISTORTION OF THE TRUE ORIGINS OF ANTITRUST LAWS

YOON TAE NAM

Introduction

Competition is an essential ingredient to an effective market. It forces companies to attract consumers by offering cheaper and better products; thereby promoting the welfare of consumers.\(^1\) Paradoxically, unrestricted competition is a “brutal warfare and [is] injurious”\(^2\) as it eventually leads to “the destruction of all [weaker competitors] but one”.\(^3\) American legislators in the nineteenth century thought as much, which led to the emergence of the first federal antitrust statute in 1890: the Sherman Antitrust Act. To date, 122 years have passed since its enactment but the Act remains one of the principal antitrust regulations governing the United States economy.\(^4\) However, there is evidence that suggests the possibility of the distortion in the original intent of the

* LLB(Hons)/BCom (in progress), The University of Auckland. The author would like to thank Professor David V Williams for his support and guidance and Ga-Young Gwon for her ongoing encouragement.


4 US Department of Justice, above n 1.
Act. As one academic put it, “it is one of the great ironies in the history of the U.S. jurisprudence and free-market capitalism that the Sherman Act became the foundation of modern economic regulation”.

The standard view of antitrust law is based on the public interest theory: that intervention by government is to regulate and promote the economy to protect the welfare of its consumers. Contrary to the standard view, this article will affirm that the passage of the Sherman Act did not accommodate the interests of the general public. A careful recollection of three non-mutually exclusive historical jigsaw pieces – the protection of inefficient competitors, the Senator Sherman’s payback motive, and a smoke screen to the enactment of McKinley Tariff Act – will prove there was no legitimate justification for passing the Sherman Act other than it being a product of the flaws in the United States democratic legal system. This article will conclude with an examination of the possible practical effects of the distorted legislative intents of the Sherman Act to the present day.

A. Antitrust Law — Public Interest Legislation

Anti-competitive initiatives and monopolies have existed for a long time, which dates back to the Ancient Greek society and the Roman

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Empire. The names for the corresponding law differed from time to time; but the fundamental idea behind the regulatory approach must have been the same. That is, competition plays an important role in creating an effective market; therefore any anti-competitive behaviour must be restricted.

Antitrust is a public policy process where the government is driven by an objective, which is to serve the general public’s interest. This is based on the notion that private individuals are motivated by self-interest whereas government decision makers are guided by the interest of the general public. The government should therefore intervene “to restrain the forces of private monopoly with the intention of benefiting that most diverse and unorganised of interest groups, consumers”. In this sense, the purpose that an antitrust law should strive to achieve is promotion of competition and protection of consumers via prohibiting monopolistic arrangements to ensure lower prices and better and a wider range of products to consumers. It is important to note though that these purposes are only plausible when based on the conventional

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10 Shughart II, above n 6, at 19.
view that law makers “act in [a] single-minded pursuit of the public interest”.\textsuperscript{12}

This article, however, suggests that to be a naive view. It denies the fact that those politicians – just like private individuals – may have acted with their self-interest, where legislation was used as a means to achieve their own goals. This will be demonstrated by analysing the legislative history of the first federal antitrust legislation in the United States, the Sherman Act.

\textbf{B. The Sherman Antitrust Act 1890}

The Sherman Act was the first federal statute passed by the fifty-first Congress against trusts in 1890 and is widely considered as “the first antitrust law in the USA”.\textsuperscript{13} The introducer and principal contributor of the Sherman Act was a Republican senator, John Sherman. The enactment of the Act was under the constitutional power of Congress “to regulate Commerce with foreign Nations, and among the several States”.\textsuperscript{14} Upon its introduction, political support for the Sherman Act was overwhelming with merely one vote against its enactment from the Senate and unanimous votes from the House.\textsuperscript{15}

\begin{itemize}
  \item \textsuperscript{12} At 197.
  \item \textsuperscript{14} US Const art I, § 8, cl 3.
  \item \textsuperscript{15} George J Stigler “The Origin of the Sherman Act” (1985) 14(1) Journal of Legal Studies 1 at 5.
\end{itemize}
The major sections under the Act are as follows:\textsuperscript{16}

\$ 1 Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations is declared to be illegal …

\$ 2 Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony …

Despite the support the outcome was a vague law, which has caused difficulties for academics and judges ever since its passage. For example, even after 50 years of its enactment, State Supreme Courts were not sure of the meaning of the terms under the Act:\textsuperscript{17}

The prohibitions of the Sherman Act were not stated in terms of precision or of crystal clarity and the Act itself does not define them. In consequence of the vagueness of its language … the courts have been left to give content to the statute, and … courts should interpret its words in the light of its legislative history.

Likewise, the ambiguousness directed scholars and the judiciary to explore the history, in search of its true meaning:\textsuperscript{18} In doing so, the motivation behind Congress in passing the Act became the centre of controversy as its intentions were not clear.\textsuperscript{19} However, it is unmistakable that the Sherman Act was passed to meet purposes other

\begin{itemize}
\item \textsuperscript{16} Sherman Act 13 USC §§ 1 and 2.
\item \textsuperscript{17}  \textit{Apex Hosiery Co v Leader et al} 310 US 469 (1940) at 489.
\item \textsuperscript{18} James May “Historical Analysis in Antitrust Law” (1990) 35 NYL Sch L Rev 857 at 857.
\item \textsuperscript{19} Carey, above n 3, at 337.
\end{itemize}
than the aims of the standard view of antitrust law, which is to promote competition and to protect consumers. As one academic pointed out: 20

… the record of the debates in Congress in 1890 shows that Congress believed it was meeting more than one aim in the legislation. Furthermore, the record suggests that … few, if any members of the Congress, has worried more than verifying about insuring the consistency of these aims.

Historical analysis of economic data prior to the enactment of the Sherman Act clearly points to the implausible justifications in passing the antitrust law. Coherently, the passage of the Sherman Act merely appears to have been the means to achieve the secret master plan drawn by the architects’ and their allies.

C. The Desirability of Antitrust Law in the Nineteenth Century

Senator John Sherman — as is indicated by the name of the Act — was one of the principal contributors to the Sherman Act; hence “understanding … the motives and the views of Senator Sherman is crucial to understanding the intent of [the] law [which] bears his name”. 21 Senator Sherman expressed his concerns about trusts in supporting the antitrust bill. 22

20 At 338.
21 Dickson and Wells, above n 5, at 5. Also agreeing are: Thomas W Hazlett “The Legislative History of the Sherman Act Re-examined” (1992) 20 Economic Inquiry 263 at 266; and Robert H Bork “Legislative intent and the Policy of the Sherman Act” (1966) 9 JLE 7 at 14.
The *popular mind* is agitated with problems that may disturb social order, and among them all none is more threatening than the inequality of condition, of wealth, and opportunity that has grown within a single generation out of the concentration of capital into vast combinations to control production and trade and to break down competition …

Congruent with this speech, DiLorenzo and Bork also pointed out a strong justification for Senator Sherman and his allies in introducing the antitrust bill, which was that trusts tend to restrict outputs thereby increasing price. Sherman and his allies took the phenomenon of the increase in price and reduction of outputs to their advantage, in contending their indications of industries being monopolised by trusts.23 This economic consequence of monopolisation would have been an excellent measure of the need for introducing the antitrust law.

Upon close examination of the price and outputs of some industries that were allegedly being monopolised prior to the passage of the Sherman Act, it is evident the introduction of an antitrust law was undesirable. The Congressional Record of the fifty-first Congress included the following industries as being monopolised by trusts: “salt, petroleum, zinc, steel, bituminous coal, steel rails, sugar, lead, liquor, twine, iron nuts and washers, jute [and] castor oil…”24 Due to the lack of data, an examination of all industries is difficult.


However, an investigation into some of the major industries contradicts Sherman’s claims. There was an average increase in the outputs and growth in the named industries, and the general price reductions in the industries were even greater than the reduction in the consumer price index at the time.\textsuperscript{25} The Congressional Record also shows senators’ acknowledgement of trusts’ positive effect on prices of sugar and petroleum - the two most widely criticised industries.\textsuperscript{26}

Close examination of the available market data for the 1880s proves a conflicting view to the desirability of the antitrust law strongly asserted by Sherman. What is more interesting is that in the construction of an important public policy statute like the Sherman Act, the rationale for its enactment was not influenced by economists of the era. One historian wrote that “… the Congressional debates indicated that no influence whatsoever was exercised by [economists] upon the development of the national legislative policy …”\textsuperscript{27} in relation to antitrust.\textsuperscript{28} If Congress was uninformed about economists’ views in passing the Sherman Act, how could it be sure it was doing the right thing for the public? Also, what was the basis on which Sherman made the claim that the popular mind was agitated in trusts restricting the outputs and raising prices?

\textsuperscript{25} At 31.
\textsuperscript{26} 21 Cong Rec 4100 (1890) as cited in Hazlett, above n 21, at 266.
\textsuperscript{27} John D Clark \textit{The Federal Trust Policy} (The Johns Hopkins Press, Baltimore, 1931) at 31.
\textsuperscript{28} At 31.
Economists’ general consensus during the 1880s was not hostile to trusts, but rather to the view that antitrust law was desired. For example, John Bates Clark - “one of the best younger economists,” insisted that legislative restrictive measures on trusts and combinations would denote a reverse in the economic development.

Examination of market data for the 1880s indicated “there [was] no persuasive evidence that [the Sherman Act] was inspired to enhance economic efficiency” hence protecting consumers. It was further demonstrated by economists’ opinions in the nineteenth century.

D. The Distortion of Legislative Intent

(1) A shield to inefficient competitors

Academics suggested the Sherman Act was enacted to protect inefficient competitors from large-scale and more efficient competitors. For example, economist Robert Bradley highlighted that “[the Sherman Act] discouraged scale economics [which] promoted lower costs and prices, penalized successful market entrepreneurships, and

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29 George Gunton “The Economic and Social Aspect of Trusts” (1888) 3(3) PSQ 385 at 389.
31 John B Clark “The Limits of Competition” (1887) 2(1) Pol Q 45 at 55.
rewarded the political entrepreneurship of less-efficient business rivals”.

Two main pieces of evidence supporting this view are the letters received by John Sherman from inefficient companies lobbying for the introduction of antitrust law; and the farmers’ demand for such action.

(2) Letters to John Sherman

John Sherman received several noteworthy letters from inefficient companies. In particular his correspondence with small oil refiners shows his sympathy for inefficient competitors. Given his significant contribution to the passage of the Sherman Act:

… his letters can be viewed as a barometer of antitrust sentiment.

Take[n] as a whole, the Sherman letters undermine the traditional view that consumers lobbied for, and supported, anti-trust [law].

The letters from small oil refiners are the most active proponents for the introduction of the antitrust law against the Standard Oil Trust and other big oil companies. Their primary grievance was directed at large-scale oil companies, which were granted railroad rebates for tank cars thereby reducing transportation costs. One particular letter addressed to Sherman contained the precise wordings of the Bill which they wished

35 At 291.
36 This is a “train-tanker” in American English.
Sherman would use to introduce. Following this, Sherman introduced an anti-tank car Bill, reflecting the proposed wording in the letter.\textsuperscript{37}

Sherman’s support and defence for small competitors was obdurate despite other senators’ coherent arguments. Numerous senators affirmed that the tank car rebates promote economic efficiency therefore ultimately benefiting consumers with discounted oil prices. For example, Senator Gray – also known as the *antitrust person* – stated that tank cars allow a “great economy in the distribution”.\textsuperscript{38} Likewise, Senator Reagan sarcastically commented “I do not think there is any human being on earth who will contradict”\textsuperscript{39} the fact that tank cars reduce the transportation cost.

To counter these arguments, Senate Sherman argued that the anti-tank car Bill would keep small competitors within the industry, thereby promoting competition:\textsuperscript{40}

> All this [legislation] is designed to do is to guard against the monopoly which … the oil-transporting companies with their tank car will have over the others. All that is asked by the people, most of whom are struggling now for their existence, is that their oil … shall be carried at the same rate per gallon in the barrels … as the Standard Oil and other companies …

Regardless of the unsuccessful anti-tank car Bill; small oil companies applauded Sherman for his attempt and further encouraged him to persist in his commitment against Standard Oil.\textsuperscript{41} This letter was seen as

\textsuperscript{37} At 280.
\textsuperscript{38} 50th Cong 2d Sess 2436 (1889) as cited in Troesken, above n 34, at 281.
\textsuperscript{39} At 281.
\textsuperscript{40} At 282.
\textsuperscript{41} Troesken, n 34, at 282.
an attempt by smaller refiners to protect themselves from more efficient oil trusts as they were unable to access the new transportation technology due to their small-scale business.

In sum, Sherman’s empathy towards inefficient businesses was elicited upon the introduction of the anti-tank car Bill following the letters from small refiners, and his continued vigorous defence for them throughout the debate. Also, in light of other letters received by small inefficient companies, it is plausible to deduce that a substantial amount of his opinion of agitated popular mind was occupied by the interest of inefficient companies rather than a variety of different groups from the general public.

(5) Political movements by farmers

Behind the passage of the Sherman Act were politically powerful farmers led by “[o]rganisations such as the Grangers and the Farmer’s Alliance … the most powerful political interests of the day”.42 The American economy was predominated by the agricultural industry until the late 19th century, where most businesses were relatively small. As the century progressed, technology, transportation and communication developed and opened the era of mass-production. The by-product of this phenomenon was the creation of large and more efficient business enterprises that drastically changed the United States economy.43 On the flipside, this posed a competitive threat to small farmers, who

42 Dilorenzo “the Origins of Antitrust: An Interest-Group Perspective”, above n 23, at 75.
therefore had to seek refuge in the regulatory powers of the government.\textsuperscript{44}

Sanford Gordon analysed the public’s attitude towards monopoly prior to the Sherman Act and pointed out that: \textsuperscript{45}

\begin{quote}
[T]he most violent reaction [against industrial combinations] of any single special interest group came from farmers … They singled out the jute bagging and [the] alleged binder twine trust, and sent petitions to both their state legislators and to Congress demanding some relief … In Georgia, Mississippi, and Tennessee the [farmers’] alliances passed resolutions condemning the jute bagging trust and recommended the use of cotton cloth.
\end{quote}

Furthermore, an overwhelming number of petitions and memorials flew into the fifty-first Congress and they were “…almost exclusively from farm groups”.\textsuperscript{46}

Accordingly, prior to the Sherman Act there was the passage of several intrastate antitrust laws. Academics claim the possibility of a correlation between these statewide antitrust movements and the Sherman Act: \textsuperscript{47}

\begin{quote}
The Sherman Act was not enacted in the Washington, D.C., political vacuum. It emerged from the same economic and political forces that gave rise to state antitrust legislation. It is particularly relevant that in
\end{quote}

\begin{itemize}
\item \textsuperscript{44} Dilorenzo “The Origin of Antitrust: Rhetoric vs Reality”, above n 24, at 30.
\item \textsuperscript{45} Sanford D Gordon “Attitudes towards Trusts prior to the Sherman Act” (1963) 30(2) Southern Economic Journal 156 at 158.
\item \textsuperscript{46} At 162.
\item \textsuperscript{47} Donald J Boudreaux and Thomas J Dilorenzo “The Protectionist Roots of Antitrust” (1993) 6(2) Review of Austrian Economics 81 at 82.
\end{itemize}
1890 state legislatures still directly elected U.S. Senators and that the Sherman Act was introduced in the Senate rather than the House.

This nineteenth century statewide antitrust activism was investigated by Boudreaux, DiLorenzo and Parker - three credible economists. Their works included research into the development of Missouri’s antitrust law, which was considered as a “… representative of the states that enacted antitrust legislation during [the] late 1880s …” Proponents of the antitrust law were exclusively farmers who argued that the introduction of such law would benefit consumers from the artificial manipulation of prices and outputs by monopolies. Boudreaux and others tested this protest to see whether the activism was merely rent-seeking behaviour by less-efficient competitors to protect themselves from more competitive competitors. The trio conducted a close examination of 1870s and 1880s economic data from the agricultural sector prior to the passage of the antitrust law. They had three cogent variables: an increase in the price of farm outputs, a reduction in the volume of farm outputs, and a rise in the price of farm inputs. If anyone was present, monopolistic activities could be proven. In their absence, the farmers’ activism could be shown to be rent-seeking behaviour to create a shield from more competitive forces.

Missouri’s major agricultural products were cattle, hogs and wheat, which comprised more than 60 per cent of its total agricultural output in 1889. The statistical evidence of the price and outputs in these industries during the 1880s firmly supports general reductions in prices and increases in outputs. Furthermore, the evidence provided by

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48 At 82.
Stigler does not support the allegation that monopolies were increasing the price of their inputs.  

Overall, in the absence of evidence indicating monopolisation, that is, an increase in prices of outputs and inputs, and a reduction in the volume of outputs in the economy; we can agree with DiLorenzo and others, who claimed that the proponents of the antitrust law realised a decline in their incomes. In response they urged the government to alleviate the situation.

Having established that the farmers’ political involvement was an attempt for them to seek security from large competitors, what seems more important to establish is whether the famers had sufficient political power to influence politicians to introduce and pass an antitrust law. The Missouri Farmers alliance possessed hugely influential political power. The Democrats’ success in the 1888 State Election is a good illustration. The Democrats had an affiliation with the Alliance and were “… very farm conscious. They were farmer-lawyers, farmer-bankers, farmer-teachers, farmer-preachers, farmer-editors, and farmer-druggists”. In fact, candidates for the state legislature were given pledge cards by the Alliance to decide if they would work in favour of the Farmers Alliances in 1888. The pledge card reads as follows: “I hereby pledge myself to work and vote for the [Alliance’s] demands irrespective of party caucus or action.” These cards were distributed to farmers with instructions to vote against any candidates who refused to sign. The campaign was successful in allowing 140 out of 174 State senators and representatives to sign “yes” to the pledge. “As did every

50 Stigler, above n 15, at 2.
51 Boudreaux and Dilorenzo , above n 47, at 83.
52 Frank M Drew “The Present Farmers’ Movement” (1891) 6(2) PSQ 282 at 303.
one of the congressman-elect headed for Washington … [t]he winners of all three state-wide races in 1888 had signed the pledge as well.”

From this, Boudreaux and others concluded that the driving force behind the passage of Missouri State’s antitrust law in 1889 was the political power held by the agricultural amalgamation. Of the league, the cattlemen and butchers were one of the principal driving forces that proposed such nation-wide regulation. Scholarly evidence proves that this movement had consequentially played “a prominent role in the events leading to the enactment of the Sherman Act”.

The invention of refrigeration and the development of transportation in the late nineteenth century opened doors for Chicago’s meatpacking industry, resulting in the “Big Four” meatpackers. Nationwide shipping of beef began, which reduced the consumer price of meat during the 1880s. However, this caused agitation for the local butchers and cattlemen, which led to the emergence of a rumoured “beef trust”, that is, that the Big Four would continue to cheapen the consumer price. The cattlemen and butchers lobbied for an antitrust action to counteract the realisation of such hearsay. As a result, the Vest Commission was appointed to investigate this issue but found no plausible evidence to support the lobbyists’ claims.

53 Boudreaux and Dilorenzo, above n 47, at 83.
Behind the Distortion of the True Origins of Antitrust Laws

Somewhat bizarrely the Missouri State Antitrust Legislation was nonetheless passed.²⁵ Boudreaux, Dilorenzo, and Parker therefore concluded this sort of economic and political atmosphere was relevant to plausibly deduce that the Sherman Act was also enacted in order to protect small and inefficient but politically powerful entrepreneurs.²⁶

Twenty-four states passed some form of antitrust legislation between 1867 and 1893. Twelve of these states passed laws in 1889 and six more enacted legislation in 1890 – 1891. Given the speed of this process, it is reasonable to assume that these laws were passed within the same political climate, as described earlier. It was also the same political climate in which the 1890 Sherman Act was passed.

In support of this view there is evidence that members of the Vest Committee, who held hands with the farmers, played an influential role during the process of the passage of the Sherman Act. For example, Senator Vest and Senator Coke were on the Judicial Committee which drafted the final version of the Sherman Act.²⁷

(6) Motive to Pay Back Russell Alger

Another plausible motivating event that may have triggered Sherman to introduce an antitrust Bill was his “desire to ‘pay back’ the New York industrialist-dominated delegation [Russell Alger] who he blamed for

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²⁷ Libecap, above n 54, at 29.
denying him the Republican nomination for presidency at the 1888 Convention”.

Sherman’s desire to win the presidential nomination during his long political life in Washington and a number of unexpected defeats prior to the 1888 Convention assists our understanding of the degree of Sherman’s disappointment and resentment towards General Alger for his corrupt campaign, which in Sherman’s belief, was a principal cause of his defeat in the 1888 Convention. Sherman devoted his life as a public servant to Washington yet his desire to win the presidential nomination was never fulfilled.

The 1880s was Sherman’s decade of passion to win the presidential election. The most noteworthy is the 1888 Convention where Sherman’s desire to win presidency peaked after failing twice in the previous Conventions. He realised this would be his last opportunity to get to the White House, due to his retiring age and therefore the end to his political career. For this reason, he was more cautious to ensure that he had the full support from the Ohio delegation. He considered his chances of success were fairly high, but contrary to this expectation, Sherman’s lead in the early ballots did not reach until the very end. From the fourth ballot, a majority of the votes from New York went to Benjamin Harrison, a Civil War Hero from Indiana. This flipped the

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58 Letter from Donald J Boudreaux to the editor (Wall Street Journal) regarding a plausible John Sherman’s intention (19 July 2008).
60 John Sherman John Sherman’s Recollection of Forty Years in The House, Senate and Cabinet (The Werner Company, New York, 1895) at 787.
situation and unfortunately for Sherman ended with Harrison’s victory.\footnote{Kolasky, above n 59, at 86.}

Sherman mainly blamed two people as contributors to his failure. First was Tammany Thomas C. Platt, leader of the New York delegation. Sherman believed Platt made a corrupt bargain to direct New York’s votes to Harrison.\footnote{Sherman, above n 60, at 793.} The second person whom Sherman furiously accused for his defeat was one of his principal rivals, Governor Russell Alger of Michigan. Sherman’s accusation was an allegation that Alger secretly bought votes.

Interestingly enough, the allegation about Alger’s corrupt campaign was reported in a subtle manner by The New York Times early in the convention in June 20 1888, following a test vote on a different issue: “Alger had picked up some Southern delegates intended to be used for Sherman. Their change in allegiance was attributed to the use of money.”\footnote{“Everything Still In Doubt: The Contest Hotter Than Ever – Harrison Believed to Have The Best Chance- Depew’s Boom Extremely Weak- None of the Other Candidates Gaining” \textit{The New York Times} (The United States, 20 June 1888) at 1.} Whether this led Sherman to retain his view about Alger’s corrupt bargain is unknown. However, a number of subsequent publications and Sherman’s furious statement in his autobiography, \textit{Recollection Book} clearly showed this was a very serious issue. After decades from the Convention Sherman firmly wrote that: \footnote{Sherman, above n 60, at 793.}

\begin{quote}
I believe, and had, as I thought, conclusive proof, that the friends of Gen. Alger substantially purchased the votes of many of the delegates
\end{quote}
from the Southern States who had been instructed by their conventions to vote for me …

He further stated that: 65

The only feeling of resentment I entertained was in regard to the action of ... Gen. Alger in tempting with money poor negroes to violate the instruction of their constituents.

This statement was quite controversial and there were several subsequent publications in The New York Times about Alger and Sherman. One publication revealed Sherman’s reply to Alger’s private letter dated 19 July 1888. In this letter, Sherman expressed his resentment against Alger; despite Alger’s initial letter to Sherman, written in a positive manner. Sherman replied: 66

… You made a good show of votes, and if you bought some, according to universal usage, surely I don’t blame you … To me it is a mystery that any man of ability should want a four-year office, sure to cost him all his real friends and pleasures of life, with no adequate compensation except the fealty and adulation of the multitude and of false friends …

65 At 795.
Furthermore, the publication noted Sherman’s furious statement towards Alger’s corrupt bargain was “written in the present tense, showing the present state of his mind upon the subject”. 67

Sherman’s strong resentment against Alger’s alleged corrupt campaign seemed to last even after a decade. Sherman’s reference to the decision of the Michigan Supreme Court in Richardson v Buehl 68 in his speech in support of the antitrust Bill only after two years from the incident, supports the view that the Bill’s introduction was used as a means to exact revenge on Alger for denying him the Republican nomination in 1888. This case found Alger’s Diamond Match Company to be an unlawful combination in restraint of trade under the Michigan State law. The case highlighted Alger’s participation in an unlawful monopoly, calling him a monopolist General Russell Alger. The next day, The New York Times sensed Sherman’s hostile motive towards Alger. During a report of Sherman’s speech, the paper sarcastically noted “with reluctance what Mr Sherman directed the attention of the Senate and the country to Gen. Alger’s connection with this unlawful combination.” 69

This hostile payback motive was also confirmed later by President Benjamin Harrison. While signing the Sherman Act, he stated that “John Sherman has fixed General Alger.” 70 Additionally, surrounding circumstances at the time of the introduction of the antitrust Bill

68 Richardson v Buehl 43 NW 1102 (Mich 1889).
70 Matilda Gresham Life of Walter Quintin Gresham, 1832 - 1895 (Rand McNally & Company, Chicago, 1919) at 632.
provide a plausible inference for the view that the passage of the Sherman Act was a payback directed at Alger. First, as rightly questioned by the author of On the Origin of the Sherman Antitrust Act “why did he wait until July 1888 to bring his antitrust crusade”71 after a long political career? He was in his mid-60s by the time he proposed the Bill and was described as “an aging man at times impatient and confused”72 who suddenly became interested in trust issues immediately after his defeat in the Republican nomination.

There does not seem to be any clear evidence to answer these questions, but sometimes silence in history speaks louder than words. It is plausible that there was a payback motive involved for Sherman to introduce the antitrust Bill.

(7) A Smoke Screen over the Passage of the McKinley Tariff Act of 1890

The third persuasive explanation for the legislative intent behind the Sherman Act is its objective in serving a political function: “a smoke screen behind which politicians could grant tariff protection to their big business constituents …”73 On this view the Sherman Act was used to maximise Sherman’s and his allies’ re-election prospects. This smoothed the enactment of the McKinley Tariff Act of 1890 under which one of the principal beneficiaries were their big business constituents.

71 Bradley, above n 33, at 740.
73 Dilorenzo “The Origins of Antitrust: Rhetoric vs Reality”, above n 24, at 31 (emphasis added).
The McKinley Tariff Act was passed only three months after the enactment of the Sherman Act. It increased the tariff rate on manufactured products to as high as 49.5 per cent. The general consensus at the time was that high tariffs had a positive effect on combinations as it discouraged foreign competition; therefore protecting trusts and combinations altogether. Due to this counteractive effect to the Sherman Act on trust issues, the enactment of the McKinley Tariff Act almost immediately attracted substantial criticism from the public and brought controversy towards the true intention of the Sherman Act. The New York Times noted the suspicious connection between the Sherman Act and the McKinley Act, and heavily criticised the purpose of the former.

Surprisingly, Sherman himself acknowledged his clear knowledge regarding the contradictory nature and functions of the McKinley Tariff Act and the Sherman Act on many occasions. In response to Democratic President Cleveland’s annual message to Congress, Sherman admitted that one effective approach to regulating trusts was through tariff reductions: “[w]hen such combinations to prevent reduction of price by fair competition exist, I agree that they may and

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75 Mary L Azcuenaga “The Tariff is Still the Mother of the Trust” (1990) 29 Washburn LJ 359 at 361.

76 “Mr. Sherman’s Hopes And Fears” *The New York Times* (The United States, 1 October, 1890) at 4.
ought to be met by a reduction of duty.”77 Also, during the debates over the antitrust Bill, Sherman attacked the trusts on the basis that they “subverted the tariff system [and] … undermined the policy of government to protect … American industries by levying duties on imported goods”.78

Nonetheless Sherman soon contributed to the passage of the tariff Bill. During this time his conscience about the counteractive effect was subtly noted on the date of which the Tariff Act was enacted. Sherman expressed his concerns about the effect of the Tariff Act on combinations: 79

[T]his protective policy must not degenerate into monopoly, into Trusts or combinations to raise the prices against the spirit of the common law … I do hope now that this bill when it becomes a law will be acted upon by the manufacturers in our country judiciously, that they will avoid those contracts that have been made and which occasioned popular discontent, that they will invite fair competition … If they do not, I for one, will be as ready to repeal this law as I am now ready to vote for it.

On 29 September 1890 Senator Sherman intended to voice his true mind about the McKinley Act and its effect on combinations; it was withdrawn by the Senator himself for dubious revision purposes. However, the abridged copy of the original speech was forwarded to a

79 21 Cong Rec 10668 (1890) as cited in Dickson and Wells, above n 5, at 11.
New York Times reporter, which was subsequently published as follows:80

We direct attention to those passages [of Sherman's speech] relating to combinations of protected manufacturers designed to take full advantage of high tariff duties by exacting from consumers prices fixed by agreement after competition has been suppressed … Mr. Sherman closed his speech with words of warning and advice to the beneficiaries of the new tariff. [His] earnest manners indicate[d] that he is not at all confident as to the outcome of the law. The great thing that stood in the way of the success of the bill, he said, was whether or not the manufacturers of this country would permit free competition in the American market. The danger was that the beneficiaries of the bill would combine and cheat the people out of the benefits of the law. They were now given reasonable and ample protection, and if they would resist the temptation attaching to great aggregations of capital to combine and advance prices, they might hope for a season of great prosperity … He did hope, the Senator concluded, that the manufacturers would open the doors to fair competition and give its benefits to the people … [Also that] the manufacturers would agree to compete one with another and would refuse to take the high prices that are so easily obtained.

The two speeches above clearly display Sherman’s awareness of the likely effect of the McKinley Act on trust issues. This included an enhancement of monopoly problems, which undermines the essential purpose of the passage of the Sherman Act. What is peculiar about this speech is Sherman’s hope towards manufacturers. He wished they would not make use of the protective Tariff Act in order to advance their interest; thereby benefitting consumers. This sentiment directly contradicts his earlier statements from less than a year ago, where he

80 “Mr. Sherman’s Hopes And Fears”, above n 76.
acknowledged that the trust “subverted the tariff system; [and] … undermined the policy of government to protect … [the] American industries by levying duties on imported goods”. How can Sherman change his expectations in a mere year’s time, for the public to respect an even higher tariff system which would be more appealing for trusts? This, in turn supports the view that the passage of the Sherman Act was not motivated with genuine intentions to promote competition and increase the economy’s efficiency.

One question still remains: given such inconsistency, why did Sherman and his allies support both Acts? The answer to this question can be sought with reference to the pre-1888 Convention era. The direct relationship between the trust problem and the tariff was widely known – hence the public’s ample attention to trust problems. A number of attempts were also made by Democrats to link the tariff with trust problems and then to propose tariff reductions. Since the Post-Civil War era Republicans have continually advocated for high tariffs. Undoubtedly, the Democrats’ attempts were seen as a threat for the Republicans’ election prospects. The Republicans therefore wanted to be sure the Democrats “[would] not be able to ride the swelling public antipathy towards trusts to victory in November”. Consequently, trusts and tariff issues were important for both parties in the 1888

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83 19 Cong Rec 11 (1887). See also Thomas Hudson Mckee The National Conventions and Platforms of All Political Parties, 1789 to 1904: convention, popular, and electoral vote; also the political complexion of both Houses of Congress at each biennial period (Friedenwald Company, Baltimore, 1904) at 235.
84 Kolasky, above n 59, at 86.
election. The antitrust plank was particularly crucial in attracting public votes. The public’s view towards antitrust was so overwhelming that according to the *Cincinnati Commercial Gazette*, anyone who had connection with trusts or favoured the trusts could not be elected. 85

While the Republicans were aware of the importance of the anti-trust planks in catching votes for the November election, they also wanted to maintain their position as a long opponent of tariff reductions. Therefore it was also in their best interest to “to reduce the pressure to lower tariff barriers and ... [to] assure that whatever legislation was passed was not too radical”. 86 Their efforts were noted in the Republican’s Declaration of Principles 87 and in The New York Times: 88

> The Republican platform is very, very long and its merit is inverse proportion to its length ... [They have] declared that [they] will not touch the protective and monopoly breed features of the tariff ...

In sum, Sherman and his allies supported both the Sherman Act and the McKinley Tariff Act in spite of their clear knowledge regarding the contradictions. This supports the view that the enactment of the Sherman Act was not motivated by the genuine intention to promote competition thereby maximising the efficiency of the economy in order

85  Gordon, above n 45, at158.
86  Kolasky, above n 59, at 86.
to benefit consumers. Instead, given the strong public opinion – from politically strong, inefficient competitors against trusts – it is plausible to view the passage of the Sherman Act as crucial to maximising re-election prospects. Additionally, the Republicans’ persistence with the pro-tariff position and the passage of the McKinley Tariff Act can be seen as an attempt to advance their re-election prospects further by winning the favour of their big constituents. In achieving their objective, the Sherman Act played an important role as it appeased the public – in particular the inefficient entrepreneurs – from their fear of trusts. This smoothed the passage of the McKinley Tariff Act without greatly compromising their political support which. In this sense, the Sherman Act was indeed a great tactful smoke screen to achieve Republicans’ political objectives.

E. True Intention

This article has so far established several plausible legislative intentions behind the passage of the Sherman Act, but one question is yet to be answered: the most plausible intent. Without clear written records of what was in Congress’ mind, answering this question in a conclusive manner would be a perilous act. Instead I suggest the three plausible intentions are not mutually exclusive. There also remains a possibility that the passage of the Act may have been due to a combination of the several explanations. What can be said with confidence is: given the analysis of economic data and the opinion of economists at the time of enactment, the Sherman Act was undesirable. Therefore, the legislative intent according to the standard rationale of antitrust law was undermined.

However, recognising the flaws of democracy and accepting that it does not necessarily lead to rational, predictable and consistent decision-
making, one can justify the passage of the Sherman Act from a political perspective. Politicians have an incentive to act in favour of their constituents to maximise re-election prospects in a democratic system. Meanwhile politically strong lobbyist groups may take advantage of this incentive to “redistribute wealth from society as a whole to themselves”. In a sense, this is like a “cozy back-scratching relationship between politicians and interest groups” where each party exchanges their own interest at the expense of the general public. A product of this can be irrational legislation motivated by an ill intention to favour a particular interest group. This defect in democracy does not seem to be a one-off incident; rather, this is widely known as the “emblem of democracy”. This was observed by Judge Learned Hand:

I will not of course, deny that there are statutes of which we can say that they carry something like the assent of a majority. But most legislation is not of that kind; it represents the insistence of a compact and formidable minority.

91 Reynolds, above n 89, at 1642.
92 At 1648.
95 Reynolds, above n 89, at 1645.
It would be difficult to conclude our question with a particular position. We can, however, explain how public interest legislation – an antitrust law – was passed irrationally without much consideration to its actual effects on the public. This political view seems to sit well with all of the three plausible explanations discussed.

F. Practical Implications to Present Day

The next question to explore is the importance of legislative history to the present time. Legal history of the Sherman Act continues to affect the present day in potentially two aspects: the statutory interpretation and determination of its constitutional legitimacy.

When interpreting statutes it is generally agreed that the judiciary relies on extrinsic materials such as legislative history and intent. This is due to the fact that these help to ascertain clearer statutory meanings and legislative intent, the purpose of the statute as well as in crafting policy.

Should not, then, the Act be interpreted so that small and inefficient competitors can be protected from large and efficient competitors, or be limited in its enforcement for parties with vengeance motives? Or perhaps, disregard it at all, as the current tariff rate is low enough on its own to soothe the public’s fear of trusts, or acknowledge that it is a product of the flaws in democracy? Theoretically this sounds viable.


98 Beth M Henschen “Judicial Use of Legislative History and Intent In Statutory Interpretation” (1985) 10(3) Legis Stud Q 353 at 354.
In addition, should not the Sherman Act be declared void under the power of American courts to review Acts of Congress? Theoretically speaking, the courts may inquire into hidden legislative motives and strike down statutes if they are unconstitutional. Therefore, in theory the ulterior purposes behind the Act’s passage should warrant the courts to strike down the Sherman Act.

In sum, the legislative history and perverted intentions of the Sherman Act should theoretically present a substantial matter of contention regarding its legitimate status, as well as its provisional application. However, the practical chances of such are highly unlikely due to two well-known legal concepts: judicial activism and the doctrine of precedent.

(1) Statutory interpretation

A downside of judicial activism is the risk that judicial discretion is used to jeopardise duties to harmonise legislative intent and purpose in statutory application. This replaces the legislature’s intent with judicial will. This discretion in judicial activism extends to the use of extrinsic materials even down to their selection; this gives judges discretion to choose what they believe is right. In the context of the Sherman Act, this effect seems to be more predominant as a result of deliberate assignment of more discretion to the courts. This was pointed out by Robert Bork who, after examining the Congressional

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99 Marbury v Madison 5 US 137 (1803) at 177–178.
101 Marbury v Madison, above n 99.
102 Todd, above n 97, at 189.
103 Henschen, above n 98, at 358–360.
Debates, said that the Sherman Act was deliberately drafted vaguely to allow judicial activism.\textsuperscript{104}

Given this, it seems no coincidence that the use of legislative history in statutory interpretation of the Sherman Act is particularly low. Beth Henschen’s study of cases from 1950 to 1970 confirmed that the courts tend to use interest balancing and plain meaning methods to interpret Acts in antitrust cases, as opposed to using its legislative history and intent.\textsuperscript{105} This pattern is even more prevalent in the Sherman Act than in other antitrust statutes.\textsuperscript{106} A study of all Supreme Court cases involving statutory interpretation from 1953 to 2006 confirms a similar modern trend.\textsuperscript{107}

In conjunction with this low use of legislative history regarding the Sherman Act, the doctrine of precedent may further reduce the practical effects of the distorted legislative history of the Sherman Act to the present day. The Sherman Act has been used to protect consumers for over a century and cases have been developed under such assumptions. This directs future courts to interpret in a similar manner. Professors Richards and Kritzer have observed that the courts tend to set up a self-imposed system to provide guidance for future courts in choosing relevant considerations as well as the appropriate

\textsuperscript{104} Bork, above n 21, at 47.
\textsuperscript{105} Henschen, above n 98, at 361.
\textsuperscript{106} At 363.
\textsuperscript{107} David S Law and David Zaring “Law versus Ideology: The Supreme Court and the Use of Legislative History” (2010) 5 Wm&Mary L Rev 1653 at 1706.
level of scrutiny in statutory interpretation. This means the relatively low use of legislative intent in statutory interpretation over the years has probably created precedential guidance that legislative intent is a less useful consideration in the context of interpreting the Sherman Act.

(2) Constitutional legitimacy

The effect of the doctrine of precedent and judicial activism diminishes the influence of legislative history in determining the constitutionality of statutes. American courts have power to strike down statutes if the legislative intent and purpose of the statutes contradict the authorised constitutional power. But for a long time courts have declined to strike down “an otherwise constitutional statute on the basis of an alleged illicit legislative motive”. The reason for this was not because the legislative history was considered irrelevant. Instead, the court claimed restrictions on the judicial review of legislative purpose, thereby justifying their restraint in taking active steps to ascertain the distorted intention other than looking at the face of the statute. Therefore, unless there is certain and complete

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109 Todd, above n 97, at 189 judicial activism is described in the following terms: “[where] the judicial fails to take every reasonable measure available to discern the legislature’s intent, it can be considered an affirmative act of replacing the will of the legislature with that of its own.”


information on the face of the statute, courts will continue to decline to hold the Act as unconstitutional.\textsuperscript{112}

While the modern trend has been for courts to be more active in reading the legislative history when assessing constitutionality,\textsuperscript{113} the difficulties in standard of proof remain.\textsuperscript{114} Moreover, the doctrine of precedent directs the modern Supreme Courts to cases decided under the old approach: where the judiciary failed to take reasonable steps to obtain an Act’s legislative history “to the extent that those precedents declined to investigate the legislature’s true motivation”.\textsuperscript{115} This has conveyed a misunderstanding to the modern courts that legislative history has no relevance in determining constitutional legitimacy.\textsuperscript{116} Therefore, in practice the legislative history is an irrelevant consideration in assessing the Act’s constitutionality.

In sum, the hurdle of the standard of proof which the courts would need to overcome prior to using legislative history as a means to strike down a statute, and the misconception created by precedents will jeopardise the practical effect of the legislative history of the Sherman Act in statutory interpretation and determining its constitutional legitimacy. Therefore, it is unlikely that the plausible distorted legislative intent will lead to the striking down of the Sherman Act.

\textsuperscript{112} At 1785.
\textsuperscript{113} Village of Arlington Heights v Metropolitan Housing Development Corp 429 US 252 (1977) at 266-268; Hunt v Cromartie 526 US 541 at 546. Ranch House Inc v Amerson 238 F3d 27 (11\textsuperscript{th} Cir 2011) at 1280.
\textsuperscript{114} Nelson, above n 111, at 1856.
\textsuperscript{115} At 1879.
\textsuperscript{116} FCC v Beach Commc’ns 508 US 307 (1993) at 315; DiMa Corporation v Town of Hallie 185 F3d 823 (7th Cir 1999) at 829; Tenney v Brandhove 341 US 367 (1951) at 377.
G. Conclusion

Given the Sherman Act’s reputation to regulate the United States economy, it is natural for one to have faith in its intent: to protect the welfare of consumers through the promotion of competition and maximising the economy’s efficiency. However, an examination of the economy prior to the passage of the Sherman Act and opinions of economists indicate otherwise. This article has explored relevant historical evidence in search for plausible ulterior legislative motives behind the Sherman Act; several non-mutually exclusive intents were found. Yet, none aligned with the apparent rationale for the introduction of this antitrust statute.

While this article refrained from guessing at the truest intention, a deeper insight into the United States democratic system was able to expand our view. It revealed the relevance of politicians’ motives to win people’s hearts in pursuit of re-election. This in turn allowed us to justify, although uncomfortably, the rationale behind the Sherman Act’s enactment. However, this is starkly different from claiming a valid justification. The legislative intent argued in this article is deviant from the standard antitrust law account.

The article also suggested two possible areas which this distorted legislative intent may impact on in the present day, namely: statutory interpretation and the Act’s constitutional legitimacy. It is somewhat surprising that the distorted original legislative intent is unlikely to substantially affect the operation of the Sherman Act in the present day. The article can, however, explain how the Sherman Act is still considered one of the principal antitrust laws in the United States of America.