

## Children, medical treatment and religion: defining the limits of parental responsibility

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The responsibility of parents for the medical treatment of their children raises significant and complex problems for the state, particularly in situations where their religion is at odds with modern medicine. This article seeks answers to the three most pressing questions in this largely underdeveloped field of the law: who should be the ultimate arbiter of the child's best interests in medical treatment cases? What are the child's best interests, and how do the religious beliefs of parents fit in? And is the current legal framework adequate? Addressing these issues is the first step towards formulating a just and comprehensible body of medical law for children.

### Introduction

*Freedom of religion is a fundamental right and represents a major triumph of our democratic society. The philosophical and political values underpinning ... democracy recognise the need to respect the diverse opinions and beliefs that guide our consciences and give direction to the lives of all members of our society*

— LeBel J in *Congrégation des témoins de Jéhovah de St-Jérôme-Lafontaine v Lafontaine (Village)*, 2004, at 64

The responsibility of parents for the medical treatment of their children raises significant and complex concerns for legal systems, particularly in situations where religion is involved. First, and most fundamentally, there is the issue of *who* should be the ultimate arbiter of the child's best interests in medical cases. Currently, the state has the final word on medical treatment, but there are strong arguments for investing parents with the authority to definitively identify and weigh the child's interests in such cases. Second, what *are* the child's best interests? In determining this, the state is concerned, on the one hand, about the health and welfare of children; while on the other, it *should* be interested in respecting the autonomy of parents, the right to hold and practise religious beliefs, and the integrity of the family unit. There is a worry that the current dominant legal position appears to reflect an incomplete understanding of the best interests of the child, with the result that the state fails to give due significance to the religious features of cases. In order to correct this imbalance, the law should

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adopt a stance that accommodates religious beliefs as much as possible *within* the framework of upholding the welfare of children. And finally, is the current legal framework adequate? Unfortunately, Australia is marked by a lack of pertinent legislation, conflicting jurisdictions and an uncertain development of the common law. These issues must be addressed in order to develop a just and comprehensible body of medical law concerning children.

The first part of this article defines the scope of this discussion and a number of the concepts that require clarification. The second part explores the current legal framework operating in Australia, and the three different and sometimes overlapping sources of responsibility: self, parental and state. With regard to the state's powers of intervention, it also investigates the extent to which the religious convictions of parents are recognised and respected and the degree to which the courts are willing to consider the child's welfare within a broader cultural context. Finally, in the third part of the article, an evaluation of the current function and substance of the law is presented and a number of recommendations for addressing the issues are made.

### Dimensions of the enquiry

Before embarking into an area of law so broad in scope, it is necessary to outline some parameters of exploration. First, this article is restricted to an analysis of the religiously motivated decisions of responsible parents with respect to the medical treatment of their children. Unfortunately, it will be unable to examine the legal issues involved where children themselves make medical decisions based on personal religious beliefs, and the interesting use of the *parens patriae* jurisdiction (to be discussed) by the courts to override the decisions of competent children — a topic on which many academics have written and disagreed (see Smith 1997, 122; Didock 2006, 93; Bridge 1999b, 591). Nor will this article survey the cases of parental negligence, which look at the issues from a *post facto* perspective.

Furthermore, for the purposes of this article, the concept of religion is not to be understood so broadly as to include all claims of conscience or all matters about which one feels very deeply. Instead, it emphasises 'first, belief in a supernatural Being, Thing or Principle; ... and second, the acceptance of canons of conduct in order to give effect to that belief' (Mason and Brennan JJ in *Church of the New Faith v Commissioner of Pay-Roll Tax (Victoria)*, 1982–83, at 132). The most common sources of religious conflict in medical law are the requirement of male circumcision under the Jewish and Muslim faiths; the view of Christian Scientists that physical illness is a misperception or a form of mental illness for which medical treatment is inappropriate; and the refusal of Jehovah's Witnesses to consent to blood transfusions. Limiting the discussion to cases involving religion means

that other controversial areas of the medical law concerning children will not be examined (such as the sterilisation of intellectually disabled children).

Finally, three matters must be noted concerning the jurisdictional scope of this article. First, the current Australian legal framework in this field operates on both a state and federal basis. Therefore, an evaluation of the law necessitates certain analysis at a state level, and references to some state instruments and bodies are made at certain points in the discussion. The operation of the law at both of these levels causes numerous statutory complexities and institutional deficiencies, which are the subject for an entirely separate article. Second, the common law in Australia is largely underdeveloped in this sphere of medical law and it is often necessary (as is the process of judicial interpretation) to draw upon the case law and developments of other jurisdictions to interpret the legal principles. Throughout this process, one must be cautious of the existence and effect of jurisprudential dissimilarities, such as the constitutional guarantees according more weight to parental autonomy that are at play in the US cases. Third, although this article is an analysis of the Australian context, most of the issues covered, arguments documented and recommendations made are equally applicable to other jurisdictions.

### **The law concerning the medical treatment of children in Australia**

*While there is now no rule of law that the rights and wishes of unimpeachable parents must prevail over other considerations, such rights and wishes, recognised as they are by nature and society, can be capable of ministering to the total welfare of the child in a special way, and must therefore preponderate in many cases. The parental rights, however, remain qualified and not absolute for the purposes of the investigation*

— Lord MacDermott in *J v C*, 1970, at 175

The regulation of the medical treatment of children is complex and the legal framework in Australia, consisting of the common law and various state and federal statutes, outlines an assortment of stances. In certain circumstances, the right to make medical decisions for children is vested with the children themselves. In other situations, parents are both privileged and obliged to decide as part of their general duty for the daily care and control of the child. And finally, the state retains a paternalistic obligation to intervene where the child's condition is serious and the parents fail to provide the medical care essential to avoiding unnecessary suffering or death.

### ***Self-responsibility: competent children***

Sometimes, children are themselves capable of consenting to or refusing medical treatment. Competency is an issue that has largely been left to the common law to determine. However, in South Australia, interestingly, s 6 of the *Consent to Medical*

*Treatment and Palliative Care Act 1995* (SA) provides that any 'person of or over 16 years of age may make decisions about his or her own medical treatment as validly and effectively as an adult'. Ultimately, competency will depend not on the child's age, but rather on their demonstrated aptitude. In *Marion's* case, 1992, the High Court upheld (at [237]–[238]) the principle derived from the House of Lords case of *Gillick*, 1986, that a minor is capable of giving informed consent when he or she 'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'. The child must appreciate the nature of the proposed treatment; its physical and emotional consequences; and the predicted outcomes of a failure to treat (Lord Donaldson MR in *Re R*, 1991, at 601–603). The effect of these decisions has been to create a category of children in Australia, often described as 'Gillick-competent', who do not require surrogate decision-making on their behalf (Thomas 2004, 126). In theory, the competence of Gillick-competent children may also extend to the refusal of medical treatment, although no Australian court has been called upon to determine this.

### ***Paental responsibility: incompetent children***

Both the common law and statute recognise that it is generally parents who assume the decision-making responsibilities for the maintenance, protection and education of their children where the children do not pass this threshold of competency (see s 61B of the *Family Law Act 1975* (Cth) (FLA)). Lord Scarman commented in *Gillick* (at 184) that 'it is absolutely plain that the law recognises that there is a right and a duty of parents ... to give or withhold consent to medical treatment'. Most fundamentally, this involves the ability to make simple day-to-day health-care decisions. However, it can also extend to certain non-remedial procedures, and in *Marion's* case (at 232) Deane J cited male circumcision as a situation 'in which it plainly lies within the authority of the parents of an incapable child to authorise surgery'.

The situation becomes complicated when parents disagree among themselves as to whether or not to authorise medical treatment. In New South Wales, for example, s 49(1) of the *Minors (Property and Contracts) Act 1970* (NSW) appears *prima facie* to permit treatment to proceed on the consent of one of the parents only:

... where medical treatment ... of a minor aged less than sixteen years is carried out with the prior consent of a parent or guardian of the person of the minor, the consent has effect in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, the minor were aged twenty-one years or upwards and had authorised the giving of the consent.

However, this section operates solely in respect of the tortious liability of medical practitioners, and such an interpretation of the section has not been reached by the courts and would seem to be inconsistent with Div 2 of the FLA, which confers parental responsibility onto both parents and presumes that it will be shared equally in joint decision making, especially in cases of serious medical treatment (although this responsibility can be affected or curtailed by an order of a court or varied by agreement between the parents in a parenting plan). Section 61DA, in particular, creates a judicial presumption that equal and shared responsibility is in the best interests of the child. Feigenbaum (1992, 869) notes that 'both parents possess this right and, absent some form of incapacity or contractual relationship to the contrary, one parent is not entitled to exercise this right to the exclusion of the other'. In any case, where parenting disputes arise, they are likely to be sent for final decision to the Family Court, which can rely on its powers under ss 67ZC(1) and 68B to make orders for the welfare of children.

No Australian court has yet been called upon to resolve a parental dispute that is derived from a conflict of religious beliefs concerning a child's medical treatment. However, in the English case of *Re J*, 1999, a disagreement arose between separated parents (an Anglican mother and a Muslim father) over whether their son should be circumcised. Wall J, in assessing the best interests of the child, stated that the major benefit of approving the procedure would result from the child firmly identifying with his father and also confirming the child as a Muslim according to the Islamic faith. However, he went on to note that in the circumstances where the child would not actually grow up in a Muslim family or community, these benefits were weakened (at 367–368). In addition, the procedure would be painful and irreversible; would create difficulties for the mother (as the primary care provider) in explaining the procedure to her son; and would have, at best, highly contested health benefits. Hence, the court concluded that on balance it was not in the best interests of the child to approve the circumcision.

### *State responsibility*

#### *Sources of state responsibility*

##### **The common law**

The common law confers on the state Supreme Courts a general power to safeguard the welfare of children, known as the *parens patriae* jurisdiction. Dating back to 13th-century England, the doctrine of *parens patriae* provides that the state has a duty to ensure that every child within its borders receives proper care and treatment.

Therefore, where invoked, it permits the Supreme Court to authorise or refuse procedures against the wishes of parents. Burden-Osmond (2002, 216) remarks that 'the court acts as though it is the parent or guardian of the child, thereby overriding the natural guardianship of the parents'. The courts have made it clear that this jurisdiction is of a more inquisitorial, rather than adversarial, character and the Family Court may even appoint child representatives to represent and promote the interests of the child through the case (s 68L of the FLA and the Family Court *Guidelines for Child Representatives*). The primary consideration is always 'the best interests of the child', which the court is to ascertain objectively and according to various factors that include:

- (i) the particular condition of the child which requires the procedure or treatment; (ii) the nature of the procedure or treatment proposed; (iii) the reasons for which it is proposed that the procedure or treatment be carried out; (iv) the alternative courses of treatment that are available in relation to that condition; (v) the desirability of and effect of authorising the procedure or treatment proposed rather than the available alternatives; (vi) the physical effects on the child and the psychological and social implications for the child of: authorising the proposed procedure or treatment, or not authorising the proposed procedure or treatment; (vii) the nature and degree of any risk to the child of: authorising the proposed procedure or treatment, or not authorising the proposed procedure or treatment; and (viii) the views (if any) — expressed by the guardian(s) of the child, a person who is entitled to the custody of the child, a person who is responsible for the daily care and control of the child, and the child — to the proposed procedure or treatment and to any alternative procedure or treatment. [Santow J in *DOCS v BB*, 1999, at 23.]

Furthermore, the common law has also established that particular procedures are categorically incapable of being undertaken without court approval, irrespective of the consent of the parents. In *Marion's* case, the majority of the High Court (Deane J dissenting) established that non-remedial sterilisation was one such procedure, and Brennan J even suggested that the courts were never capable of approving these procedures (at 229–263). But, more importantly, there appears to be no reason in principle why the ruling could not apply equally to other major medical procedures that have similar features of being 'irreversible and ... of an emotive, sensitive and potentially controversial character' (Ross-Jones J in *Re Elizabeth*, 1989, at 62). In *Re J (No 2)*, 2000, Butler-Sloss P commented that male circumcision is such an important undertaking that 'in the absence of agreement of those with parental responsibility, ought not to be carried out or arranged without the specific approval of the court' (at 588). Furthermore, the Family Court recently asserted that these principles should not necessarily be confined to cases involving surgery, but could apply equally to treatment with a similarly irreversible effect involving, for example, the use of radiation or pharmaceuticals (Nicholson CJ in *Re Alex*, 2004, at 178).

### Statute

As mentioned above, the FLA vests the Family Court with a general jurisdiction to make orders regarding the welfare of children. This has been likened to the *parens patriae* jurisdiction of the Supreme Court; however, the concept of the best interests of the child is defined in greater detail. The court is conferred with a broad power to intervene whenever it determines that the medical treatment is of a sufficiently serious nature. This *seriousness* has been established in a number of different situations, including cases involving the gender reassignment performed on a hermaphroditic child (*Re A*, 1993), life-saving heart surgery (*Re Michael*, 1994) and the prescription of the contraceptive pill to a teenage girl (in anticipation of a later sex change) (*Re Alex*).

In addition, most states have implemented legislation that purports to directly regulate aspects of the relationship between the medical treatment of children and parental religious beliefs. In New South Wales, for example, the state has introduced four such pieces of legislation. First, it expressly criminalised procedures of female genital mutilation (whether based on religious grounds or not) under s 45 of the *Crimes Act 1900* (NSW). Although beyond the scope of this paper, it is interesting to note, given this prohibition, that the state has chosen not to regulate, but rather leave to the courts to monitor, other medical procedures and religious practices. However, it has legislated on the treatment of children in emergency situations. Section 174(1) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (CYPA) permits a practitioner to proceed with an operation without a parent's consent if he or she is of the opinion that it is necessary to save the child's life or prevent serious harm. Therefore, in these specific cases, the state has chosen to decisively override the potential religious objections of parents to medical treatment.

Third, the state introduced the *Guardianship Act 1987* (NSW) (GA), creating the Guardianship Tribunal, which imposes specific limits on the parental discretion by requiring external authorisation for certain medical procedures. Where a child is under the age of 16, a medical practitioner cannot carry out 'special medical treatment' without obtaining approval from the Tribunal, except in cases of emergencies (s 175 of the CYPA). The types of treatment to which this applies include, *inter alia*, treatment that is intended or is reasonably likely to render the young person permanently infertile and treatment involving the administration of an addictive or psychotropic drug or a long-acting hormonal substance for the purpose of conception or menstruation. The Tribunal can only consent to the treatment if it is satisfied that it is necessary to save the child's life or prevent serious damage to the child's health. Where a child is aged 16 or over and incapable of giving consent, similar rules apply, except the definition of 'special treatment' is varied slightly to include the termination of pregnancy and forms of aversion therapy, and exclude the administration of hormonal substances and psychotropic drugs (ss 33, 36 and 37 of the GA). Furthermore, the standard of

proof is lowered in these circumstances (with the exclusion of sterilisation cases), such that the Tribunal need only be satisfied that the treatment is the only or most appropriate way of treating the child and is manifestly in their best interests (s 45(3) of the GA). And, finally, there is also scope for the Children's Court to become involved if, through New South Wales child protection legislation, the child is considered to be in need of care and protection on the basis of medical neglect (see, in particular, ss 34, 43, 46, 48, 49, 61, 71(1)(d), 72 and 79(1)(b) of the CYPA).

Therefore, in Australia the final decision about how, and whether, to treat a child (where the treatment is in dispute) lies not with the parents, but with the state Supreme Courts, the Family Court, or other state-level bodies such as the Guardianship Tribunal and Children's Court. This clearly creates some substantial uncertainties in the law and complex jurisdictional questions, which are inexcusable given that often the condition of the child requires an immediate and decisive response.

### *The extent of state responsibility*

#### **Life-threatening cases**

Generally, where the life of the child is threatened, the court will intervene and override any parental objections, whether religious or not, that would seek to deny treatment. Two recent cases demonstrate the operation of the *parens patriae* jurisdiction in such circumstances. In *Director-General of DOCS v BB*, the parents of a child suffering from leukaemia were Jehovah's Witnesses and refused blood transfusions as part of the child's treatment. Although the court ultimately held that the case involved circumstances of an emergency, in which case the law in New South Wales permitted the doctors treating the child to override the parents' wishes (via s 20A, the precursor to s 174, of the CYPA), it further held that it was capable of employing its *parens patriae* jurisdiction to make orders for the procedure to occur.

The English Court of Appeal took a similar approach in the *Conjoined Twins* case, 2000. This case concerned conjoined twins who were both likely to die within a matter of weeks unless surgically separated. Medical opinion was unanimous that the operation could only save the stronger twin (Jodie), and that the weaker (Mary) would not survive. The parents refused to consent to the operation because of their religious beliefs that such a decision should be left in God's hands and that no person should intentionally kill, even in order to save another's life. In deciding whether to authorise the operation, the court sought to determine the best interests of each child. Ward LJ (Brooke LJ agreeing) noted that while it was clearly in Jodie's best interests to have the operation because it would greatly improve her prospects for life, it was not

in Mary's best interests because her life itself had value and the operation would only serve to accelerate its demise (at 996–1004). In these situations where the best interests do not coincide, the court held that a balancing process is necessary to determine where the greatest benefit rests (Ward LJ, at 1010). It concluded that notwithstanding the parents' view to the contrary, the best interests of the twins favoured the operation because it gave 'the chance of life to the child whose actual bodily condition is capable of accepting [it]' and to 'remain alive and conjoined ... would be to deprive them of ... bodily integrity and human dignity' (Ward LJ and Brooke LJ, at 1011–1012 and 1018). Judicial intervention thereby derailed a parental decision based on religious beliefs, again in a context where the life of the child was at stake. The rationale was that 'the child's interest in the preservation of his or her own life is paramount and overrides any parental decision to the contrary, even in light of religious objections' (Vorys 1981, 818).

### Non-life-threatening cases

Therefore, the law is settled that in circumstances where the court is faced with the prospect of the death or grievous injury to the child, then medical treatment will ordinarily be authorised or denied (depending on the circumstances), despite the religious protestations of parents: 'when a child's right to live and his parent's religious belief collide, the former is paramount, and the religious doctrine must give way' (Boyer 2004, 147). What remains uncertain, however, is the extent to which the courts will override these religious objections where the life of the child is not threatened (Bridge 1999a, 145). At one end of the spectrum, there are the minor and routine procedures on children where parental freedoms attract little controversy. However, at the other end there are more major health decisions where the child may suffer permanent and damaging consequences (the most common examples being circumcision and blood transfusions). In *Director-General of DOCS v BB*, Santow J hypothesised that the best interests of the child would be served by allowing for blood transfusions in order to alleviate 'an appreciable risk of damage to the child's health' (essentially as a broad preventative measure). In contrast, others suggest that the *parens patriae* jurisdiction will only be used 'in circumstances where a refusal of treatment will in all probability lead to the death of the child or to severe or permanent injury' (New South Wales Law Reform Commission Report, 4.15).

This exact issue was examined in the New Zealand decision of *Auckland Healthcare Services Ltd v Liu*, 1996. The case involved a 12-year-old boy who needed urgent surgery to avoid loss of eyesight from a detached retina. However, both the boy and his parents refused to consent to the surgery because they were devoted Baptists and believed that only God could cure his condition. The court considered the best interests of the child and noted that despite the 'emotional trauma' that would be caused to

the family by interfering with their religious views, as well as the risks associated with the medical procedure, the child's welfare would be best preserved by doing everything possible to prevent the loss of eyesight (Tompkins J, at 5–8). Therefore, the court exercised its powers and authorised the operation.

However, in this area the US authorities are unclear. On the one hand, a string of cases has followed the lead of *Re Sampson*, 1970, where the court ordered medical treatment against the wishes of the mother (a Jehovah's Witness objecting to the blood transfusions), in circumstances where the child's life was not in danger and the operation was only required to improve the function and extreme disfigurement of the child's facial structure. The court held that it could not 'permit his mother's religious beliefs to stand in the way of attaining through corrective surgery whatever chance he may have for a normal, happy existence' (at 658). This precedent of overriding parents' religious objections in non-life-threatening situations was also followed in *OG v Baum*, 1990 (court ordered blood transfusion necessary to save a child's right arm), *Re Eric*, 1987 (court ordered periodic monitoring of a child to detect possible reoccurrence of cancer), *Re Karwath*, 1972 (court ordered surgical removal of child's tonsils and adenoids which posed no immediate danger to life or limb) and *Re Gregory*, 1971 (court ordered dental care for child suffering from cavities, fractured teeth and an umbilical hernia).

The judiciaries in these cases have given very little discussion to the parents' religious beliefs and have instead emphasised the role of the court in giving due weight to the parents' wishes and balancing those against the duty of supervising the welfare of the children (Cohan 2006, 871). Wadlington (1994, 320) suggests that this line of authority underscores that 'quality of life, as distinct from physical survival, can serve as a criterion for intervention in at least some instances'.

On the other hand, another more accommodating, although less common, line of authority has developed from the judgment of *Re Green*, 1972. There, the court determined not to overturn a parent's decision to refuse consent to a procedure to correct her son's paralytic scoliosis (which prevented him from standing or walking). The court held that 'the State does not have an interest of sufficient magnitude [to] outweigh ... a parent's religious beliefs when the child's life is not immediately imperilled by his physical condition' (at 392). Similarly, in *Re Seiferth*, 1955, the court refused to appoint a guardian for a boy with a harelip and cleft palate since there was no life-endangering present emergency. This authority would seem to suggest that the sincerity of the parents' religious beliefs is critical and that the courts would have ordered the treatment in their absence. This line of authority is in large part a product of the First Amendment to the United States Constitution (1788), which guarantees that 'Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof'.

Therefore, in non-life-threatening situations the law is unclear and no sharp line demarcates when courts will intervene (Trahan 1989, 320). The dominant trend, however, seems to be towards greater state intervention, and an increased willingness to override the religious consciences of parents. As Wadlington (1994, 326) observes, religious objection tends to not be highlighted or play a significant part in the decisions of the courts, except perhaps in resolving especially difficult or 'long shot' cases. In *Re Eric*, for example, the court overturned the parents' refusal of medical monitoring and treatment when the child in question faced no immediate danger, while in *Re Willmann*, 1986, the court ordered chemotherapy when such treatment posed additional hazards of its own which were not even addressed in the decision (in the earlier case of *In the Matter of Hofbauer*, 1979, the court, concerned about the effects of chemotherapy, refused to order the cancer treatment). These cases show that the state may order follow-up monitoring, treatments of long duration, or even treatments with debilitating side effects over the religious objections of parents where the child is not in terminal danger. However, it must be remembered when using the US authorities referred to in this section as guidance for interpretation of the Australian law that US law may be partly affected by, for example, constitutional guarantees of family privacy and autonomy, and the US government has not yet signed the UN Convention on the Rights of the Child (1990).

#### **Incurable or undefinable afflictions**

There are a number of particular categories of cases where the court is more lenient towards the religious convictions of parents. First, where the child is suffering from a terminal illness but the medical treatment would only serve to prolong life, courts have typically upheld the refusal of parents (Simeonidis 2002, 57). The flipside of this is that the courts are unlikely to order treatment, even when the parents desire it, where the child's situation is futile. The parents in *Re C*, 1998, on the basis of their Orthodox Judaism, '[did] not believe that it [was] within their religious tenets to contemplate the possibility of indirectly shortening life' (at 389). Nevertheless, the High Court, without giving much consideration to the religious undertones of the case, refused to order the continuance of the treatment because the consensus of the medical profession was that further treatment would only delay death without alleviation of suffering. On this judgment, Fortin (1999, 416) comments that 'it rather negates the point of seeking the court's assessment of situations involving children if the judicial answer must always be that the doctors are to be guided by their own clinical judgment'.

Second, the judiciary is unwilling to compel medical treatment over parents' objections when the proposed treatment is inherently dangerous and invasive, or involves extreme pain and suffering that overwhelm the potential benefits. In refusing to compel

chemotherapy in *Newmark v Williams*, 1991, the court commented that 'the proposed medical treatment was highly invasive, painful and involved terrible temporary and potentially permanent side effects, posed an unacceptable low chance of success and a high risk that the treatment itself would cause his death' (at 1118). Often, proposed medical treatments may fail, or even run the risk of aggravating physical handicaps or impairing mental development (Parness and Stevenson 1982, 44).

Third, courts tend to uphold the parental discretion where the proposed procedure would provide no clear medical benefit to the child (Shapiro and Barthel 1986, 832). This may be because the child's condition is too severe to be remedied, or because opinion is unclear as to the successful application of the procedure. In *In the Matter of Hofbauer*, where a child was in an advanced stage of cancer, the court concluded that 'no American court ... has ever authorized the State to remove a child from the loving, nurturing care of his parents and subject him, over parental objection, to an invasive regimen of treatment which offered ... only a forty percent chance of "survival"' (at 1018). A similar approach was also taken in *Re Philip*, 1979 (court refused to order cardiac surgery for a child suffering from Down's syndrome who had a low likelihood of survival), *Re Guardianship of Barry*, 1984 (court refused to overturn the parent's decision to terminate the life support of a terminally ill 10-month-old baby because the child had no hope of ever achieving awareness or normal brain functioning) and *Custody of a Minor*, 1982 (court refused to order treatment for a child suffering from serious congenital heart malformation because patients with such a condition normally die within a year, with or without treatment). But again, the law here becomes grey as to where to draw the line in terms of what level of professional medical agreement or likelihood of successful treatment is necessary before the court will intervene.

Finally, there generally must be some form of harm to the child before the court will intervene. In *Re Appeal in Cochise County*, 1982, a mother refused to provide general medical treatment to her several children for religious reasons. Even though the action was brought after one of her children died from an intestinal rupture that went undetected because of the mother's attitude against doctors, the court refused to declare the mother responsible and order the other children to see a practitioner in the future because none of the children suffered actual ailments requiring medical treatment.

### Summary

Thus, the legal position in relation to children and medical treatment, particularly in scenarios involving non-terminal conditions or uncertain procedures, remains unclear. This is in part due to institutional and statutory deficiencies. More importantly,

however, the common law has failed to sufficiently conceptualise and outline how the religious convictions of a child's parents may be relevant to or influence the child's best interests in such medical cases. Dwyer (1994, 1403) notes that 'no court has suggested it is altogether a mistake to find that parents have a right to determine the course of their children's lives merely on the basis of [their] religious preferences'. All that is clear is simply that the decision of the parents (without necessarily regard to the fundamental reasons for that decision), the severity and nature of the child's condition, the evaluations of the medical profession, and the prospects of success weigh heavy in the minds of justices: 'As the immediacy and magnitude of potential for harm to the child increases, the likelihood for government involvement increases for the child's protection' (Scott 1990, 88).

### Evaluating the law in Australia

*When the jurisdiction of the court is invoked for the protection of the child the parental privileges do not terminate. They do, however, become immediately subservient to the paramount consideration which the court has always in mind, that is to say, the welfare of the child.*

— Lord Oliver of Aylmerton in *Re KD*, 1988, at 824–825

### *Parent or court: who should be the ultimate arbiter?*

The issue at the most fundamental level of this discussion is whether the body most capable for determining the best interests of the child is the parents or the judiciary (see Robinson 1991, 415). Strong arguments exist for leaving responsibility in the hands of parents. First, parents know their children at the most intimate level and the 'natural bonds of affection' cause them to act in their child's best interests (*Bellotti v Baird*, 1979, at 638). In *Re Jobes*, 1987, the court noted that the family is 'best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of the special bonds with him or her' (at 445). The parents alone know the child's particular needs as an individual and, although these cases often involve big decisions, they do not consider them lightly. Second, given that parents are expected to cope and live with the consequences of any medical decision that is made, they should be able to claim control over the decision-making process. Parents 'know their values, priorities and resources better than anyone else ... [T]hey more than anyone else must live with the consequences' (Parness and Stevenson 1982, 63–64). Parenting rights constitute a fundamental liberty interest and, if they are eroded, then parents in society may feel threatened, incompetent or violated (see *Santosky v Kramer*, 1982, at 753). Additionally, with regard to protecting the integrity of the medical profession, there is concern that a physician who enforces a court-ordered treatment may be perceived to have transformed the physician–patient relationship into an adversarial one, leading

to distrust and the weakening of confidentiality (Cohan 2006, 912). Finally, the requirement to seek external authorisation can, in many circumstances, cause crucial time delays and significant expense and trauma for families.

However, the reasoning behind state intervention is relatively clear. Parents do not only have a *right* to decide what is in the child's best interests, they also have a *duty*, and as such some form of review is necessary to ensure that this is complied with. Certain medical procedures have such serious consequences that the judgment about whether they should be carried out must be made by an independent objective party, which will ensure heightened accountability in the decision-making process and safeguard the child's wellbeing from unsound judgment. Sometimes parents can become submerged within their own emotions, or simply do not have the level of comprehension to understand the true nature and consequences of a given situation, and are thereby incapable of ascertaining the best interests of their child (Tomasso 2002, 793). Furthermore, the state has a number of strong societal interests that deserve recognition, including the preservation of human life, the protection of innocent parties unable to protect themselves, and the endurance of a productive and self-perpetuating society (Feigenbaum 1992, 855–57). Certain procedures, such as sterilisation, involve such great social implications that they should be weighed up as public policy issues rather than private family matters. Also, from the medical profession's perspective, the involvement of the courts eases its burden when participating in difficult moral and ethical decisions. Therefore, state supervision in children's medical cases is important.

### *The best interests of the child: when should religion be relevant?*

Most commentators have reached a consensus that there must be some form of state administration. Given this, the difficulty lies in establishing not *if* the state should supervise, but *how* it should approach such cases involving religion and ascertain the *best interests* of the child. As Fortin (1999, 32) puts it, the difficulty is in establishing 'a formula which authorises paternalistic intervention to protect [children] from making life-threatening mistakes but restrains autocratic and arbitrary adult restrictions on their potential for autonomy'.

As discussed earlier, it is clear that the trend in case law is shifting to a system of more widespread intervention in non-terminal cases. Adhar and Leigh (2005, 275) comment that, 'given the courts' strong adherence to the principle of paramountcy of the welfare of the child, it may be that the majority of decisions in the grey area of non-life-threatening yet curable afflictions will be resolved in favour of intervention'. This can be seen particularly from Santow J's decision in *Director-General of DOCS v BB*, where the parents' wishes were overridden merely as a preventative measure to

avoid the possibility of future medical harm. The apparent assumption here seems to be that intervention guarantees the welfare of the child, even though the best interests of the child are subjective (see Kuther 2003, 344 and Hawkins 1996, 2080). Indeed, a number of arguments have been made that overturning religious-based parental decisions may not necessarily be in the best interests of children. These traditionally fall into three key categories: parental autonomy; freedom of religion; and protection of the family paradigm.

### Parental autonomy

It must first be emphasised that the view expressed above (that courts should be the ultimate arbiter) does not disregard the importance of parental autonomy as a social value; it merely advocates consideration of that value as one component of a thorough balancing process (Sher 1983, 172). Parental autonomy must be respected, and the courts have recognised that a strong presumption in favour of parental decisions exists. In *Re O'Hara*, 1900, Fitzgibbon LJ (at 240) commented that 'in exercising the jurisdiction to control or to ignore the parental right the court must act cautiously ... acting in opposition to the parent only when judicially satisfied that the welfare of the child requires that the parental right should be suspended or superseded' (see also Ward LJ in the *Conjoined Twins* case, at 995; Johnson J in *Re Z*, 1997, at 32; and *Griswold*, 1965). This stems from a belief that parental responsibility free from state interference has its own benefits and contributes to the physical and psychological wellbeing of the child by promoting continuity in their life (Goldstein 1977, 649). However, is any different value to be placed on parental autonomy guided by personal conviction rather than religion?

Many commentators believe that religious beliefs should play little, if any, part in the judicial determination of the best interests of the child. First, some argue that judges should avoid any distinctive favouring of religious grounds, given that they have not been instructed in such a way by the legislature, and this was the spirit of the decision in *Employment Division v Smith*, 1990. Second, a more theoretical argument runs that when parents have specific religious grounds for opposing medical treatment, there is less basis to support that decision than where a parent has refused after a reasoned, practical and logical process of weighing the costs and benefits of treatment. Trahan (1989, 333) argues that in these cases the state interest in intervening is stronger not because their common law or constitutional rights are weaker, but because the parents' unconsidered judgment deserves less deference (see also Greenawalt 2006, 810). Vorys also supports this logic, commenting that 'the parental decision to withhold medical treatment from a child should not be upheld in the absence of a solid medical basis backing up the parental choice' (Vorys 1981, 828).

Some judgments appear to reflect this thinking. In *Re T*, 1997, the court upheld a mother's refusal of treatment to alleviate the suffering of a liver defect, despite the fact that medical opinion was relatively unanimous in favour of the procedure. The court gave significant weight to the fact that the mother was a former nurse and thereby had a 'deep seated concern' about the benefits of the treatment and the difficulties involved. This implies that the courts will look more favourably upon objections rooted in personal professional convictions, even if sometimes seemingly wrong and irrational, rather than religious or cultural beliefs, which Waite LJ (at 514) described in *Re T* as 'scruple or dogma of a kind which is patently irreconcilable with principles of child health and welfare'.

However, this attitude is both worrying and flawed. Bridge argues that the child's interests cannot possibly include parental convenience or lifestyle factors, or particular parental attitudes, values or expectations (Bridge 1999a, 8). For example, a parent's belief that they would be unable to cope with a living but disabled child is entirely irrelevant. Bainham (1997, 50) agrees, remarking that *Re T* represents a backward step in the case law that risks a return to 'nineteenth century notions of the natural rights of parents'. These opinions correctly identify a concern, but require some moderation, since to swing the other way and hold that parental attitudes and conveniences are entirely irrelevant to the interests of a child is impractical, given the realities of a parent's role in the child's welfare and upbringing. Robinson (1991, 431) puts it aptly, stating that 'whether parents choose to forego conventional medical treatment for either religious or non-religious reasons, their wishes should be honoured, just as parental decisions are honoured in many other areas'. The child's interest in the autonomy of their parents is about the development and continuity of the parent-child relationship, a benefit that does not depend on the particular parents' beliefs or convictions. Therefore, parental autonomy is a value to protect *at least* as much in cases involving religion. Children benefit from a relationship with their parents, whether they are religious or not.

### Freedom of religion

Some parents believe that the state's intervention infringes their free right to religion. Ingram (1988, 65-66) notes that 'if people sincerely believe that a higher principle is more valuable than physical life, society cannot deny them this choice without doing violence to a constitutional protection that is supposed to be fundamental' (see also Vaillant 2000, 480 and Treene 1993, 135). But on this topic, the courts have rightly taken a strong stance. On a number of occasions, they have distinguished state interference with religious *beliefs* from interference with religious *practices* (see *Wallace v Labrenz*, 1952, at 774; *Prince v Massachusetts*, 1944, at 168-172; *Reynolds v United States*, 1878). Although the former is never justified, the latter can be where a strong public interest,

such as the preservation of life, dictates: 'The right to practice religion does not include the right or liberty to expose the community or the child to ill health or death' (*In the Interest of DLE*, 1982, at 276). And, when dealing with the interests of the child, the interests of the parents in religious expression cannot have unlimited primacy. Parents seem to forget that they have a duty, not a right, to care for their children. Such religious freedoms may permit them to indoctrinate their children about religion, and significantly direct the child's day-to-day clinical treatment, but they do not grant the right to endanger a minor's physical health or wellbeing.

Many religious advocates bring into question the rigid stance of the common law in life-threatening cases. Is life always in the best interests of the child? The courts assume so, but take, for example, the situation in the *Conjoined Twins* case, where it was far from obvious that the twin who survived was better off alive than dead, at least if one were to believe in life after death. The survivor will have significant physical disabilities and the court overlooked the possibility of psychological harm as a result of survivor guilt. Is it possibly appropriate to defer to genuine religious beliefs in such circumstances where the life of the child would be marked by serious pain and dysfunction? The problem with this approach, however, is that it places a theoretical value on life — who can rightly say if another's life is not worth living? — and introduces criteria that would be incredibly difficult to conceptualise: What kind of post-existence beliefs must the parents hold? What condition must the child be in? For courts to de-prioritise human life in such a way would bring into jeopardy the ethical integrity of the system. As Plastine (1993, 65) notes, while the 'parent's rights of free exercise [of religion] and parental autonomy are fundamental rights of obvious importance, the life of a child is paramount and necessarily trumps all other rights'.

Parents who refuse treatment on religious grounds often assert, in addition, that there is no proof that nonmedical religious methods (such as prayer healing) are less successful than conventional procedures. Should such cases be treated any differently? Lederman (1995, 923) argues that 'a court cannot distinguish ... total deference to a physician from submission to a higher authority inherent in religious belief'. Both methods involve risks and rely on the sincere belief that the particular treatment is the most effective, and the courts have declined elsewhere to order treatment where it would be no more or less likely to benefit the child than an alternative course of action chosen by the parents. In *Weber v Stony Brook Hospital*, 1983, for example, the court refused (at [686]) to order surgery for a child with spina bifida, among other conditions, where the parent's course of conservative treatment was 'well within accepted medical standards'. In response, however, others point towards studies that reveal that a much higher incidence of death occurs in circumstances where alternative religious treatment is utilised (Asser and Swan 1999). A study of 172 child deaths that occurred when medical treatment was withheld for religious reasons revealed

that 140 of the children had at least a 90 per cent chance of survival with traditional medical care; 18 had at least a 50 percent chance; and all but three were likely to benefit from some form of treatment (Swan 1997, 491). Similarly, Merrick (1994, at 328–29) reveals that the mortality rate of children who belong to the Christian Science religion is much higher than that of children from other backgrounds. Therefore, until the evidence of religious treatment can demonstrate similar levels of success to conventional medicine, this can provide no grounding for refusal.

### Protection of family

From another perspective, one problem with traditionally narrow judicial conceptions of the best interests of the child is that the family itself has goals and purposes that are not typically concerned with the maximisation of individual welfare. Stanfield (2000, 71) discusses 'society's interest in pluralism and in the family as an essential building block of democratic culture' (see also Schoeman 1985, 54; Bridge 1999a, 5; Sher 1983, 169; Yoder, 1972, at 232). Family intimacy, which includes the child-rearing decisions of parents, projects 'an enclave of privacy', fostering a sense of identity and security (Haddon 1985, 566). The individual members of families, particularly those infused with strong religious convictions, often find meaning through their relationships with others. In particular, 'children exist in relationships to their parents, their siblings and wider family, their neighbours, their community and the society in which they live. No child exists in a vacuum' (Jones and Basser Marks 1996, 313). This would suggest, therefore, that the closeness of the family is a constitutive aspect of any child's best interests, because it promotes relationships with others that are essential for their moral and social development. More precisely, the welfare of many children born into religious families is often best served by conformity and tolerance with that religion's practices.

Looking at the current statutory and common law tests of the best interests of the child, no concept recognising the importance of the integrity of the family unit is heeded. The closest the test comes is by recognising the 'psychological and social implications' of intervention for the child, which in practice appears to have not signified much scope for religious implications. Hence the test seems to 'deny differences in lived realities by treating all children and all families the same' (Austin 1992, 591–92). The common law's list of factors for determining the child's best interests, while important, misses the critical point that upholding religious values that underpin family relationships is itself in the interests of a child and should only be sacrificed where there is a compelling reason to do so. Instead, the courts tend to look at religion solely from the perspective of the parent. Goldstein (1977, 648) writes that 'the law presumes the capacity and recognises the authority of adults to parent their children in accord with their own individual beliefs, preferences and lifestyles'.

In contrast to this narrow approach, the decision in the English case of *Re J* (discussed above) struck a different balance. When examining whether it was in the boy's best interests to be circumcised, Wall J considered (at [362]) that maintaining the familial and religious bond between the boy and his father was a very important consideration. Although the circumcision was not authorised, his Honour expressly accepted that maintaining a religious connection between parent and child is in the interests of that child. He also offered a hypothetical example of a Jewish mother and an agnostic father with a number of sons, all of whom, by agreement, had been circumcised. Upon having another son after separating, the mother wishes him to be circumcised like his brothers, but the father, for no good reason, refuses his agreement. In circumstances such as these, Wall J believed (at [368]) that the court would be likely to grant the order permitting circumcision — the justification being the maintenance of the family's religious dynamic and the inclusion of the son in it.

This welfare argument is attractive in relation to male circumcision in that it can be seen as preventing the stigmatisation of the boy within his ethnic or religious environment without significant physical harm being imposed. In 2006, controversy surrounded a practising Jewish boy who, on the verge of his bar mitzvah, was told that he was not properly circumcised and therefore was not Jewish (Zwartz 2006). This demonstrates the damage that can be caused by a child not satisfying religious demands. Social acceptance is invariably a benefit. But how far does this extend? A Jehovah's Witness child bearing the blood of another also runs the risk of rejection from both family and community, and it has been known for parents to refuse to care for a child following a blood transfusion (Ingram 1988, 62). The later lives of all involved may be adversely affected by the knowledge that the child was saved by an immoral and sinful act. And where a blood transfusion is given and the child dies regardless — as occurred in *Muhlenberg Hospital*, 1974, and *State v Perricone*, 1962 — according to the beliefs of the parents, the child has not only passed but has been denied a spiritual life and will suffer eternal damnation. In these cases, therefore, religion is something that can directly affect the child's interests and must be considered.

There will always be a balancing exercise to perform that needs to weigh the strictly medical interests against the potential social, cultural and religious implications. When the wishes of the parents are to refuse life-saving treatment or demand mutilation that is severe, the child's best interests will rarely (if ever) be served by fulfilling these religious beliefs. It is untenable to find otherwise when faced with the memory of the many unfortunate situations where children suffering from easily treated afflictions have unnecessarily perished and their parents have been found criminally responsible — cases such as *Commonwealth v Twitchell*, 1993 (Christian Scientist parents were convicted of manslaughter after relying on spiritual healing to remedy their child's obstructed bowel, which was otherwise easily curable by

modern medicine, and she suffered a slow and painful death); *Hermanson v State*, 1990 (parents were charged with third degree murder after they refused treatment for their daughter suffering from juvenile diabetes, instead resorting to spiritual healing, and she died); *Funkhauser v State*, 1988 (parents were convicted of manslaughter when their child died of pneumonia after they relied on religious healing); and *Hall v State*, 1986 (parents were convicted of reckless homicide and neglect when their son died of pneumonia after being treated only by prayer). However, in other cases, the child's welfare in the context of his or her culture, religion and family — what Feldman (1993, 159) refers to as the 'collective family interest' — may stand strong.

This more holistic approach to a child's best interests is one that ought to be adopted in Australia. The concept of the best interests of a child should recognise the reality that the child has a status within a family and a community. This is not to imply that the state should never intervene to override parental decision making, or that it should always, but rather that overly individualised conceptions of a child's best interest are misguided because families and communities are invested with meanings and ideals, sometimes religious, which should not be ignored (Schoeman 1985, 56). Greenawalt (2006, 808) is of the strong opinion that because of this, in non-terminal situations parents should have sole authority about the child's medical matters. Although this position is extreme, generally the courts should respect the autonomy of religious parents, not simply as an independent consideration, as long as it is broadly compatible with the child's best interests.

### Summary

Ideally, the state should maintain its supervisory role over medical treatment; however, it should be instilled with a broader conception of the best interests test. The judiciary should consider, among other things, the role of parental autonomy and the extent that the curtailment of the parents' religious beliefs will impact the family unit and the child's place in it. Some non-interventionist commentators advocate a role for the state that is too minimal, considering this discussion. Goldstein et al (1979, 105), for instance, argue that the state should only be permitted to intercede where three conditions are present: the medical profession is unanimous that a well-practised treatment should be given to the child; the child will die without the treatment; and if the treatment is successful, the child will have a 'life worth living'. Others, such as the Canadian Psychiatric Association (1979, 78), call for too broad a scope for state involvement.

Perhaps closer to the mark are Alderson and Montgomery (1996, 92), who believe that serious irreparable harm should generally be the minimum threshold for disregarding religious beliefs. Such an approach maximises both the autonomy of the parents and

respect for the family, but only to the extent that these values can be sensibly exercised. This would mean that intervention could generally not be used as a mere preventative measure to facilitate more convenient medical treatment (as occurred in *Director-General of DOCS v BB*). This position appears to be accepted in the United Kingdom, where practitioners refrain from resorting to blood transfusions in procedures on children for as long as possible to accommodate the religious faith of Jehovah's Witness parents. In *Re S*, 1993, and *Re R*, 1993, the English courts applauded doctors for exhausting all alternative methods of treatment prior to seeking judicial intervention in order to accommodate the religious attitudes of parents. Furthermore, the American Academy of Paediatrics (1997, 297) has called on paediatricians to 'show sensitivity to and flexibility toward the religious beliefs and the practices of families', and suggested that doctors combine both religious and traditional healing via collaboration with families — an approach 'that respects parental religious beliefs and the role of parents in rearing their children' while administering accepted medical treatment.

## Conclusion

*Parents are free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.*

— Rutledge J in *Prince v Massachusetts*, 1944, at 170

This article has sought to explore a number of the issues concerning the medical treatment of incompetent children. The fundamental principle at stake is who is most apt to determine the child's best interests? Greenawalt (2006, 799) comments that the debate principally amounts to 'a tug of war' between the state and parents. It is clear, however, that the supervision of the courts is important in such cases, given that parents have a *duty*, not a *right*, to care for their children. Respecting the religious concerns of parents is often in the child's interests, since children benefit from parental autonomy and a rich familial and social upbringing. Although these considerations are not beyond limitation and will generally not outweigh the interests in life and wellbeing in serious cases, they can be persuasive in borderline cases, most obviously circumcision. The courts have not yet fully conceptualised a notion of the best interests of the child that adequately gives weight to the religious and cultural welfare of the child. In particular, the courts tend to wrongly give greater significance to nonreligious convictions in the context of parental autonomy. ●

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