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Commentary on *PM, Applicant v the Board of Management of St Vincent's Hospital and Justin Geoghegan and the Attorney General, Respondents*

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Introduction

The original case, *JM, Applicant v the Board of Management of St Vincent's Hospital and Justin Geoghegan and Attorney General, Respondents and PM, Notice Party,*[1] involved an urgent application to the High Court seeking an order directing the respondent hospital and consultant medical practitioner to administer appropriate treatment, including a liver transplant and a blood transfusion, to a woman, PM, who at the time of the hearing was in a coma and who had previously refused to accept the treatment. One of the reasons for the refusal was that PM had converted to the Jehovah's Witness faith upon her marriage. Treatment refusal cases involving Jehovah's Witnesses are not uncommon and there is relevant case-law from other jurisdictions.[2] The applicant in the original case, JM, was PM's husband. PM was a notice party to the original hearing but for obvious reasons was not present at the hearing and she was also not legally represented. The judgment was delivered by Finnegan P in the High Court and he made an order admitting PM to wardship and, exercising the inherent *parens patriae* jurisdiction of the court, directing the respondents to provide the necessary treatment.

The feminist judgment arises from fictional new proceedings brought by PM in the High Court seeking a number of declarations from the court in light of the outcome of the original case. This approach was adopted by the feminist judge, Mary Donnelly, for a number of reasons. First, because the original case was heard by the High Court in urgent circumstances with one judge sitting alone, a dissenting judgment would not have been possible. Secondly, given that the treatment ordered was described as urgent and life-saving, any appeal would also have been decided in urgent circumstances. The decision not to provide a replacement judgment was based on the fact that a feminist judge would have elicited different information from the hearing to that provided. These limitations would also apply to an appeal. By re-opening the matter as a set of new proceedings seeking declarations in relation to the conduct of the original hearing the feminist judgment is able to engage with the reasoning in that judgment, to acknowledge the constraints within which Finnegan P was operating, but also to illustrate that another approach might have been possible had greater emphasis been placed on recognising and understanding PM as an autonomous individual situated within a relational context. A broadly similar approach was adopted in *Fitzpatrick v K*,[3] which postdates JM, but which also involved an urgent application to court seeking an order to provide a blood transfusion without consent.

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[1] *JM, Applicant v the Board of Management of St Vincent's Hospital and Justin Geoghegan and Attorney General, Respondents and PM, Notice Party* [2003] 1 IR 321.

[2] In England and Wales see *Re T (Adult: Refusal of Medical Treatment)* [1992] 3 WLR 782; from Canada see *Malette v Shulman et al* (1990) 67 DLR (4th) 321 (Ont CA).

[3] *Fitzpatrick v K* [2008] IEHC 104.

The feminist judgment also identifies specific declarations sought in order to delimit the scope of the matters before the court to those at issue in the original decision. Thus, a decision was made to exclude a claim for damages.

Placing PM at the centre of the judgment

A key objective of the project of feminist judging is to tell the story of the case in as full a manner as possible and to provide the context in which the decision took place. One aspect of doing this is to place the individual most affected by the decision at the centre of the judgment. In the original judgment PM was not a party to the case. She was not legally represented and one consequence of this was that her voice was not heard, or at the very least there was nobody to put her perspective before the court and to test the medical evidence presented to the court. Throughout the judgment by Finnegan P there are multiple references to PM's husband, and to the extent that we hear the perspective of PM it is related first through her husband and then through Finnegan P. This silencing of PM is a matter of significant concern in the feminist judgment. The ongoing failure of the courts to address this issue is evident in the recent High Court decision of *PP v HSE*,[4] discussed below.

The final sentence of the original judgment is '[i]n those circumstances it is an easy decision.' The characterisation of the decision in this case as easy is perplexing, as the court was called upon to make a decision about whether to uphold a refusal of treatment, when the refusal to sign the consent form occurred in difficult circumstances, and at the time of the hearing PM was in a coma and her husband was seeking to have the treatment refusal set aside. However, the two sentences preceding the final sentence are: 'She has a child and a loving husband. The medical evidence is that she has a 60% chance of survival.' The reasoning, therefore, seems to be that because she has a husband and child she has something to live for and so should not be permitted to die. This appears to accord limited, if any, weight to PM's own views regarding the refusal of treatment. It also echoes case-law in England and Wales in relation to the refusal by women of caesarean sections. In *Re S (Adult: Refusal of Treatment)*[5] following an *ex parte* hearing the declaration to carry out a caesarean section was granted on the basis that it was in the best interests of S and the unborn child. The judgment in *Re S* was not well received and subsequent cases moved away from a reliance on the best interests of the foetus and instead restated the importance of the autonomy of the individual woman. However, notwithstanding the more pro-autonomy rhetoric, in practice courts have tended to find that the women seeking to refuse the caesarean section lack capacity. In many of these cases the autonomy and agency rights of the woman involved are blurred and undermined, usually through a finding that the women lacked capacity to refuse treatment, in order to vindicate what are perceived to be the rights or interests of the foetus. For example, in *Re MB (An Adult: Medical Treatment)*,[6] the Court of Appeal found that MB lacked capacity to make the decision regarding the caesarean section because of her needle phobia – the reasoning was that the fear of needles dominated her thinking and rendered her temporarily lacking in capacity.[7] In contrast to the judgment of Finnegan P the feminist judgment by Donnelly J emphasises that this is a difficult and challenging decision for the

[4] *PP v HSE* [2014] IEHC 622.
[5] *Re S (Adult: Refusal of Treatment)* [1992] 4 All ER 671.
[6] *Re MB (An Adult: Medical Treatment)* [1997] 2 FCR 541.
[7] A similar approach was adopted in *Tameside and Glossop Acute Services v CH* [1996] 1 FLR 76; *Norfolk and Norwich Healthcare NHS Trust v W* [1996] 2 FLR 6; and *Bolton Hospitals NHS Trust v O* [2002] EWHC 2871. See also Katherine Wade, 'Refusal of Emergency Caesarean Section in Ireland: A Relational Approach' (2013) 22(1) *Medical Law Review* 1-30.

judge. On the one hand there is the need to respect the agency and autonomous choice of the individual woman; and on the other there is the need to recognise the situated position of PM within her family context.

Hunter outlines a number of features of feminist approaches to judgment-writing and notes that several of these relate to the procedures of decision-making, among them '"including women" both in terms of writing women's experiences into legal discourse (as individual litigants and collectively, drawing on relevant research evidence) and in the construction of legal rules.'[8] One of the core objectives in this feminist approach to the case was to make PM visible within the judgment to the greatest extent possible. The feminist judgment places PM front and centre. Not only does it begin by setting out the available facts relating to PM, thus making her real and a key actor within the case, but it also highlights, through a discussion of the right to fair procedures and the requirement for legal representation, the manner in which she was silenced and rendered invisible in the original judgment. While reliance on fair procedures and constitutional justice is perhaps not an evident feminist methodology in itself, this approach is one that could plausibly have been adopted by a court in Ireland at that time and it allows for an articulation of the significant feminist concerns at the heart of the case. This approach reflects Nedelsky's argument, from a feminist perspective, about the importance of due process not just as an end in itself, but also as a means to an end, and as a way to ensure and support the exercise of autonomy.[9] The importance of participating in decisions that affect a person is neatly captured by Nedelsky who states that '[t]he right to a hearing declares their views to be significant, their contribution to be relevant. In principle, a hearing designates recipients as part of the process of collective decision-making rather than as passive, external objects of judgment.'[10]

PM was denied that right to participate in the original hearing of this case and was certainly a passive object of the judgment of Finnegan P. Undoubtedly, the fact that she was in a coma at the time of the hearing in the High Court did provide a barrier to participation, but not an insurmountable one. By way of illustration, in the case of *PP v HSE*[11] a woman, NP, who had suffered a brain injury resulting in brain stem death was artificially maintained alive on life support in order to preserve the life of her foetus.[12] As in JM a family member, NP's father, was obliged to apply to the High Court to seek a declaration to have life support withdrawn. NP was assigned legal representation, as was the foetus. This was with the agreement of the High Court during a case directions hearing prior to the hearing of the substantive matter. No further details of the arguments presented to the High Court at that prior hearing are available. The issue at the core of that particular case was whether switching off the life-support machine would violate the constitutionally protected right to life of the unborn. Clearly the PP case postdates JM but the principles of constitutional justice/fair procedures which gave rise to the appointment of representation were well established at the time of the decision in JM. This is illustrated in the feminist judgment when Donnelly J uses the decision in *SPUC v Coogan*[13] to show the importance afforded by the Irish courts to ensuring that the rights of those who could not represent themselves (in *Coogan*, the "unborn") are protected.

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[8] Rosemary Hunter, Clare McGlynn and Erika Rackley (eds), *Feminist Judgments: From Theory to Practice* (Oxford, Hart Publishing, 2010) 35.

[9] Jennifer Nedelsky, 'Reconceiving Autonomy: Sources, Thoughts and Possibilities' (1989) 1 *Yale Journal of Law and Feminism* 7.

[10] Nedelsky, ibid 27.

[11] Above n 4.

[12] There appears to be some disagreement in the judgment on the precise age of the foetus, but somewhere between 13 and 15 weeks was generally agreed.

[13] *SPUC v Coogan* [1989] IR 734.

It is, however, important to recognise the difficulties with allocating legal representation to a person in PM's circumstances – this is to say in a coma and unable to provide any instructions to her legal representatives. There exists the very real risk that the voice of the individual and her wishes will not necessarily be presented to the court, but rather what the appointed legal representative considers to be in her best interests. Nevertheless, the reasoning behind the approach adopted by Donnelly J is that by appointing legal representation to PM in these circumstances the court would at least increase the chances of her voice being heard in the proceedings. It would also be possible for the legal representative to, at a very minimum, challenge the medical evidence put before the court as to why a blood transfusion and liver transplant was necessary and to explore the possibility of alternative courses of action open to the court rather than imposing invasive treatment on PM in the absence of her consent. While this may be less than ideal it is an improvement on the alternative course of action that was adopted in the original case.

Agency

There are a number of layers to PM's case. On a surface level it concerns the right to refuse life-sustaining medical treatment and the associated rights of autonomy and bodily integrity. These are significant issues of feminist concern. However, it also draws attention to the importance of agency. The failure to recognise and respect the agency of women has been identified in similar projects. Hunter, McGlynn and Rackley note that 'women often find that when they attempt to exercise agency, such as in the context of refusing to consent to sexual activity or medical treatment, they are not taken seriously.'[14]

There is certainly a sense in the original judgment in *JM* that PM's decision to refuse treatment is not given the due consideration and respect that it deserves. It is characterised as a decision that was taken merely to please her husband. The assumption is that this means that it was not her decision. There are two difficulties with this approach. First, it discounts the possibility that as a result of her studies to join the Jehovah's Witness faith PM had in fact adopted those beliefs and would not wish to accept a blood transfusion for her own deeply held religious reasons. It also presumes that PM only adopted a new system of religious belief because of her cultural background, rather than allowing for the possibility that PM had given some level of thought to the decision to convert to the Jehovah's Witness faith. The reference to culture in the original judgment is striking. In 2003 Ireland was experiencing an increase in immigration and as a result was dealing with relatively new cultural challenges around accommodating a wider variety of cultural narratives within the State. At that time African women in particular were coming to the attention of the State during pregnancy, amid claims that they were having children in Ireland in order to gain a right to residency by having a citizen-child.[15] Following on from this there was the Supreme Court decision in *Lobe and Osayande*[16] which found that migrant parents could no longer be permitted to remain in Ireland to bring up their children. The feminist re-writing of this judgment by Siobhán Mullally and Cliodhna Murphy can be found in this collection.[17] This developing discourse ultimately resulted in what was known as the citizenship referendum in 2004 which removed

[14] Above n 8 at 22.

[15] For further discussion see Ronit Lentin, 'Migrant women's networking: New articulations of transnational ethnicity' in Gargi Bhattacharyya (ed) *Ethnicities and Values in a Changing World* (Fanham and Burlington VT, Ashgate, 2009) and Siobhán Mullally, 'Citizenship and Family Life in Ireland: Asking the Question "Who Belongs"?' (2005) 25(4) *Legal Studies* 341-358.

[16] *Lobe and Osayande* [2003] 1 IR 1.

[17] See ch 13.

the automatic right to citizenship from all children born in the State and limited it to those children who had at least one parent who was an Irish citizen or entitled to Irish citizenship.[18] References to culture at this time therefore were often shorthand for an ongoing and complex debate around Irishness, citizenship and the State. By way of contrast in the feminist judgment Donnelly J emphasises the dangers associated with cultural stereotyping. The original judgment also assumes that PM's religious conversion took place without a full appreciation of the consequences of taking on that faith. This latter assumption is undermined by the evidence that PM was aware of the importance of refusing or accepting the blood transfusion and as a result wished to discuss it with her husband and to have his input into the decision.

Second, the approach adopted by Finnegan P suggests that making a decision because PM believed that is what her husband wanted and that his opinion was an important consideration for her indicates that it is not a valid exercise of her autonomy and right to make decisions about how she conducts her life. This reflects an individualistic approach to decision-making which does not necessarily accord with the reality of decision-making for many people. From the evidence that PM asked her husband 'what he would do in the situation' it appears that PM was attempting to engage in a more relational decision-making process, which recognised her situated nature as a wife and mother, and understood that her decision had implications for those around her. However, it seems that PM's husband did not engage with her in this process as he advised her that it was her decision to make. It appears that this left PM feeling uncertain and confused. As noted by Donnelly J in the feminist judgment it is unclear whether PM received any other support from those in the hospital charged with her care and treatment. This failure to engage with PM at a difficult time when she was seeking support to clarify and communicate her wishes is deeply troubling. While the law cannot compel family members to participate in relational decision-making it can, and should, ensure that where a situation such as that of PM arises those professionally caring for the person fill the vacuum left by the family and provide the necessary support.

The complexity of the situation is also evident in the contradictory approach adopted by the court; on the one hand refusing to accept PM's refusal of treatment on the basis that she was refusing because she was doing what her husband wanted, and on the other justifying the decision to provide treatment without consent in part on the basis that it is what her husband wanted and that this fact would comfort PM. As Donnelly notes, the judgment of the High Court in the original decision in JM 'shows both the dangers of taking a social or relational approach to agency and the dangers of not doing so.'[19]

The importance of a relational approach to autonomy

Feminist theory has used the concept of relational autonomy to address issues around agency. This is subject to varied definitions.[20] However it often draws on critical feminist theories and as Nedelsky notes 'one of the contributions of feminism to relational theory is that it is

[18] This was the twenty-seventh amendment to the Constitution and the referendum was passed by a significant majority - 1,427,520 votes in favour and 375,695 votes against.

[19] Mary Donnelly, *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (Cambridge, Cambridge University Press, 2010) 62.

[20] Catriona McKenzie and Natalie Stoljar (eds), *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (Oxford, OUP, 2000); Jonathan Herring, *Caring and the Law* (Oxford, Hart Publishing, 2009); Shelley Day Sclater, Fatemeh Ebtehaj, Emily Jackson, and Martin Richards (eds), *Regulating Autonomy: Sex, Reproduction and Family* (Oxford, Hart Publishing, 2009).

particularly unlikely to make the mistake of romanticising community or relationship.'[21] Theories of relational autonomy therefore emphasise the individual in context while also retaining the importance of autonomy. Elements of this approach are evident in the feminist judgment. Nedelsky sees the aim of relational autonomy as 'transforming a traditionally individual conception of the self into a relational one without subsuming the individual into the collective.'[22] The conception of autonomy within a relational approach is different to that set out in the traditional liberal understanding. According to Nedelsky, under a relational approach autonomy is not equated with independence but rather 'autonomy is made possible by constructive relationships.'[23] Therefore it is through the existence of positive relationships and supports, including relationships of care, that individuals are in a position to exercise autonomy. One of the strengths of relational autonomy from a feminist perspective is that it does not assume that all relationships are beneficial and it does not seek to maintain them in all circumstances.[24] A functioning relational approach to law therefore should operate to balance the rights and needs of both parties and allow individuals to extricate themselves from bad relationships and enhance positive relationships which support the exercise of autonomy.

The concept of a constructive relationship working to strengthen and enhance autonomy resonates in the context of the PM case. To the extent that we get a picture of PM from the original judgment what we see is a woman reaching out to her husband for support and guidance in making a difficult decision in challenging circumstances. She was seeking to rely on what she appeared to understand to be a mutually supportive and presumably constructive relationship to assist her in making an autonomous choice. She did not, it appears, conceive of the decision to be made as a purely independent one that she alone was responsible for making. That does not mean, however, that she was giving up the right to make her decision, or that her wishes and needs should cede priority to those of others within the family group or relationship. This is where the judgment of Finnegan P runs into difficulty from a feminist and a relational autonomy perspective. He recognises the importance of relationships, highlighting that PM has a loving husband and child, but in doing so he privileges the wishes of JM and attributes those to PM without giving sufficient consideration to whether the evidence in fact supports that conclusion. It may well be the case that had JM expressed his wish that PM take the blood products at the time when PM was seeking to discuss the issue with him that she would have weighed that heavily in her decision-making process. Clearly JM's input was important to her. However, that moment had passed and PM was no longer in a position to factor that information into her autonomous decision. Finnegan P's relational approach in this case, which had the effect of placing PM at the periphery of this case rather than at the centre, did not enhance the autonomy or agency of PM.

Conclusion

As this feminist judgment is not a first instance judgment, Donnelly J was not faced with the difficult decision about whether to make an order directing the hospital to provide treatment or upholding the right to refuse treatment with the consequence that PM would die. However,

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[21] Jennifer Nedelsky, *Law's Relations: A Relational Theory of Self, Autonomy and Law* (Oxford, OUP, 2011) 32.
[22] ibid 13.
[23] ibid 118.
[24] Mary Donnelly and Claire Murray, 'The Role of Family in Mental Health Law: A Framework for Transformation' (2013) 25(4) *Child and Family Law Quarterly* 380, 399.

it was also the situation that no new evidence was put before the court and so in reviewing the original decision of the High Court Donnelly J was required to determine if, given the facts that were before the court at the time the original decision was made, the High Court adopted the correct approach. Ultimately the feminist judgment finds that the procedure adopted by Finnegan P in the High Court was inadequate and breached PM's constitutional right to fair procedures. This failure to adhere to fair procedures and to permit PM to participate in the decision-making process may well have had an impact on the evidence that was before the court, as PM's position was not fully articulated and discussed before the court. Nor was the evidence of the other parties to the case tested. In identifying these procedural shortcomings this feminist judgment also highlights that feminist judging is about more than just the act of writing judgments that draw on feminist theories or feminist teachings. It emphasises that a feminist judge would have approached the case in a fundamentally different manner – a feminist judge hearing this case in urgent circumstances would most likely have asked different questions, he or she would have identified different material as relevant to making the decision, and had such an approach been taken at that point it may have been the case that the judgment delivered would have been different.

Based on the evidence that was before the court, Donnelly J determined that it was not possible to find that PM had exercised a fully autonomous choice to refuse treatment and therefore Finnegan P in the High Court did not violate her rights in ordering the provision of the necessary treatment. This conclusion could be seen as falling into the same pattern as existing case-law on treatment refusal outlined above, of strongly upholding the right to refuse in principle but not following through in practice. However, the strength of this feminist judgment lies in the manner in which it illustrates the importance of proper and fair procedures, both as an end in and of themselves, but also as a means to an end. In this case the procedural shortcomings which resulted in PM's voice being silenced had a very direct and significant impact on the ability of the court to adequately vindicate the substantive right to autonomy. Participation as a means to enhance and secure autonomy is therefore at the centre of this case and the contribution of the feminist judgment to discussion in this field is to illustrate this within the context of treatment refusal.

PM, Applicant v. **the Board of Management of St Vincent's Hospital** and **Justin Geoghegan** and **the Attorney General,** Respondents

High Court 18th June, 2003

Donnelly J. 18th June, 2003

[1] PM has applied to this Court for declaratory relief in respect of medical treatment which was administered to her, notwithstanding her prior refusal to sign a consent form, following an order of Finnegan P., dated 24th October 2002 (reported in *JM, Applicant v the Board of Management of St Vincent's Hospital and Justin Geoghegan, Respondents and PM, Notice Party* [2003] 1 I.R. 321). This order authorised the respondents to provide to PM appropriate medical treatment, including a liver transplant and blood transfusion. This is not a rehearing of the case and no new evidence is introduced. Rather, the court proceeds on the basis of the evidence which was before the court at the time the matter was heard.

[2] PM requests the court to make the following declarations:-

(a) A declaration that her right to constitutional justice and fair procedures under Article 40.3.1° of the Constitution was breached by the order of the High Court for the administration of treatment to her without her consent which was made without independent legal representation

(b) A declaration that the order of the High Court to authorise the administration of treatment to her in the absence of her consent failed to respect her rights to autonomy and bodily integrity under Article 40.3.1° of the Constitution.

The Facts

[3] On 24th October 2002, JM, the husband of PM, made an application to the High Court for an order to authorise the administration of appropriate medical treatment, including a liver transplant and the administration of blood transfusion(s) to PM, notwithstanding that on 20th October PM had refused to sign a consent form in respect of this treatment. PM's decision to refuse treatment derived from her religious beliefs as a Jehovah's Witness. Abstention from blood represents a fundamental tenet of this religious faith.

[4] At the time of the application PM was on medication and on a ventilator. She was in a coma and was unable to communicate her present views regarding the proposed treatment. The medical evidence provided to the Court was that, although there was a possibility that PM could recover consciousness, this was unlikely to occur in sufficient time to allow the necessary treatment to be provided. It was also asserted that it was unlikely that PM would be able to make a decision for herself during any period of recovery. The matter came before the Court in circumstances of considerable urgency due to the serious medical condition of PM. Medical evidence was provided that PM was critically ill and that she required immediate blood transfusions and a liver transplant. The medical experts stated that, if the treatments sought under the application were carried out, PM had a 60% chance of survival.

[5] JM provided evidence to the Court. He stated that PM had become a Jehovah's Witness on her marriage to him some months previously, having commenced studying to become a Jehovah's Witness in March 2002. JM also attested that, on 19th October, JM and PM had discussed the proposed treatment and JM 'spoke to her and told her that the decision was important and that she shouldn't feel obliged to refuse because of him as it was her decision'. PM asked him what he would do in her situation but he said that he left the decision to her. She then said that she would think about the decision to be made. JM's evidence is that PM was lucid at the time of this conversation. JM attested that the following

day, PM's condition had deteriorated. She was physically weaker; her speech was less clear and she also appeared to be less clear in her mind. When he spoke with her, she cried and said that she would take blood. He communicated this to the liver transplant team. However, ten minutes later, when a member of the liver transplant team came to PM and asked her to complete a consent form, she refused to do so.

[6] Finnegan P. found that the Court's authority to consider the matter derived from the *parens patrie* jurisdiction, the application of which in Ireland had been confirmed by Hamilton C.J. in *In re a Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 I.R. 79, 103. He recognised, as stated by Hamilton C.J. in *Re Ward of Court*, the right of the competent adult who is a terminally ill patient to forego ongoing treatment and found that PM was terminally ill. However, he found that PM had not made 'a clear final decision to have or not have the treatment.'

Conduct of the hearing

[7] The manner in which the hearing was conducted is significant in respect of both declarations sought. Due to the medical circumstances, the hearing took place in urgent circumstances. For this reason, Finnegan P. proceeded on foot of a draft plenary summons and took evidence on oath. The application was brought by JM, PM's husband. The first respondent was the Board of Management of the hospital in which PM was a patient and the second respondent, Mr Geoghegan, was the consultant surgeon who was responsible for the medical care of PM. PM was a notice party. The applicant was legally represented, as was Mr Geoghegan. Neither the first respondent nor PM was represented.

Fair Procedures

[8] The decision before the Court concerned one of the most serious matters which can come before a court of law: the resolution of a conflict between an individual's life and her right to make fundamental decisions regarding how her life should be lived. The resolution of the application would result either in PM's death or in a potentially profound bodily intrusion and, as PM may see it, a risk of her eternal damnation for failing to accord with the tenets of her religious faith.

[9] The right to fair procedures derives from the common law and from the principle of constitutional justice which, as recognised first by Walsh J. in *McDonald v Bord na gCon* [1965] I.R. 217 is enshrined in Article 40.3.2° of the Constitution. As has been recognised by the Supreme Court on many occasions, including *In re Haughey* [1971] I.R. 217 and *The State (Gleeson) v Minister for Defence* [1976] I.R. 280, the obligation to hear the other side – *audi alteram partem* – is core to the principle of constitutional justice. At the time of the hearing, PM was clearly not in a position to speak for herself and defend her rights. Moreover, she was not legally represented.

[10] While it is not the case that respect for the principle of *audi alteram partem* requires that an affected party be afforded a right to independent legal representation in all instances, it has, on several occasions in the context of access to legal aid, been recognised by that the protection of the constitutional right to fair procedures requires the provision of legal representation (see *Stevenson v Landy & others*, unrep High Court, 10 February 1993 and *Kirwan v Minister for Justice, Ireland and the Attorney General* [1994] 2 I.R. 417). In *Kirwan*, in upholding a right to legal aid for a hearing of an application for release of a person who had been detained in the Central Mental Hospital, Lardner J found that, whether or not a right to legal aid existed depended on several factors: the seriousness of the charge; the nature of the penalty faced and the capacity of the person to speak for himself and defend himself.

While clearly arising in a different context, the factors identified by Lardner J in *Kirwan* are relevant in this case. Applying these to the facts of this case, it is clear that the issue before the Court was very serious; the consequences of a decision either way were profound; and, PM could not speak for herself and defend her own interests.

[11] I note also the decision of *The Society for the Protection of Unborn Children Ltd v Coogan and Others* [1989] I.R. 734 where the Supreme Court recognised the importance of ensuring the vindication of personal rights when the holder of rights is not in a position to vindicate his or her own rights. Although the circumstances were different - in *Coogan*, the party unable to vindicate his or her rights was the 'unborn' within the meaning of Article 40.3.3° of the Constitution - the principle that in certain circumstances special procedures may be required to vindicate constitutional rights is applicable in this case.

[12] There are also instrumental reasons why the lack of independent legal representation for PM was problematic. Within an adversarial system, such as ours, the lack of independent representation rendered it very difficult to reach even approximate conclusions regarding what PM would wish to happen. All information was mediated through JM who, inevitably, had his own distinct position on the matter to be determined and which may well have coloured the evidence presented. PM was at the centre of this case yet the Court was afforded limited opportunity to make determinations regarding her preferences or views. Although, those preferences would not necessarily be determinative, they must constitute a key aspect of judicial consideration.

[13] The absence of legal representation for PM also restricted the capacity of the Court to engage in the necessary evaluation of the medical evidence. Medical evidence played a crucial role in this case. The urgent nature of the case was determined on the basis of medical evidence as was the need for the blood transfusions and liver transplant. However, medical evidence was also important in other respects. Important questions to be considered by the Court included the mental state of PM on the day on which she refused to sign the consent form and the extent to which medical staff engaged with PM in discussing the implications of her decision to refuse the proposed treatment and ensuring that she was fully informed of the consequences of the decision. Given the centrality of the medical evidence in this case, it was important for the Court to have an opportunity to evaluate the evidence provided through the process of cross-examination, which is at the core of our adversarial system of justice. Cross-examination would have afforded the Court an opportunity to evaluate the necessity of proposed actions and to consider whether there were alternatives to the treatment sought which might have been more respectful of PM's wishes.

[14] It is of course relevant that this case came before the Court in urgent circumstances. Where such circumstances arise, in the interests of the administration of justice, the court must respond. Certain procedural inadequacies may be overlooked and a more informal approach may be adopted. Steps such as proceeding on the basis of a draft plenary summons and taking evidence on oath, which were adopted in this case, may be justified on the basis of the constitutional obligation of the court to administer justice within the necessary time. However, there are fundamental elements of the process which cannot be set aside on the basis of the urgent circumstances. The function of the court is to administer justice and some procedural inadequacies are so fundamental as to limit the capacity of the court to do this. In the circumstances of this case, for the reasons outlined above, I am of the view that justice could not be administered without some form of representation of the person whose fundamental rights were at stake.

[15] I am, of course, aware that independent legal representation does not, of itself, guarantee that the views of the individual whose rights are at issue will be represented adequately. For this reason, where possible, the services of a guardian *ad litem* should be utilised, as they were in the application for the withdrawal of treatment in *Re a Ward of Court*

(withholding medical treatment) (No 2) [1996] 2 I.R. 79. I recognise that circumstances may arise where such services may not be possible and accept that the emergency nature of this case was one. Nonetheless, it is important to emphasise the strong principle that in a case such as this, which concerns fundamental constitutional rights, every effort should be made to ascertain and adequately represent the views of the person who is not able to represent her or himself and to ensure that legal representatives and guardians are held to account regarding their performance of this function by the court.

[16] The importance of ensuring adequate representation of the person, whose rights are at issue, requires that, insofar as is possible, the practice of making applications of this kind in urgent circumstances must be avoided. In this case, PM declined to consent to treatment some four days prior to the hearing. It may well be the case that the urgency of the matter only became apparent with the passage of time. However, it may also be the case that an application could have been made at an earlier point and that, had this occurred, more attention could have been given to ensuring adequate representation of PM.

[17] The application in this case was made by JM, PM's husband. Having to make the application must have added considerably to JM's emotional distress at a very difficult time. A question arises as regards what would have happened if JM had not brought this application. Would the respondent have sought the involvement of the court or would PM's lack of consent have been considered determinative, notwithstanding that there may have been reasons to question the validity of her refusal? The involvement of the court in a matter of fundamental rights should not be dependent on whether or not a spouse or family member decides to refer the matter for judicial consideration. In this respect, I agree with Lord Donaldson M.R. who, in broadly similar circumstances, in *Re T Adult: Refusal of Medical Treatment* [1992]3 W.L.R. 782 at page 798, stated that the step of seeking court involvement 'should not be left to the patient's family, who will probably not know of the facility and may be inhibited by questions of expense'. This accords with the 'public interest in the vindication of [a] private right which has been guaranteed by the Constitution', which was identified by Walsh J in *The Society for the Protection of Unborn Children Ltd v Coogan and Others* [1989] I.R. 734 at page 743.

The Requirement for Consent to Medical Treatment

[18] At the hearing of this matter, the Court was informed that on 20th October, PM refused to sign a consent form given to her by a member of the liver transplant team. The importance of consent to medical treatment was described by Denham J. in *In re a Ward of Court (withholding medical treatment) (No. 2)* [1996] 2 I.R. 79 at page 156 as follows:

> Medical treatment may not be given to an adult person of full capacity without his or her consent. There are a few rare exceptions to this e.g., in regard to contagious diseases or in a medical emergency where the patient is unable to communicate. This right arises out of civil, criminal and constitutional law. If medical treatment is given without consent it may be trespass against the person in civil law, a battery in criminal law, and a breach of the individual's constitutional rights.

[19] Although it is common practice for hospitals to require patients to complete consent forms, the completion of such forms should not be confused with the actuality of consent. The existence of a form certainly makes life easier for medical professionals and indeed for the court. However, a consent form is no more than evidence of consent. The reason this case arises is not because PM did not complete a consent form but because by refusing to complete the consent form, she indicated that she did not consent to the treatment. Thus, the court's concern is not with the absence of a signed consent form but with what this absence means about PM's wishes.

[20] In *In re a Ward of* Court, the Supreme Court upheld the right to refuse treatment (in this case artificial nutrition and hydration) of a woman who, as a result of a medical catastrophe which had occurred some 23 years previously, was in a 'near PVS state'. The right was derived from the constitutionally protected rights to autonomy and self-determination and the right to privacy, protected under Article 40.3.1° of the Constitution. Hamilton C.J. at page 125 accepted the view which had been put forward by the former President of the High Court, writing extra-judicially, that '[a] competent adult if terminally ill has the right to forgo or discontinue life-saving treatment'. He further found at page 126 that the Ward was terminally (rather than chronically) ill on the basis that, without the nourishment being provided to her by the treatment in question, she would die. The right to refuse treatment was also recognised by Denham J. who found at page 156 that '[i]f medical treatment is given without consent it may be trespass against the person in civil law, a battery in criminal law, and a breach of the individual's constitutional rights.' Although Hamilton C.J. identified a right to refuse treatment only in circumstances of terminal illness, it is clear from his finding that the Ward was terminally ill that Hamilton C.J. did not regard terminal illness as arising only in circumstances in which the trajectory of a disease will lead to inevitable death. On the basis of Hamilton C.J.'s understanding, PM would also be considered to be terminally ill. This was also the approach taken by Finnegan P. in respect of the original application.

[21] Moreover, even if one were to adopt a less expansive understanding of terminal illness, there is nothing in the judgment of the Supreme Court in *Re a Ward of Court* to indicate that a right to refuse treatment should not extend to a patient who is not terminally ill. In her extensive judgment, Denham J does not refer to the nature of the patient's illness and states the right to refuse treatment in terms which indicate that it applies to all patients of full age and capacity on an equal basis regardless of the nature of their illness.

[22] An important aspect of the right to refuse treatment as identified by Denham J. is that the right does not depend on the court's assessment of the rationality of the reasons for the refusal. Denham J. stated at page 156 that '[t]he consent which is given by an adult of full capacity is a matter of choice. It is not necessarily a decision based on medical considerations. Thus, medical treatment may be refused for other than medical reasons, or reasons most citizens would regard as rational, but the person of full age and capacity may make the decision for their own reasons.' Thus, it is not for this Court to determine whether or not PM's decision to refuse treatment is appropriate or reasonable. Rather, the function of the Court is to determine whether, in the circumstances of this case, PM's constitutionally protected right to refuse treatment should be upheld.

Status of Advance Refusals in Irish Law

[23] In the passage referred to above, Denham J. identified as an exception to the requirement for consent, the situation of a medical emergency where the patient is unable to communicate. This case is different to that envisaged by Denham J., because although PM was unable to communicate her consent or refusal contemporaneously, she had in advance indicated a refusal of treatment. The matter of a non-contemporaneous refusal of treatment has not to date been considered by the courts in this jurisdiction. However, courts in other jurisdictions have on several occasions upheld a right to refuse treatment, including life-saving treatment, in circumstances in which the refusal had been stated in advance and the patient was unable to communicate current wishes. In several of these cases, the refusal has derived from the patient's religious belief as a Jehovah's Witness. In the Canadian case of *Malette v Shulman et al* (1990) 67 D.L.R. (4th) 321, 330 Robins J.A., found that 'A doctor is not free to disregard a patient's advance instructions any more than he would be free to

disregard instructions given at the time of the emergency.' A similar approach to advance instructions may be found in decisions from England and Wales including the decision of the Court of Appeal in *Re T (Adult: Refusal of Medical Treatment* [1992] 3 W.L.R. 782 and the High Court in *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 W.L.R. 290.

[24] It is difficult to see any reason in principle why the constitutionally protected right to refuse treatment should not apply, solely on the basis that the refusal is communicated in advance. In upholding the right to refuse treatment in *Re a Ward of Court*, the Supreme Court was clear that an individual's constitutional rights are not lost because of insentience or incapacity. As described by Denham J. at page 163 '[s]imply it means that the right [to privacy] may be exercised by a different process.' There may, however, be differences at an evidentiary level in determining whether, in the circumstances of an individual case, an advance refusal should be upheld. I will return to this matter below.

Other relevant Constitutional Rights

[25] The right to refuse medical treatment is not the only right implicated in this case. Other relevant constitutional rights, which were also recognised in *In re a Ward of Court,* are the right to life and the right to bodily integrity. It should also be noted that PM has a constitutionally protected right under Article 44.2.1° to the free profession and practice of religion. As was recognised in *Quinn's Supermarket Ltd v Attorney General* [1972] I.R. 1, this right is not restricted in its application to specified or designated religions and therefore would encompass PM's faith as a Jehovah's Witness. However, this right is not central to the determination of the matters at hand because the right to refuse treatment as recognised in *In re a Ward of Court* is not restricted to refusal on religious grounds only.

[26] The right to life is of particular relevance in the circumstances of this case given the medical evidence that, in the absence of the treatment which the applicant seeks to have authorised, PM's life is at risk. The constitutional significance afforded to the right to life is described by Denham J. in *Re a Ward of Court* at page 160 in the following terms:

> The right to life is the pre-eminent personal right. The State has guaranteed in its laws to respect this right. The respect is absolute. This right refers to all lives – all lives are respected for the benefit of the individual and for the common good.

However, Denham J. continued at page 160 by stating that '[t]he State's respect for the life of the individual encompasses the right of the individual to, for example, refuse a blood transfusion for religious reasons. In the recognition of the individual's autonomy, life is respected.' Thus, it is clear that respect for the right to life does not require that treatment, such as a blood transfusion, be imposed on a patient against his or her will in order to preserve the patient's life and indeed, such imposition would fail to respect the individual's right to life.

[27] The right to bodily integrity, recognised by the Supreme Court in *Ryan v Attorney General* [1965] I.R. 284 protects the individual from violation and mutilation of their body. The treatment at issue in this case (blood transfusion/s and a liver transplant) would constitute a very grave infringement of the right to bodily integrity if imposed without the consent of PM. On the basis of the legal interpretation of the right to life as set out by Denham J. in *Re a Ward of Court*, the fact that treatment may save PM's life would not justify the imposition of this treatment if it is imposed contrary to PM's wishes.

[28] Thus, PM clearly had a right to refuse the treatment. The question to be determined is whether she had exercised this right.

Presumptions

[29] Given that the right to life is 'the pre-eminent personal right', a question arises as to whether the Court should adopt a presumption in favour of life so that in cases of uncertainty, any uncertainty will be resolved in favour of the action which saves the person's life. In this case, this approach would have placed the burden of proof on PM. Given that PM did not have any form of representation, this would have effectively pre-determined the case.

[30] I am not convinced that the application of a presumption on the basis of protection of life is desirable in a case such as this. Applied in a general manner, it seems to me to unduly undermine the rights to autonomy and bodily integrity. I note also Lord Donaldson M.R.'s refusal to impose a presumption in favour of life in broadly similar circumstances in the English case *Re T (Adult: Refusal of Medical Treatment)* [1992] 3 W.L.R. 782 at page 792, citing his instinctive dislike of introducing presumptions in 'reaching a decision of fact as crucial as this.' Thus, the burden of showing that treatment should be provided must fall on JM. Having said this, I am conscious of the seriousness of the decision which had to be made and of the irreversible consequences of upholding the decision to refuse potentially life-saving treatment. It is appropriate that a court would proceed with great care and would scrupulously examine the evidence in such circumstances.

The Evidence Provided

[31] In reaching the decision to order the administration of treatment, Finnegan P. identified as relevant two aspects of JM's evidence. The first related to the kind of person which PM was; the second related to the circumstances in which PM's refusal of treatment took place.

[32] In respect of the kind of person PM was, Finnegan P. stated at page 324 that he took account of the fact that PM was African and that it was part of her culture to adopt her husband's religion on marriage. He found at page 325 that her decision to refuse treatment was because of her cultural background and her desire to please her husband and not offend his sensibilities: '[s]he was pre-occupied with her husband and his religion as a Jehovah's Witness rather than with whether to have the treatment and her own welfare'. He considered at page 325 that, if PM was aware of her husband's decision to seek the intervention of the Court, she would agree to have the treatment and would be comforted by her husband's attitude.

[33] As Irish society becomes more culturally diverse, the Irish courts must be increasingly careful to avoid the risks of cultural stereotyping. Clearly, not all African women (or indeed women from any other ethnic background) share the same cultural traits. Therefore, a more accurate summation of the evidence presented to Finnegan P. is that PM's particular cultural heritage predisposed her to adopt her husband's religion on marriage; that, as a matter of fact, she did convert on her marriage and that, accordingly, her decision to refuse treatment was found to derive not from her own inherent beliefs but from those of her husband.

[34] Those who hold religious beliefs may do so for different reasons. Some beliefs derive from the religion of birth. In other instances, a person may convert to a religion at some point in their lives. It is feasible that a reason for conversion may be the assumption of the religion of one's spouse. It is also feasible that a person's religious belief may derive not from an inherent personal commitment but from an allegiance to a spousal, or indeed a parental, belief. Many religious beliefs or, indeed the rejection of such beliefs, may derive from the cultural and social context within which the person lives. This is not to cast doubt on the sincerity of individual beliefs nor to indicate that individual beliefs should not be

respected by the law. Rather, it indicates that any court should be very cautious before undertaking an attempt to evaluate the sincerity or depth of any individual's religious belief.

[35] As has been noted throughout, an unfortunate element of this case was that very little was known about PM. We do know however, that she was an adult. There is no indication that she encountered any cognitive difficulties or that she was unusually vulnerable or susceptible to undue influence. There is also no indication that she was subjected to such influence. Indeed, JM's evidence is that when she asked him what he would do in her circumstances, he responded that it was her decision. Thus, there are no specific factors which might cause concern to the Court. Rather, the Court is being asked to evaluate the impact of (possible) cultural influences on a decision made. It is very difficult to see how a court can do this – especially in the absence of any evidence beyond that of JM, whose evidence, as already noted, must be viewed with some caution given the inevitable pressures of the unfortunate situation in which he finds himself. On this basis, I find that PM's broader motivations in becoming a Jehovah's Witness and the nature of her beliefs are factors which are beyond the purview of this Court.

[36] The second relevant aspect of JM's evidence related to the circumstances in which PM refused the treatment. From JM's evidence, it appears that, on 19th October, the day before PM refused to complete the consent form, she attempted to discuss the proposed treatment with JM, asking him what he would do, and that he responded that this was her decision. It seems from this that PM envisaged that the decision should be made following consultation within her family unit. In this, she was no different to many, perhaps most, people who make important decisions not in a solely self-regarding or individual way but in the context of their relationships with others. It may reasonably be expected that, especially when a person is under physical and mental stress, as PM undoubtedly was, they will look for some form of help or support in making difficult decisions and that family members will be the most likely source of support. However, it would appear from his evidence that JM did not engage in discussion of the matter, stating that it was PM's own decision and leaving PM to think about the matter. Thus, it would appear that PM was left without any opportunity to discuss the decision to be made and without information about something which was clearly important to her – her husband's views on the matter.

[37] In light of this, it is perhaps no surprise that, on the following day, when her physical condition had deteriorated, PM vacillated between consent and refusal of the treatment, first agreeing to the treatment and then, apparently changing her mind when presented with the consent form by a member of the transplant team. PM was seriously ill and vulnerable. She asked for her husband's advice. Clearly, it is not for this Court to direct how spouses should respond to requests for advice. However, it is a source of concern that in these circumstances, there is no indication that the medical staff attempted to provide support to PM in reaching a decision. Thus, we find PM struggling to make a decision with very significant consequences for her life and the way she wished to live it. She vacillated and appeared to be uncertain although she ultimately refused to sign a consent form.

[38] By identifying the absence of decision-making support in this case, I do not intend to suggest that an individual's decision should be respected only where she or he has been provided with such support. Such a suggestion would inappropriately undermine the importance of the individual's right to make decisions about how to live his or her own life. I emphasise the lack of support in the unique circumstances of this case because one factor which is clear within the very limited amount of information which this court has about the way in which PM's decision was reached, is that she asked her husband what he would do and he responded to her that it was her decision.

[39] As I have mentioned, this Court is not concerned with the absence of a consent form – this is merely a form of evidence of PM's wishes. Rather, the concern of the Court is

with whether or not PM consented to the treatment. On the basis of the evidence before the Court at the time the order was made, I cannot conclude that PM's refusal to sign the consent form represented a considered decision to refuse treatment.

Decision

[40] PM has raised two issues in respect of the decision to authorise the administration of appropriate medical treatment. In respect of the first, the absence of fair procedures, I find that there was a breach of PM's constitutional rights which in turn had implications for the way in which the court considered the substantive question. I am conscious in making this finding of the urgency of the matter and the significant time pressures on the Court at the time the order was made. This was in no way the fault of the Court which facilitated the application in every way possible. Nonetheless, I am of the view that the absence of any form of representation for PM meant that the Court was unable to give sufficient consideration to the core element of the application, the perspective of PM.

[41] In respect of the decision to order treatment, I have reached the same conclusion as Finnegan P, although for a different reason. I consider that, in the absence of clear evidence of undue influence, a court should be very slow to reach conclusions regarding the nature of an individual's religious belief. Given that relationships are infinitely variable, it is possible that PM's refusal emerged from her pre-occupation with her husband and his religion rather than from her own beliefs. It is also possible that it did not. Bearing in mind that the burden of proof lay on JM, I do not consider that the evidence justified that conclusion that this was in fact the case.

[42] However, I am persuaded that the circumstances in which the refusal to sign the consent form took place do not indicate a considered decision to refuse the treatment. Through no fault of PM, it would appear that she was not given the support and information needed to reach a decision which can fairly be assumed to represent her views. In such circumstances, I cannot find the order to authorise the administration of treatment to constitute a breach of PM's constitutional rights to autonomy and bodily integrity. In so finding, I would like to stress my concerns regarding the lack of decision-making support provided to PM by her medical advisors and to note the importance of ensuing that such support is made available to patients who find themselves in the difficult and distressing position of having to make a momentous decision of the kind faced by PM. Such cases are likely to be rare but when they arise in the future, I would expect that the court should be provided with evidence of what forms of decision-making support were provided.