1. **REPORTABLE**

2. CASE NO: SA 57/2012

3. **IN THE SUPREME COURT OF NAMIBIA**

4. In the matter between:

5.

6. **ES** 7. **Appellant**

8. and

9. **AC** 10. **Respondent**

11.

12. **Coram**: SHIVUTE CJ, MAINGA JA and O'REGAN AJA

13. **Heard:** **13 October 2014**

14. **Delivered:** **24 June 2015**

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16. **APPEAL JUDGMENT**

17. _____

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18. SHIVUTE CJ (O'REGAN AJA concurring):

Introduction

[1] Mrs ES, a 38 year-old married woman, is the appellant in this matter. The respondent is Mr AC, the appellant's eldest brother. Mrs ES and her husband are parents to three children including one son (aged 13 years) and two daughters (aged 6 and 2 years). In the interests of the minor children the names of the parties have been anonymized. At the time of the hearing of the appeal, Mrs ES worked as a lecturer at a tertiary institution in the country.

[2] Mrs ES and her husband are both Jehovah's Witnesses. Accordingly, they believe in following a specific moral and religious code that includes a scriptural command to abstain from the ingestion of blood. Mrs ES has been a Jehovah's Witness for over 20 years, and during this time she has held firmly to her beliefs. The Royal College of Surgeons of England has characterised adherence to the command to abstain from the ingestion of blood as a 'deeply held core value' of Jehovah's Witnesses, who 'regard a non-consensual transfusion as a gross physical violation'.[1]

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[1] Council of the Royal College of Surgeons of England (2002), *Code of Practice for the Surgical Management of Jehovah's Witnesses*, para 2,

[3] Mrs ES appeals against the order made by the High Court on 13 September 2012, amongst others, appointing Mr AC as curator to the person of Mrs ES, principally it would appear, for the purpose of authorising the administration of medical procedures on her, including blood transfusions, if so advised by health professionals. The appeal also lies against the order and judgment handed down by that court on 25 September 2012 directing the treating doctor or any other medical practitioner appointed by the treating doctor to render 'appropriate medical treatment' including a blood transfusion to Mrs ES.

[4] In the judgment of 25 September 2012, the High Court found that the respondent's case rested on two pillars: the first, that Mrs ES was not *compos mentis* to exercise her right to refuse treatment in the form of a blood transfusion; the second, that Mrs ES enjoyment of her freedom of individual autonomy should be considered against the rights of Mrs ES newborn child, her two elder children, and the interests of her wider family and society in general. Relying on the

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https://www.rcseng.ac.uk/publications/docs/jehovahs_witness.html (Accessed 15 October 2014).

evidence of Mrs ES's treating doctor, Dr Burmeister, who supported Mr AC's application and rejecting the other expert evidence presented for Mrs ES, the High Court found that there was a possibility that the appellant may not have been *compos mentis* due to a lack of oxygen to the brain. On this basis, the court granted Mr AC's application and did not find it necessary to consider the second pillar of the respondent's case.

[5] As I understand the arguments of the parties, there are three issues that this court is called upon to determine. First, given that Mrs ES now appears to be well and healthy, is the matter now moot? Second, did the High Court err in law by granting Mr AC's applications to be appointed as curator to his sister and in effect to force Mrs ES to undergo a blood transfusion in September 2012? Third, in circumstances where a parent has young children, should the right of those children to be raised by their parents supersede the right of an individual to refuse a blood transfusion in a life-threatening situation where such treatment is advised?

[6] I should pause to mention that both parties lodged their heads of argument slightly late and accordingly filed applications for condonation. After hearing submissions in support of both applications,

these were granted. Before considering the three central issues set out above, I first present the factual background of the case and the evidence presented in the initial applications by the parties.

Background

[7] In August 2012, Mrs ES was pregnant with her third child. Her physician at this time was Dr G H Burmeister. Dr Burmeister had delivered the appellant's second child by caesarean section and was also the S family doctor. On 21 August 2012, Mrs ES had an appointment for her final pre-delivery consultation with Dr Burmeister. According to Mrs ES, during this appointment she stated that she would not accept a blood transfusion if complications arose during delivery.

[8] On 5 September 2012, Mrs ES signed a document titled 'Durable Power of Attorney for Health Care' (DPA). In the DPA, Mrs ES appointed her husband, Mr S, as her designated health-care agent and a certain Mr FN as an alternate health-care agent. During the appeal hearing, the court pointed out to counsel for the appellant that Mr S had signed the DPA as a witness. Counsel for Mrs ES conceded that it was not best practice for the person designated the health-care agent to witness the principal's signature, as had happened here, but

submitted that regardless of this defect, the DPA constituted clear evidence of Mrs ES's consistent intention to refuse the transfusion of blood in any and all circumstances.

[9] On 8 September 2012, when Mrs ES's pregnancy had progressed eight months, she began bleeding and was urgently taken to the Mediclinic Hospital in Windhoek. There she was seen by Dr Burmeister, who decided that an emergency caesarean section was necessary.

[10] During preparations for the surgery, Mrs ES told the anaesthetist that she was a Jehovah's Witness and would not accept a blood transfusion in the event of an emergency. Dr Burmeister later

testified that this was the first time he realised that Mrs ES was a Jehovah's Witness.

[11] During the caesarean section, Mrs ES's child was successfully delivered but it soon became apparent that a hysterectomy was urgently required. As Mrs ES was anaesthetised and unconscious, Dr Burmeister left the delivery room to seek oral consent from Mrs ES's husband for the hysterectomy, which was to be performed by Dr Smith, a specialist gynaecological surgeon. At this time, Mr S gave his consent for the hysterectomy in his capacity as health-care agent and handed a copy of Mrs ES's DPA to Dr Burmeister.

[12] During the operation, Mrs ES sustained a major haemorrhage. Her haemoglobin (Hb) reading dropped to a level below 7g d/l. Typically, patients who accept blood are routinely transfused when their haemoglobin drops below 7g d/l. Despite the low Hb reading, Dr Burmeister did not administer a blood transfusion at this point as he knew that Mrs ES was a Jehovah's Witness and had knowledge of the directives outlined in the DPA.

[13] Mrs ES spent the next two days in intensive care and was then transferred back to the maternity ward. She was not given a blood transfusion during this period even though her Hb levels stayed well below 7g d/l.

The *ex parte* application

[14] On 13 September 2012, Mr AC filed an *ex parte* application to be appointed the curator of Mrs ES in order to authorise the administration of medical procedures, including blood transfusions, if so advised by health professionals.

[15] Notably, neither Mrs ES nor her husband (in his capacity as designated health-care agent) was given notice of Mr AC's application at this time. Furthermore, in their evidence neither Mr AC nor Dr Burmeister referred to the DPA that had been completed by Mrs ES on 5 September 2012. Nor did they mention that Mrs ES's husband had been appointed as her health-care agent. In spite of this, there is no

doubt at the time of the application that both Mr AC and Dr Burmeister considered that they were acting in the best interests of the patient.

[16] In the course of the proceedings before the High Court, Mr AC said that he was the eldest of Mrs ES's siblings and a pastor in the Pentecostal Church. Mr AC testified that he had attempted to speak with his sister on the subject of the blood transfusion but that 'she kept still saying that she still believes a miracle will happen'. When the court enquired as to the views of Mrs ES's husband, Mr AC responded that Mr S 'does not go against the decision of the family, which is an urgent transfusion of blood'. Mr AC said that he believed that his appointment as curator was in the best interests of Mrs ES because when he had spoken to his sister the previous day, she had told him that 'she does not want to die'.

[17] As already mentioned, Dr Burmeister also gave evidence in support of Mr AC's application. At the time he testified, Dr Burmeister

had been in medical practice for 32 years and specialised in obstetrics. Dr Burmeister stated that he had performed the caesarean section on Mrs ES and that during the operation a hysterectomy became necessary in order to inhibit uncontrolled bleeding. After the hysterectomy, Mrs ES had to be admitted to intensive care to be placed on a respirator and her Hb fell to 4.2. Dr Burmeister testified that Mrs ES would 'definitely have to get a blood transfusion' in order to correct the situation.

[18] At the time of the respondent's application, Mrs ES's Hb level had dropped to 3.4. Dr Burmeister told the court that with an Hb at this level, Mrs ES could enter a coma at any time, which could lead to her death. Dr Burmeister anticipated that Mrs ES would make a full recovery if she received a blood transfusion.

[19] Dr Burmeister further testified that he could not be sure that Mrs ES was '100% functioning mentally'. Dr Burmeister said that Mrs ES was awake, but her vital organs (including her brain) could not be receiving sufficient oxygen given her low blood count.

[20] Having heard evidence from both Mr AC and Dr Burmeister, the court below granted the application. In an order dated 13

September 2012, the respondent was appointed as Mrs ES's curator and given the authority to instruct medical practitioners to render appropriate medical treatment to Mrs ES, including blood transfusions if so recommended.

The application for rescission

[21] Following the order of the High Court, medical staff at Mediclinic Hospital attempted to place Mrs ES on a drip for the purpose of administering a blood transfusion. Mrs ES refused to cooperate and resisted the blood transfusion.

[22] On 15 September 2012, Mrs ES lodged an urgent application seeking to rescind the order of the High Court dated 13 September 2012. In this application, it was argued that since the appellant was of sound mind at the time the application was brought, there was no lawful basis for the appointment of Mr AC as curator. In addition, the court should not have ordered a blood transfusion in contravention of Mrs ES's religious beliefs and her right to bodily autonomy.

[23] Mr AC correspondingly filed a counter-application praying that the court make an order that Dr Burmeister (or any other appropriate

practitioner as directed by Dr Burmeister) be authorised to administer any appropriate treatment including blood transfusion on Mrs ES.

Evidence for the appellant

[24] In her affidavit supporting the application, Mrs ES argued that the order should be rescinded on the basis that her views on the matter had not been put before the court. Mrs ES also emphasised in the affidavit that both she and her husband had completed the DPA on 5 September 2012, and that she had appointed her husband as her health-care agent (with Mr FN as an alternative health-care agent).

[25] Also provided to the court was an email annexed to the appellant's affidavit from Dr Matti Kimberg, a gynaecologist and obstetrician, who stated that he had seen the patient at 15h00 and 18h00 on 14 September 2012. Dr Kimberg stated that at these times Mrs ES was 'sitting comfortably in bed, was fully conscious, not visibly distressed, and fully oriented for time and place'. Dr Kimberg said that Mrs ES had 'openly discussed her decision to refuse [a] blood transfusion and expressed an understanding of the potential morbidity and mortality relating to her decision'.

[26] Mr S, the appellant's husband, also deposed to an affidavit in which he refuted Mr AC's previous assertion to the court that Mr S 'would not go against the decision of the family' in the event that they sought a blood transfusion for his wife. Mr S stated that in fact he had told Mr AC that the family should 'go and ask [Mrs ES] whether she wanted to take blood', and that he could not 'stop them from doing what they wanted to do', but that at all times he maintained the position that 'no blood transfusion would be allowed'. He further said that he 'emphasised again and again to Mr AC and other family members that the decision to have a blood transfusion or not was the decision between my wife and God. Nobody can decide for her, except herself'.

[27] An affidavit sworn to by Dr Reinhardt Sieberhagen, a psychiatrist, was also put before the court. Dr Sieberhagen stated that he had performed a psychiatric evaluation of Mrs ES on 14 September 2012. He opined that Mrs ES was 'preeminently in full control of her mental faculties and fully understands her clinical situation and the risks involved and is able to express her opinion and her wishes regarding her treatment'.

Evidence for the respondent

[28] At the proceedings, Mr AC testified that saving Mrs ES's life by way of the administration of a blood transfusion would immeasurably benefit the children and the family. Under cross-examination, Mr AC conceded that people choose to live in a certain way, and that those choices have risks. He agreed that one's choices depend on what one wants as an individual but also argued this was only the case so long as the individual's choices do not affect others. He proceeded to contend that 'others also have rights . . . when we are talking about children involved who do not even have a voice . . . somebody must speak for those who cannot speak'. At this point, counsel drew the court's attention to an additional affidavit sworn to by Mr S on 15 September 2012, in which he stated that he and his wife had discussed what would happen to the children should she die and said that he would care for the children in that event..

[29] Mr AC also said that he believed that Mrs ES had been placed under a substantial amount of pressure from other Jehovah's Witnesses. He reported that there had been others at the hospital who claimed membership of a health committee of the Jehovah's Witnesses. Mr AC referred in particular to an incident that had occurred on the previous Thursday, which had resulted in efforts by himself and his siblings to 'expel' the members of the health committee

from the hospital. The incident resulted in the hospital security staff being called to the scene. One of the individuals specifically mentioned was a lawyer who subsequently withdrew from this case in the High Court as junior counsel. According to Mr AC, the lawyer told a doctor present at the hospital that she risked a legal suit if she transfused blood. Mr AC expressed serious concern that others appeared to be involved in the making of important decisions that Mr AC considered should be the domain of Mrs ES's family.

[30] Dr Burmeister also gave evidence at the rescission proceedings. In addressing Dr Burmeister, counsel for Mr AC indirectly raised the possibility of involvement or influence of other Jehovah's Witnesses on Mrs ES by asking Dr Burmeister whether Mrs ES had 'a wide knowledge' of material of the kind published in the British medical journal 'Anesthesia' (an article from this journal concerning alternative non-blood treatments was attached to Mrs ES's affidavit).

[31] Dr Burmeister told the court that Mrs ES's Hb levels had been 3.4 by Thursday, 13 September 2012 but by Saturday, 15 September 2012 were 3.6, which meant that her condition had not substantially improved and that if she had an infection she would go into a coma. He also said that whilst he agreed with the psychiatrist that she was

fully awake, he did not agree that she was ‘100% *compos mentis*’, adding that 'with 25% of red blood cells available we know that the brain also does not get enough oxygen at this stage’. He confirmed his previous testimony that a blood transfusion was necessary to prevent Mrs ES from going into a coma and dying.

[32] Oral evidence was also presented by Prof Clarissa Hildegardt Pieper, who was Head of Department of Pediatrics at Katutura State Hospital. Prof Pieper testified that she had experience as a general practitioner and in paediatrics, and was a registered neonatologist. Prof Pieper had not treated Mrs ES but gave evidence in her capacity as an expert in the area of neonatology. Prof Pieper stated that patients with a very low Hb level are likely to be hypoxic (i.e. deprived of adequate oxygen supply). Prof Pieper said that individuals who are hypoxic often believe that they are rational despite the fact that their body is unable to function properly. She also said that she was concerned about Dr Sieberhagen’s report because no standardised test grading cognitive performance had been conducted. In addition, Prof Pieper related to the court the results of several studies that indicated maternal mortality affected a newborn baby’s chance of survival, that early childhood trauma was correlated with poorer developmental and behaviour outcomes, and that a quick recovery

(induced by a blood transfusion) would probably lead to better bonding between Mrs ES and her premature newborn baby, who at this stage was being treated in an incubator.

[33] On 25 September 2012, the High Court dismissed the appellant's rescission application and granted the respondent's counter-application. As previously observed, the court below considered Mr AC's case as being based on two pillars; the first being that Mrs ES was not *compos mentis* to exercise her right to refuse treatment in the form of a blood transfusion. The second pillar was that Mrs ES's enjoyment of her freedom of individual autonomy should be balanced against the rights of Mrs ES's three children and the interests of her extended family and society in general.

[34] The High Court rejected Dr Sieberhagen's affidavit regarding his psychiatric evaluation of Mrs ES on the basis that it was not conventional or ethical for Dr Sieberhagen to conduct an evaluation on a patient in a hospital whom he was not treating. Therefore the only medical evidence before the court regarding competency was that of Dr Burmeister, who testified that Mrs ES may not have been *compos mentis* due to a lack of oxygen to the brain. The court below therefore found it unnecessary to consider the second pillar of Mr AC's case. On

this basis, Mrs ES's rescission application failed and Mr AC's counter-application succeeded.

[35] However, on 26 September 2012, and before any blood transfusion had been administered, Mrs ES was discharged from the hospital as she had sufficiently recovered with the administration of alternative non-blood procedures.

[36] Also on 26 September 2012, Mrs ES filed an appeal against the entirety of the judgment and orders handed down by the High Court on 25 September 2012. On 23 October 2012, an amended notice of appeal was filed to include an appeal against the entire judgment and orders handed down on 13 September 2012.

Is the appeal moot?

[37] As noted above there are three issues to be determined in this appeal. The first question to be considered and decided is whether this appeal is moot. Given that Mrs ES left the hospital without having a blood transfusion administered and now appears to be in good health, is there any live issue for the court to determine? Counsel for Mrs ES argued that the appeal was not moot because the respondent still possessed a sealed order of the High Court that allows him to

authorise medical treatment, including blood transfusion, to be administered to Mrs ES. Were Mrs ES to be involved in a car accident, for instance, Mr AC could still direct medical staff to administer a blood transfusion. Counsel noted that the order was prepared without including a time limit within which it would remain operative, and that the only remedy available to the appellant to amend the order was to appeal to this court. Counsel for Mr AC conceded that the order granted by the High Court is open-ended and still appears valid today. In those circumstances, so the concession goes, the matter is not moot. I agree.

19.

[38] Furthermore, it is my considered view that the court has an interest in matters that concern constitutional questions in relation to an individual's rights. Whilst it is true that the court does not issue advisory opinions, and must only decide what it is necessary to decide as was held by this Court in *Kauesa v Minister of Home Affairs and Others* 1995 NR 175 and other cases, the court can take a broader view in the interests of justice to hear a matter that would otherwise be declared moot. In *MEC for Education: Kwazulu-Natal and Others v Pillay* 2008 (1) SA 474 (CC), Langa CJ at para 32 listed factors that are relevant in assessing whether it is in the interests of justice that a matter be heard in spite of the consideration that it may be moot.

These include:

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(a) the nature and extent of the practical effect that any possible order might have;

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(b) the importance of the issue;

(c) the complexity of the issue; and

22.

(d) the fullness or otherwise of the argument advanced.

23.

[39] I respectfully agree with Langa CJ's reasoning on this aspect. In light of these factors, I consider that this matter is one that clearly warrants the attention of this court. The facts of this matter concern some of most essential human right issues likely to arise in litigation.

They relate to the right to bodily autonomy, the right to freely practice one's religion, and the freedom from discrimination. The facts also relate to relationships within families, and the extent to which familial obligations compromise, or should compromise, one's own individual freedom. The decision may also have far-reaching implications for medical practitioners. For these reasons, I consider that it is appropriate for the court to hear this matter.

24.

The *ex parte* proceedings

[40] I turn now to the events as they unfolded in the *ex parte* proceedings. As I have emphasised above, there is no question that in making and giving evidence in favour for the *ex parte* application, both Mr AC and Dr Burmeister believed that they were acting in the best interests of the appellant. Counsel for Mrs ES, however, was critical of Dr Burmeister's decision to give evidence, and also submitted that insufficient material had been put before the court in relation to methods of non-blood treatment available for treatment of Jehovah's Witnesses.

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[41] However, there was no need for the application to have been made on an *ex parte* basis. No effort was made to inform Mrs ES or her husband about the application despite the fact that their

whereabouts were known. As a direct consequence of this failure, the court heard no evidence in connection to the DPA signed by Mrs ES, and Mr S was not afforded an opportunity to speak as Mrs ES's designated health-care agent or refute the assertion that he left the decision regarding the blood transfusion to Mrs ES's extended family. On the facts of this case, the lodging and hearing of the application on an *ex parte* basis was entirely inappropriate. There is persuasive English authority for the proposition that it is generally inappropriate for a court to authorise medical treatment against a non-consensual patient where the application for that order is made on an *ex parte* basis: See *St George's Healthcare NHS Trust v S, R v Collins and others, ex parte* S [1998] 3 ALL ER 673 (CA) at 700 d – f. I also agree with the submission of Mrs ES's counsel that the open-ended order should have included a return date upon which Mr AC's status as curator could have been reassessed by the court and continued or discontinued as appropriate.

26.

The application for rescission

[42] The next question for consideration and decision is whether the High Court correctly decided the application for rescission and the related counter-application heard on 15 September 2012. The court's decision clearly turned on whether Mrs ES could be declared *compos*

mentis. The evidence on this point was contradictory. Giving evidence for Mrs ES, Dr Kimberg reported as already noted that the patient was 'sitting comfortably in bed, was fully conscious, not visibly distressed, and fully oriented for time and place'. Dr Kimberg said that Mrs ES had 'openly discussed her decision to refuse [a] blood transfusion and expressed an understanding of the potential morbidity and mortality relating to her decision'. Similarly, a qualified psychiatrist, Dr Sieberhagen, evaluated that Mrs ES was 'preeminently in full control of her mental faculties and fully understands her clinical situation and the risks involved and is able to express her opinion and her wishes regarding her treatment'. On the other hand, Dr Burmeister and Dr Pieper, who gave evidence for Mr AC, both expressed serious concern that in the absence of sufficient oxygen to the brain (which is consistent with the low Hb levels experienced at the time by the appellant), it is quite possible that a patient may appear *compos mentis* but in actual fact be incapable of making rational decisions.

27.

[43] As previously observed, the court *a quo* resolved this dilemma by finding that it was unsatisfactory for Dr Sieberhagen to give evidence in light of the fact that he was not Mrs ES's treating doctor. The court therefore placed most weight on Dr Burmeister's evidence and on this basis Mr AC's counter-application was granted.

[44] There is no doubt that the court at this point was in an unenviable position. Two choices lay before the judge. First, the court could accept the evidence that Mrs ES was *compos mentis* and rule in favour of Mrs ES's application with the effect that potentially life-saving treatment would not be administered to Mrs ES. Second, the court could accept Mr AC's contention that Mrs ES was not *compos mentis*, with the effect that Mrs ES would be forced to have a blood transfusion of the kind she had physically resisted two days previously. One of the issues that potentially made the decision more difficult for the court *a quo* was the fact that Mr AC had given evidence that he was concerned Mrs ES was being pressured by individuals from her church group not to accept a blood transfusion. In the event that it was questionable whether Mrs ES was indeed *compos mentis,* one can imagine the concern of the judge *a quo* that Mrs ES may have been more susceptible to pressure than in other circumstances.

[45] Nevertheless, in my view the High Court erred when it ruled against Mrs ES's application for rescission of the earlier order and in

favour of Mr AC's counter-application. I begin my reasons for this conclusion with some general remarks.

[46] The Namibian Constitution affords every individual in Namibia certain rights. Art 7 (protection of liberty) prescribes that no person shall be deprived of personal liberty except according to procedures established by law. Article 8(1) (respect for human dignity) states that the dignity of all persons shall be inviolable. Article 8(2)*(a)* specifically states that: '[i]n any judicial proceedings . . . respect for human dignity shall be guaranteed'. This provision therefore places direct responsibility upon the courts to guarantee the human dignity of those individuals who come before the court for relief, or who are otherwise affected by its rulings. Furthermore, Art 10(1) states that all persons shall be equal before the law, and Art 10(2) provides that 'no persons may be discriminated against on the grounds of sex, race, colour, ethnic origin, religion, creed or social or economic status'.

[47] In addition to individual rights, the Namibian Constitution also reflects the importance of family to communities and society more broadly. Article 14(3) provides that '[t]he family is the natural and fundamental group unit of society and is entitled to protection by society and the State'. Children are also afforded particular protection

by the Constitution, which reflects their uniquely vulnerable status as members of society who lack the autonomy to make their own decisions, are dependent upon the care of others, and are more susceptible to unfair or dangerous employment practices. Therefore Art 15 provides that children shall have the right to a name, to a nationality, and to be protected from any work likely to be hazardous, interfere with their education, or harmful to their health or 'physical, mental, spiritual, moral or social development'. In particular, Art 15(1) provides that children shall have the right, as far as possible, to know and be cared for by their parents, subject to legislation enacted in the best interests of children.

[48] In a case concerning the refusal of an adult patient of full mental capacity to have a blood transfusion administered, the starting point must be the principle of patient autonomy, which embodies both Art 7 (protection of liberty) and Art 8 (respect for human dignity) of our Constitution. The principle of patient autonomy reflects that it is a basic human right for an individual to be able to assert control over his or her own body. Adhering to this principle requires that a patient must consent to medical procedures after having been properly advised of their risks and benefits, so that the consent is informed. Medical practitioners must inform their patients about the material risks and

benefits of the recommended treatment but it is up to the patient to decide whether to proceed with a particular course of treatment. For this reason, it is the patient's judgment of his or her own interests that is the most important factor.

[49] The corollary of patient autonomy is that a patient may refuse to undergo specific medical procedures, and that refusal must ordinarily be respected so long as the patient is an adult of sound mind and the patient understands the implications of the refusal. It is important to note that the subject of children undergoing medical procedures raises different and difficult concerns that do not require consideration in the case presently before the court.

[50] Pertinently, it is not for medical professionals or judicial officers to judge the basis upon which an adult of sound mind has taken a decision to accept or refuse a specific medical procedure (excepting certain exceptional circumstances such as duress: see, for instance,

the English authority of *Re T (Adult)* [1992] 4 All ER 649). This means that in the present case, the court is not called upon to consider whether it agrees with the religious basis upon which Mrs ES elected to refuse treatment involving blood transfusions. Importantly, Art 10(1) of the Constitution states that all persons shall be equal before the law and that no person may be discriminated against on the grounds of sex, race, colour, ethnic origin, religion, creed or social or economic status (Art 10(2)).

[51] These principles were set out clearly in *Castell v De Greef* 1994 (4) SA 408 (C). In this case, the Full Bench of the Cape Provincial Division of the Supreme Court of South Africa (as it then was) stated as accurately reflected in the headnote that:

> 'It is clearly for the patient, in the exercise of his or her fundamental right to self-determination, to decide whether he or she wishes to undergo an operation, and it is in principle wholly irrelevant that the patient's attitude is grossly unreasonable in the eyes of the medical profession: the patient's right to bodily integrity and autonomous moral agency entitles him or her to refuse medical treatment.'

[52] *Castell v De Greef* was recently endorsed by this court in *Government of the Republic of Namibia v LM and Others* [2014] NASC 19. In particular, the court referred to a quote from an unpublished doctoral thesis by Van Oosten entitled: 'The Doctrine of Informed Consent in Medical Law' which reads:

> 'The fundamental principle of self-determination puts the decision to undergo or refuse a medical intervention squarely where it belongs, namely with the patient. It is, after all, the patient's life or health that is at stake and important though his life and health as such may be, only the patient is in a position to determine where they rank in his order of priorities, in which the medical factor is but one of a number of considerations that influence his decision whether or not to submit to the proposed intervention. But even where medical considerations are the only ones that come into play, the cardinal principle of self-determination still demands that the ultimate and informed decision to undergo or refuse the proposed intervention should be that of the patient and not that of the doctor.'

<u>The DPA</u>

[53] As noted above, the High Court perceived that the determinative issue in this case was the assessment of Mrs ES's capacity. Despite the fact that Mrs ES had consistently and repeatedly voiced her objection to receiving blood (both before and after the operations), a question mark was raised by Mr AC and Mrs ES's treating doctor, Dr Burmeister, as to whether Mrs ES could be said to be *compos mentis* in light of her low Hb levels and the oxygen available to her major organs, including her brain.

[54] In its assessment, however, the court *a quo,* gave insufficient weight to the Durable Power of Attorney (DPA) signed by Mrs ES some days before the operation. Advanced directives or powers of attorney anticipate a future moment when a patient may lack decisional capacity or be otherwise incapacitated so that he or she cannot participate in making decisions regarding his or her health treatment. A document of this nature sets out an individual's treatment decisions, which may include the preemptive refusal of certain treatments and/or the nomination of a specific individual to make healthcare decisions on behalf of a patient unable to make decisions for him or herself.

[55] In jurisdictions across Canada, the United Kingdom, and Australia courts have accepted the common-law validity of advance

health care directives, or durable powers of attorney, in which adults make provision for health care decisions, either by appointing another person to make them on their behalf (a power of attorney), or by indicating what treatment they are willing or unwilling to undergo. (See, in this regard, *Fleming v Reid* 82 DLR (4th) 298 (Ont CA) (1992)); *Hunter and New England Area Health Service v A* [2009] NSWSC 761; *HE v A Hospital, NHS Trust* [2003] EHWC 1017 (Fam) at para 20). In addition, legislation has been passed in jurisdictions in Australia, Canada and the United Kingdom that recognizes legal status of advanced directives as this has developed in the common law (See, for example, s 24 of the Mental Capacity Act 2005 (England and Wales), Advance Care Directives Act, 2013 (South Australia), Medical Treatment Act, 1988 (Victoria), Substitute Decisions Act, 1992 (Ontario)).

[56] No such legislation has been passed in Namibia, but in my respectful view written advanced directives which are specific, not compromised by undue influence, and signed at a time when the patient has decisional capacity constitute clear evidence of a patient's intentions regarding their medical treatment. To subject a patient to treatment against his or her stated wishes in circumstances where there is no reason to believe that the patient has changed his or her

view (i.e. the instructions contained in the advanced directive are consistent with the conduct and communications of the patient) risks contravention of that person's constitutional rights, including Art 7 (protection of liberty) and Art 8 (respect for human dignity).

[57] As previously mentioned, in the present appeal, it has been conceded by counsel for the appellant that Mr S did indeed witness the execution of the DPA, which, as the nominated health-care agent, he should not have done. This is certainly undesirable. Nevertheless, in my considered opinion despite this technical defect and regardless of the document's legal status in this country the DPA as evidence of Mrs ES's intention is instructive as to her intentions at the time she signed it.

[58] It has become necessary to look more closely at the salient provisions of the DPA. In para 2 thereof, Mrs ES directs that no blood transfusions (including transfusions of whole blood, red cells, white cells, platelets, or plasma) should be given to her under any circumstances, even in the event that health care providers believe that such treatment is necessary to preserve her life. In para 7 of the DPA, Mrs ES states that she gives no one (including her appointed health-care agent) authority to disregard or override her instructions as

set out in the DPA. It is stated emphatically in that paragraph as follows: ‘Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions’.

[59] The DPA was, in fact, specifically drafted to address precisely the type of situation presented by the circumstances in this case. When a patient is unable to give her consent to a particular medical procedure, or there is a question mark over a patient’s mental capacity, the DPA sets out the patient’s intentions and the type of medical procedures that the patient has chosen to consent to or not consent to. The wording of the DPA in this case could not be clearer: Mrs ES directs that no blood transfusions or blood products should be administered to her person under any (including life-threatening) circumstances. She gives no one, including her health-care agent, the authority to disregard these instructions. Second, the DPA appoints a health-care agent (and an alternate) so that if consent is required for a particular procedure, that person has authority to give it so long as this does not contradict any of the direct provisions in the DPA.

[60] It is also relevant that the terms of the DPA were consistent with Mrs ES’s behaviour and communications at all times both before

and after the operations. Due to the consistency of Mrs ES's beliefs and conduct, this case presents different facts when compared to those of a case such as *Re T (Adult)* above, in which it was questionable whether the patient continued to practice and believe in the central principles of the Jehovah's Witnesses religion.

[61] In my view, it was not necessary at least in the second application for the court *a quo* to evaluate the competing evidence to make a determination as to whether Mrs ES was or was not *compos mentis*. What is significant is that she had established her intentions and wishes regarding her medical treatment in the DPA. This stance on her part was consistent with all of her conduct both before and after the operations. Regardless of whether or not the DPA can be said to have formal legal status, it clearly establishes the wishes of Mrs ES in connection with her ongoing medical treatment. The document was signed voluntarily at a time when it is common cause that Mrs ES was competent to make such a decision. There were no circumstances to suggest that she had changed her mind subsequent to her signing the durable power of attorney. Therefore the court below should not have refused Mrs ES's application and granted Mr AC's counter-application on the basis that Mrs ES was not *compos mentis.*

The interests of the children

[62] Given the above finding, I now turn to consider and decide whether the ruling of the High Court can be saved on the basis that Mrs ES's application should have been refused because she is the mother of three young children who have the constitutional right to know and be cared for by their parents as far as possible as provided for by Art 15(1). The respondent contends that the court in this situation should 'strike a balance' between the competing rights of Mrs ES and her children.

[63] Respondent's counsel stressed that the issue of children's rights is an area that is consistently developing in both international and domestic legal spheres. Courts across many jurisdictions have placed the best interests of children at front and centre when deciding cases where parents have refused the administration of medical treatment to a child for religious reasons. In this regard, the attention of the court was directed to the South African case of *Hay v B and Others* 2003 (3) SA 492, in which parents had refused to permit a blood transfusion to be administered to their infant child due to their religious beliefs and concern about contamination. In that case, the court held that 'a child's best interests are of paramount importance in every matter concerning the child' and the court granted an order authorizing

a pediatrician to administer a blood transfusion to the baby. In light of Art 15(1) of our Constitution and the rapid development in the area of children's rights, counsel for the respondent argues that in an emergency situation where a parent of young children is refusing medical treatment, a court can legitimately consider the best interests of the children as a factor in its decision as to whether life-saving medical treatment should be administered to a patient without his or her consent.

[64] The case presently before the court must be distinguished from those matters in which parents refuse to have essential medical treatment administered to children on the basis of their own religious beliefs. As noted previously, such cases raise difficult but different concerns when compared to matters that involve adult persons with decisional capacity.

[65] Counsel for the Respondent also relied on article 15(1) of the Constitution, which was referred to at para 47 above. In this regard, it should be noted that although Art 15(1) envisages that children have the constitutional right to know and be cared for by their parents, that right is qualified by the inclusion of the words 'as far as possible', meaning that the Constitution anticipates circumstances, unforeseen

and otherwise, that may prevent children being raised by their natural mother and father. This right must not be construed as an absolute right that takes precedence over a parent's right to liberty and bodily integrity.

[66] The weight of authority to which this court was referred would support the conclusion that the interests of children in parental care should not outweigh the interests of parents in being able to make decisions about medical treatment that affect the parents themselves. Courts in England and Wales have on several recent occasions affirmed the right of a pregnant woman to refuse to medical treatment even if may imperil the life of her unborn child. For instance, Lady Justice Butler-Sloss in the Court of Appeal in *Re MB (An Adult: Medical Treatment)* [1997] 2 FLR 426 stated at para 60:

> 'A competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reason at all, choose not to have medical intervention, even though … the consequence may be the death or serious handicap of the child she bears, or her own death'. (At 561)

Similarly, in *St George's Healthcare NHS Trust v S, R v Collins and others, ex parte S* [1998] 3 All ER 673 (CA)), the Court of Appeal found that a competent adult woman was entitled to refuse a caesarean section even if that decision led to the death of a 36 week old unborn child. The court stated:

> 'While pregnancy increases the personal responsibilities of a woman, it does not diminish her entitlement to decide whether or not to undergo medical treatment. … Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant'. (at 692 a – b)

These two cases represent a shift away from the earlier case of *Re S. (Adult: Refusal of Treatment)* [1992] 3 W.L.R. 806, which held that a court may order an operation to be performed notwithstanding the mother's refusal of consent where the lives of the mother and the unborn child would both be at risk if the operation were not performed.

The approach in the latter two cases, however, accords with the current state of the law, as formulated in *HE v A Hospital NHS Trust and Another* [2003] EHWC 1017 (Fam) where Munby J held that a 'competent adult has an absolute right to refuse consent to any medical treatment or invasive procedure, whether the reasons are rational or irrational, existent or non-existent and even if the result of the refusal is the certainty of death.' (at para 20)

[67] The interests of living children (as opposed to unborn children) have featured more prominently in the case law of the United States. This may be because the right of patient autonomy is not formulated in 'absolute' terms (see the dictum of Munby J cited in the previous paragraph) in the United States as it is in England and Wales. In the United States, the courts have developed the principle that a person has a right to refuse medical treatment, but it is not absolute and may in certain circumstances be overridden by countervailing considerations. (See, for example, *Northwood Hospital v Munoz* 409 Maxx. 116 (1991); 564 NE 2d 1017.) The countervailing consideration that would be relevant to the case we are considering would relate to the courts' duty to protect innocent third parties. American courts consider that based on the principle of the state's role as *parens patriae*, courts will not permit a parent to abandon his or her children.

This principle was relied on in *Application of the President and Directors of Georgetown College Inc.* 331 F. 2d 1000 (D.C. Cir. 1964), where the District of Columbia Circuit Court upheld the decision of a lower court to authorise the administration of a blood transfusion to a 25-year old mother of a 7-month old child. Justice Wright at p 1008 noted that '[t]he state as *parens patriae* will not allow a parent to abandon a child'.

[68] However, there have been a string of more recent cases that have held that where there is another parent or other close relatives to look after the child, a refusal of medical care by a parent of small children will not constitute 'the abandonment of a child'. (See, for example, *In Re Dubreuil* 629 Se 2d 819 (1993) (Florida), *Wons v Public Health Trust of Dade County,* 500 So. 2d 96 (Florida), *Fosmire v Nicoleau* 75 N Y 2d 218 (1990), and *Northwood Hospital v Munoz* (1991) 564 NE 2d 1017 (Mass.)) There were dissents in the two Florida cases, reasoning that the circumstances were such that would warrant overriding the mother's ordinary right to refuse to receive medical treatment. In *Re Dubreuil,* one dissenting judgment asserted that –

> 'Children need, and are entitled to have, their mothers, this need is sufficiently great to outweigh one's free exercise of religious beliefs.' (Per MacDonald J)

The majority in the same case responded to similar reasoning by the lower court by observing that such could –

> '… perpetuate the damaging stereotype that a mother's role is one of caregiver, and the father's role is that of an apathetic, irresponsible or unfit parent.'

[69] It seems clear that under the Namibian constitutional order, it would not be appropriate to differentiate in regard to the right to parental care between mothers and fathers without very sound justification. The principle of gender equality entrenched in our Constitution would ordinarily require that any limitation of a parent's

right to refuse medical treatment must apply to both mothers and fathers.

[70] One of the American cases in which a parent's right to refuse medical treatment was upheld was *Fosmire v Nicoleau* 75 N Y 2d 218 (1990). In that case, the New York Court of Appeals held (at 229-230) that the state's interest in protecting minor children should not override the right of a competent individual to refuse medical treatment: 'at common law the patient's right to decide the course of his or her own medical treatment was not conditioned on the patient['s] being without minor children or dependants'. At para 7, Chief Judge Watcher writes:

> 'The State's interest in promoting the freedom of its citizens generally applies to parents. The State does not prohibit parents from engaging in dangerous activities because there is a risk that their children will be left orphans. There are instances, as the hospital notes, where the State has prohibited the public from engaging in an especially hazardous activity or required that special safety precautions be taken by participants. But we know of no law in this State prohibiting individuals from participating in inherently dangerous activities or requiring them to take special safety precautions simply because they have minor children. There is no indication that the State would take a more intrusive role when the risk the parent has assumed involves a

> very personal choice regarding medical care. On the contrary, the policy of New York, as reflected in the existing law, is to permit all competent adults to make their own personal health care decisions without interference from the State'.

[71] I respectfully agree with this viewpoint. The right to choose what can and cannot be done to one's body, whether one is a parent or not, is an inalienable human right. Were courts to hold that the right of parents to exercise this right would be limited in the best interests of children the logical endpoint may be that parents of young children should not be employed in the armed forces, that they should be prohibited from engaging in high-risk sports, or publicly censured for consuming non-prescribed drugs and alcohol. The most extreme application of this principle might require a parent being compelled to undergo an operation for the purposes of organ donation if his or her child required a kidney to survive. Even though as a society we recognise and promote the importance of families and relationships, this court is also compelled to protect the liberty, self-determination and dignity of the individual, especially in matters where medical treatment to one's own person is concerned.

[72] The principle of patient autonomy must be the overriding principle that guides the courts in cases such as the one presently before the court. This is consistent with the trend in many common law jurisdictions throughout the world and the promotion of rights to liberty, privacy, and health as embodied in a range of international instruments to which Namibia is a party, including the *International Covenant on Civil and Political Rights* and the *International Covenant on Economic, Social and Cultural Rights*. To accept the argument of the respondent would significantly impair the principle of patient autonomy and potentially greatly restrict the liberty of parents. In *Malette v Shulman et al,* Robins JA commented at 334 that 'individual free choice and self-determination are themselves fundamental constituents of life. To deny individuals freedom of choice with respect to their health care can only lessen, and not enhance, the value of life'.

[73] I respectfully agree with these sentiments. Moral autonomy is of central importance to the protection of human dignity and liberty in free and open democracies such as ours.

[74] It is patently clear that the *ex parte* application brought by Mr AC was well meaning and *bona fide*. This, however, is not sufficient a reason for it to succeed. The appeal, therefore, should be allowed.

Costs

[75] Counsel for the appellant submitted that costs should follow the event, and that costs should be awarded on an attorney and client basis. However, counsel for the respondent appeared *pro amico* in this court and in the High Court. The rule that where a litigant is represented *pro amico* a costs order will not ordinarily be made should have been applied. The costs order in the High Court should therefore be set aside. It is fitting in the circumstances of this case that there be no costs order in either court.

Order

[76] The following order is made:

1. The appeal is allowed.

2. The order of the High Court dated 13 September 2012 is set aside and is substituted for an order dismissing the application.

3. The order of the High Court dated 25 September 2012 is set aside and is substituted for an order:

   (i) rescinding and setting aside that court's order granted in favour of the respondent on 13 September 2012, and

   (ii) dismissing the counter application brought by the respondent.

4. The order of costs made by the High Court in the proceedings of 25 September 2012 is set aside.

5. No order as to costs is made in the appeal.

_____
SHIVUTE CJ

_____
O'REGAN AJA

28.

MAINGA JA (partially dissenting):

[77] I sincerely regret that I cannot support the judgment of the court on the third question to be determined, namely, in circumstances

where a parent has young children, should the right of those children to be raised by their parents supersede the right of their parents to refuse a blood transfusion in a life-threatening situation where such treatment is advised.

[78] My quarrel with the court on this point is that the majority has restated the doctrine of 'informed consent' in an unqualified manner which suggests that the doctrine is absolute. In my view, it is not absolute, and should be qualified by the interests of children.

[79] This case is not about medical malpractices as were *Castell v De Greef, Government of the Republic of Namibia v LM and Others*, *supra*, and many other similar cases. At issue in this case is the competition between the rights of Mrs ES to privacy and freedom of religion as guaranteed in Articles 13 and 21(c) and her statutory and constitutional duty as a parent to respect rights of her children to be cared for by her as their parent. The sanctity of the parent – child

relationship is a fundamental liberty interest protected by Art 15(1) of the Namibian Constitution. The right to conceive and raise one's own children is one of the basic civil rights of man. *Meyer v Nebraska* 262 U.S. 390 (1923). This is echoed in Art 14(1) of the Constitution of Namibia. Article 14(3) emphatically provides that 'the family is the natural and fundamental group unit of society and is entitled to protection by society and the State'.

[80] The makers of our Constitution sought to protect that natural and fundamental group unit of society – family and reiterate both the basic rights and duties of parenthood.

[81] The principles gleaned from the jurisprudence in the United States of America as set out in paras [67] and [68] of the majority judgment (excluding *Fosmire v Nicoleau* 75 NY 2d 218 (1990)), on the question of a competent adult's right to refuse medical treatment are the following:

1. A competent adult has a right to refuse medical advice and treatment but that right is not absolute.

2. The state may intervene in a given case if the state's interests outweigh the interests of the patient in refusing medical treatment. This is true whether the refusal is based on common-law or constitutional principles.

3. The countervailing state interests identified by the courts that may override the express wishes of the patient are:

a) Interest in the preservation of life;

b) need to protect innocent third parties (including children);

c) duty to prevent suicide; and

d) the need to maintain the ethical integrity of medical practice.

4. The principle mentioned in 3(b) above requires that where the refusal to accept medical treatment would result in the abandonment of children in a case the courts (as in this case) would order the administration of blood or the treatment that has been refused by the parent to prevent the abandonment of the children.

5. Whether there is a compelling interest to override the wishes of the patient is determined on a case by case, basis depending on the circumstances of each case. In *Wons,* 500 So. 2d 96 (Florida)*,* the Appeal Court stated, 'in the event, however that Mrs Wons may medically require a blood transfusion in the future due to the condition which brought her to the hospital in this case, the trial court will be guided by the principles, announced in this opinion in determining whether to order a second blood transfusion.' See also Dubreuil, infra.

[82] In this case, the majority reason at paras [62] through to [66] as follows:

> '[62].I now turn to consider and decide whether the ruling of the High Court can be saved on the basis that Mrs ES's application should have been refused because she is the mother of three young children who have the constitutional right to know and be cared for by their parents as far as possible as provided by art 15(1). The respondent contends that the court in this situation should 'strike a balance' between the competing rights of Mrs ES and her children.
>
> [63] Respondents counsel stressed that the issue of children's rights is an area that is consistently developing in both international and domestic legal spheres. Courts across many jurisdictions have placed the best interests of children at front and centre when deciding cases where parents have refused the administration of medical treatment to a child for religious reasons. In this regard, the attention of the court was directed to the South African case of *Hay v B and Others* 2003(3) SA 492, in which parents had refused to permit a blood transfusion to be administered to their infant child due to their religious beliefs and concern about contamination. In that case, the court held that "a child's best interests are of paramount importance in

every matter concerning the child" and the court granted an order authorizing a pediatrician to administer a blood transfusion to the baby. In light of Art 15(1) of our Constitution and the rapid development in the area of children's rights, counsel for the respondent argues that in an emergency situation where a parent of young children is refusing medical treatment, a court can legitimately consider the best interests of the children as a factor in its decision as to whether life-saving medical treatment should be administered to a patient without his or her consent.

[64] The case presently before the court must be distinguished from those matters in which parents refuse to have essential medical treatment administered to children on the basis of their own religious beliefs. As noted previously, such cases raise difficult but different concerns when compared to matters that involve adult persons with decisional capacity.

[65] Counsel for the respondent also relied on Article 15(1) of the Constitution which was referred to at para [47] above. In this regard, it should be noted that although Art 15(1) envisages that children have the constitutional right to know and be cared for by their parents, that right is qualified by the inclusion of the words "as far as possible", meaning that the Constitution anticipates circumstances, unforeseen and otherwise, that may prevent children being raised by their natural mother and father. This right must not be construed as an absolute right that takes precedence over a parent's right to liberty and bodily integrity.

> [66] The weight of authority to which this court was referred would support the conclusion that the interest of children in parents care should not outweigh the interests of parents themselves. Courts in England and Wales have on several recent occasions affirmed the right of a pregnant woman to refuse to medical treatment even if may imperil the life of her unborn child . . . .'

[83] Respondent's counsel is correct in my view when he contended that in the circumstances of this case, the court should 'strike a balance' between the competing rights of Mrs ES and the children. To confine the enquiry in this case to the principle of patient autonomy, the majority has distorted the question the case presents. In all the cases referred to in paras [67] and [68] of this judgment from the various states of the USA, including the celebrated Canadian case on point of *Malette v Shulman,* supra, undoubtedly show how the courts laboured in the balancing exercise between the patients express wishes on the one hand and the societal interests on the other.

[84] Closer to home is the *South African case of Christian Education South Africa v Minister of Education* 2000(4) SA 757 CC, referred to by counsel for the respondent. It involved the prohibition of

corporal punishment in schools on the one hand and the rights of the parents in independent schools who considered the administration of corporal punishment to be required by their religious beliefs. The court found that corporal punishment administered in schools would be an infringement of ss 9 (equality), 10 (dignity), 12 (freedom and security of the person) and 28 (the right of the child to be prohibited from maltreatment, neglect, abuse or degradation) of the South African Constitution.

[85] At 768A-D the Constitutional Court stated:

> '[15] It is clear from the above that a multiplicity of intersecting constitutional values and interests are involved in the present matter– some overlapping, some competing. The parents have a general interest in living their lives in a community setting according to their religious beliefs, and a more specific interest in directing the education of their children. The child, who is at the centre of the enquiry, is probably a believer and a member of a family and a participant in a religious community that seeks to enjoy such freedom. Yet the same child is also an individual person who may find himself "at the other end of the stick", and as such be entitled to the protections of ss 10, 12 and 28'.

At 775E-E the court continued to say:

'(a) The test to be applied

[29] I turn now to the question of whether the limitation on the rights of the appellants can be justified in terms of s 36, the limitations clause. The appellant argued that once it succeeded in establishing that the Schools Act substantially impacted upon its sincerely held religious beliefs, the State was required to show a compelling State interest in order to justify its failure to provide an appropriate exemption. This formulation correctly points to the need for a balancing exercise to be done, but establishes a standard that differs from that required by s 36. The proposed formulation imports into our law a rigid "strict scrutiny" test taken from American jurisprudence, a test which I add, has been highly controversial in the United States. The test requires any legislative provision which impacts upon the freedom of religion to be serving a "compelling State interest". A similar test has been adopted in relation to classifications based on race'. (My emphasis.)

[86] The ‘strict scrutiny test’ is the balancing test the USA State Courts adopted in the various cases referred to in paras 67 and 68 *supra*. In *Christian Education South Africa,* the court cited a Canadian case of *P v S* 108 DLR (4th) 287 and the US Supreme Court case of *Prince v Massachusetts* 321 US 158 (1944). In *P v S* the court, amongst other things stated: ‘As the court has reiterated many times, freedom of religion, like any freedom, is not absolute. It is inherently limited by the rights and freedom of others. Similar sentiments were echoed in the Prince matter when the Court said ‘and neither rights of religion nor rights of parenthood are beyond limitation’. Consequently the appellants’ claim was dismissed.

The right of freedom of religion of Mrs ES impacts on the rights of her children to be cared for and I do not see how the majority distinguishes or finds that this case do not revolve around Mrs ES’s children’s best interests.

[87] In the Canadian case of *Malette v Shulman,* Mrs Malette a Jehovah's witness was involved in a car accident in which her husband died. She was taken to a local hospital where she was attended to by various nurses, physicians including Dr Shulman. She was semi-conscious and in shock, with profuse facial bleeding. A card was found by nurses in Mrs Malette's purse, flatly forbidding, under any circumstances, any form of blood transfusion, while authorising the use of various alternative non-blood therapies. Dr Shulman was informed of the situation but contrary to Mrs Malette's wishes Dr Shulman administered blood transfusion himself. After some weeks she recovered. She sued Dr Shulman, the hospital and others for negligence, for assault based on religious discrimination and conspiracy. Her claim was upheld against Dr Shulman only. Dr Shulman appealed.

[88] In the analysis of the four societal interests above as against the express wishes of Mrs Malette the Ontario Supreme Court, Court of Appeal reasoned as follows:

> '31. I should emphasize that, in deciding this case, the Court is not called upon to consider the law that may be applicable to the many situations in which objection may be taken to the use or continued use of medical treatment to save or prolong a patient's life. The Court's role, especially in a matter as sensitive as this, is limited to resolving the issue raised by the facts presented in this particular case. On these facts, we are not concerned with a patient who has been diagnosed as terminally or incurably ill who seeks, by way of advance directive or "living will," to reject medical treatment so that she may die with dignity; neither are we concerned with a patient in an irreversible vegetative state whose family seeks to withdraw medical treatment in order to end her life; nor is this a case in which an otherwise healthy patient wishes, for some reason or other, to terminate her life. There is no element of suicide or euthanasia in this case.

> 33. In the absence of an informed refusal, the appellant submits that Mrs Malette's right to protection against unwanted infringements of her bodily integrity must give way to countervailing societal

interests which limit a person's right to refuse medical treatment. The appellant identifies two such interests as applicable to the unconscious patient in the present situation: first, the interest of the state in preserving life and, second, the interest of the state in safeguarding the integrity of the medical profession.

34. The state undoubtedly has a strong interest in protecting and preserving the lives and health of its citizens. There clearly are circumstances where this interest may override the individual's right to self-determination. For example, the state may, in certain cases, require that citizens submit to medical procedures in order to eliminate a health threat to the community or it may prohibit citizens from engaging in activities which are inherently dangerous to their lives. But this interest does not prevent a competent adult from refusing life-preserving medical treatment in general or blood transfusion in particular.

35. The state's interest in preserving the life or health of a competent patient must generally give way to the patient's stronger interest in directing the course of her own life.

36. Safeguarding the integrity of the medical profession is patently a legitimate state interest worthy of protection. However, I do not agree that this interest can serve to limit a patient's right to refuse blood transfusion. I recognize, of course, that the choice between violating a patient's private convictions and accepting her decision is hardly an easy one for members of a profession dedicated to aiding the injured and preserving life. The patient's right to determine her own medical treatment is, however, paramount to what might otherwise be the doctor's obligation to provide needed medical care.

> 37. In sum, it is my view that the principal interest asserted by Mrs Malette in this case -- the interest in the freedom to reject or refuse to consent to intrusions of her bodily integrity -- outweighs the interest of the state in the preservation of life and health and the protection of the integrity of the medical profession. While the right to decline medical treatment is not absolute or unqualified, those state interests are not in themselves sufficiently compelling to justify forcing a patient to submit to nonconsensual invasions of her person. The interest of the state in protecting innocent third parties and preventing suicide are, I might note, not applicable to the present circumstances'.

[89] In *Re Dubreuil*, 603 50. 2d 538 (Fla. 4th DCA 1992) the district Court (Florida) held that a married but separated woman who chose not to receive a blood transfusion for religious reasons could be compelled to receive medical treatment because her death would cause the abandonment of four minor children. In *Re Dubreuil*, *supra*, the Supreme Court of Florida reversed holding that there was no abandonment proved to override the patient's constitutional rights. The Supreme Court reversed for two reasons, namely, first, under the Florida law there is presumption that had Mrs Patricia Dubreuil died, Luc her estranged husband would have become the sole legal

guardian of the couple's four minor children and would have taken care of the minor children. Secondly, there was no evidence presented as to whether anyone else, including the families of Luc and Patricia, would take responsibility for the children and that Mrs Dubreuil had stated in her affidavit that extended family members and friends were willing to assist in raising the children in the event of Mrs Dubreuil's death.

[90] Interesting is the argument Mrs Dubreuil had raised and the court sketched the argument thus:

> 'In her argument to this Court, Patricia urges us to eliminate from this line of cases any consideration given to the state interest in protecting innocent third parties from abandonment, claiming that it is inherently unsound and dangerous and cannot be consistently applied. She argues, for example, that it will lead beyond blood transfusions to major medical procedures ranging from caesarean sections to heart bypass surgery; or it will allow courts to compel a pregnant Catholic woman who is the single parent of a minor child to have an abortion against her religious beliefs if taking the pregnancy to term would endanger the mother's life. She also argues that the rule eventually will go well beyond the protection of minor children, compelling a single adult, who cares for her dependent elderly parent or

grandparent to receive unwanted medical treatment in order to advance the state interest in protecting the elderly dependent.

Patricia's argument has some merit. Parenthood, in and of itself, does not deprive one of living in accord with one's own beliefs. Society does not, for example, disparage or preclude one from performing an act of bravery resulting in the loss of that person's life simply because that person has parental responsibilities.

Nonetheless, we decline at this time to rule out the possibility that some case not yet before us may present a compelling interest to prevent abandonment. Therefore, we think the better course is the one we took in *Wons*, where we held that "these cases demand individual attention" and cannot be covered by a blanket rule. *Wons*, 541 So. 2d, at 98.' (My emphasis.)

[91] In *Fosmire v Nicoleau, supra*, regarding the societal interest in protecting minor children the court put it as follows:

> 'Clearly, in any case in which the State's interest in protecting minor children is involved, the court's determination is a particularly sensitive one and requires a most careful review of all relevant factors. Despite the concerns expressed by our concurring colleague, we are not fashioning a rigid rule to be followed blindly in every case in which there exist a surviving parent and extended family. We recognize that the court must be allowed wide latitude and broad flexibility in this area because of the endless variety of human situation which can be presented in cases of this nature. There are no preordained answers and the result in any case will be totally dependent upon the unique facts involved therein. In the case at bar, however, it would appear that the State's interest in the protection of Mrs. Nicoleau's minor child would be satisfied given the existence of a concerned and interested surviving parent, who is financially capable of supporting the child, and the existence of an involved and attentive extended family.

> Finally, we emphasize that a court in addressing an application to administer blood transfusions has a responsibility to undertake the delicate and sensitive task of balancing the express wishes of the patient with the identified compelling state interests and should do so only after conducting the most extensive inquiry possible under circumstances'. (My emphasis.)

[92] Sullivan J concurring raised the concerns referred to above and he went about saying:

> 'However, I write separately to express my view that the protection of innocent third parties, which is generally recognized as the third of the

compelling State interests that can serve to override the expressed wishes of an individual patient, is broader than that suggested by my colleagues. This interest was set forth by Circuit Judge J. Skelly Wright in Application of President & Directors of Georgetown Coll. (331 F.2d 1010, cert denied sub nom. *Jones v President & Directors of Georgetown Coll.* 377 U.S. 978). In a case remarkably similar to the matter at hand, Judge Wright functioned as the court of first instance. Mrs. Jessie Jones, the 25-year-old mother of a seven-month-old child, had lost two thirds of her body's blood supply from a ruptured ulcer. Both Mrs. Jones and her husband were Jehovah's Witnesses and were forbidden by the tenets of their religion from consenting to blood transfusions under any circumstances. Judge Wright, after advising Mr. Jones to obtain counsel, conducted an appropriate bedside inquiry and, after undertaking the delicate and sensitive task of balancing, ordered such blood transfusions as the doctors should determine were necessary to save her life.

In setting forth the analysis supporting his decision, Judge Wright discussed each of the compelling State interests and their applicability to the case of Mrs. Jones. Despite the fact that Mr. Jones was apparently available to care for the seven-month-old child, Judge Wright concluded that the State had a compelling interest in preserving the life of Mrs. Jones for the benefit of her child, observing as follows: "The state, as *parens patriae*, will not allow a parent to abandon a child, and so it should not allow this most ultimate of

voluntary abandonments. The patient had a responsibility to the community to care for her infant. Thus the people had an interest in preserving the life of this mother" (Matter of *President & Directors of Georgetown Coll*., 331 F.2d 1000, 1008, supra. . . .)

This case has been repeatedly cited with approval by the courts of this State in delineating the compelling State interests that will override the right of a competent adult to refuse lifesaving medical treatment (see, Matter of *Storar*, 52 N.Y.2d 363, 377, n 6; Matter of *Delio v Westchester County Med. Center*, 129 AD 2d 1; Matter of *Eichner* [Fox], 73 AD 2d 431, mod 52 N.Y. 2d 363; Matter of *Melideo*, 88 Misc. 2d 974; Matter of *Winthrop Univ. Hosp. v Hess*, 128 Misc. 2d 804). Such a body of decisions would seem to represent a settled principle of law. Unfortunately, the majority has recast this principle in a manner which I believe does not comport with these prior decisions or with the oft-stated public policy aimed at keeping family units viable and intact.

The majority's present suggestion that the existence of a concerned and interested surviving parent and an extended family satisfies the State's interest in protecting innocent third parties so that the parent-patient may forego life-saving treatment is totally at odds with the facts and rationale of *Application of President & Directors of Georgetown Coll*. (*supra*), Matter of *Winthrop Univ. Hosp. v Hess* (supra), and Matter of *Melideo* (*supra*). To suggest that the State will permit a child to lose one parent as long as there is a surviving parent and/or others to care for the child appears to run contrary to our own statement in Matter of *Delio v Westchester County Med. Center* (129 AD 2d 1, 25, supra . . . , that "the State's interest may well be superior to an adult's right of self-determination when the exercise of that right deprives dependents of a source of support and care."

I do not believe that the single statement supporting the majority view found in *Randolph v City of New York* (117 AD 2d 44, 50, mod 69 N.Y. 2d 844) is persuasive. This statement is made in the context of a medical malpractice case, is not accompanied by any supporting analysis or reasoning, and does not refer to any legislative or judicial authority to bolster the proposition it sets forth. I do not think that the public policy of this State concerning such a sensitive and vital subject should be altered without the most careful and considered reasoning. I fear that the change in established law propounded by the majority is unwarranted and may ultimately prove to be the source of much mischief.'

[93] *Fosmire v Nicoleau*, is the only case of the cases I did research on, which held that the interest in protecting minor children will never be allowed to override the right of a competent individual to refuse medical treatment. The Court's explanation was that 'at common law' the patient's right to decide the course of treatment was not conditioned on the patient(s) being without minor children or dependents.

[94] In *Re 'T'* (1992) EWCA Civ 18 (30 July 1992) the Supreme Court of Judicature Court of Appeal (Civil Division) (England and Wales) reiterated the doctrine of 'informed consent' and further said, 'the only possible qualification is a case in which the choice may lead to the death of a viable fetus'. The Master of the Rolls went on to say:

> ‘26 This situation gives rise to a conflict between two interests, that of the patient and that of the society in which he lives. The patient’s interest consists of his right to self-determination – his right to live his own life how he wishes, even if it will damage his health or lead to his premature death. Society’s interest is in upholding the concept that all human life is sacred and that it should be preserved if at all possible. It is well established that in the ultimate the right of the individual is paramount. But this merely shifts the problem where the conflict occurs and calls for a very careful examination of whether, and if so, the way in which the individual is exercising that right. In case of doubt, that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, he must do so in clear terms.’

[95] In this case Mrs ES brought an application to rescind an order by Parker J granted on 13 September 2012, appointing Mr AC as a curator to the person of Mrs ES and the order authorised Mr AC to instruct a medical practitioner(s) to render appropriate medical treatment to Mrs ES and consent to any such medical procedure on her behalf, such medical procedures to include a blood transfusion and any other procedure and/or treatment considered appropriate by such medical practitioner(s). Mr AC filed a counter application to the rescission application.

[96] It is common cause that Mrs ES being a Jehovah's Witness refused blood transfusion in accordance with the tenets of her faith. She had just delivered by caesarian section a premature baby and had lost a significant amount of blood. Except for reiterating that she was a Jehovah's Witness, why in her faith drinking of blood is prohibited, that the order of 13 September 2012 was obtained without her knowledge and the durable power of attorney for health care she signed prohibiting any transfusion of blood, nothing was stated about what would happen to her children in the event that she died. However I accept that it appears from the record before us that Mr S undertook that he would have continued to carry out his parenting duties in the event of Mrs ES's death.

[97] Mr AC's counter application was a reiteration of the contents of the court order of 13 September 2012. He did not file an affidavit but testified orally. It is undoubtedly that he was speaking on behalf of the C family in its extended form. He testified that as the elder brother of that family, a father to his young brother and sisters and that he had the responsibility to do whatever it takes to save the life of his sister and in the same vein save the life of her children. I take up the narrative in his own words as conveyed to the court. 'We believe that

children need the care and the love of the parents, and if she is not there they will not have that care and that love, we grew in societies where we saw children without parents, particularly in Africa suffering tremendously, even in cases where children after the mother dies and the father marries a second wife which is probably what could happen, these children will suffer . . . a man can cry for a week or two and when he is through that he gets another wife and marries but his children will suffer forever because there was no responsibility or responsible attitude to make sure that a mother is there to care for them . . ., she said I do not want to die, so we understood from that statement that we had a common bottom line, we want life'.

[98] Mr AC also testified that he realised that Mrs ES underwent a lot of pressure from members of her faith who were advising her and one member of her faith had to be forcefully removed from the hospital where Mrs ES was a patient. In cross-examination Mr AC was asked whether he was advocating that if people in life take decisions which he did not agree with as a family member which might eventually cause their deaths, people should go to court to protect the nation. His reply was:

> ‘I belief as I said it earlier if one decides to take his life, for she would not be the first, there are people hang themselves, they have decided, but you know I said it and I will say it again, when we are also infringing to other people’s rights, because children has rights, we have rights and as nationals we also have rights, so here we are looking at a situation where it is not just the right of one person but it is the right of all of us that is being at stake, now if we miss this opportunity as a nation as a people to speak for the voiceless, if we miss this opportunity to speak for those children, on behalf of those children it will become a disgrace for our nation, for I belief in Namibia we uphold the rights of children and for that I believe our nation will do anything to protect the rights of this children and I would like to do what the nation does and that is why I am here’.

[99] Mr AC was further asked a funny question in my opinion, whether when an individual takes an autonomous decision, he/she should consider America, because autonomous means decisions taken for oneself and such a decision was not the court’s business unless there is a direct involvement for instance a minor who cannot take decisions or a fetus in the mother, Mr AC’s reply was:

> ‘I believe Sir you may not be understanding what I am saying, there is a 7 or 8 days born baby who has not known a mother, could be as good as a fetus in the womb, it is the same, has not known her mother, has not felt the touch of the mother, what will happen to this child, sorry if I should ask, do you have a mother?. . . . but I believe if you do have a mother, you know what it is to have a mother, and I live in a continent called Africa where because of the war so many people lost their mothers and those who lost their mother they could not find them, themselves anymore, some went astray, became what we now have people in the streets doing evil and the nation fights to solve the problem, but I believe the answer is that if our children are raised properly by the two parents we will have a healthy nation.’

[100] He was asked whether a lady of 33 years old without a husband, without family and without children, will she be entitled as a Jehovah’s Witness to refuse blood transfusion and his reply was this:

> ‘--- I am not sure if you understood what I said before, let me try and repeat, anyone including yourself can be a Jehovah Witness and I will

> not object to that, neither my religion will do, but what are you saying, you will be a Jehovah Witness as much as you can, as much as you want and we believe God that your faith will take you where you want to go, we do not argue that, but what were you saying is whilst we have our religion let us consider the rights of others and that is more critical than being selfish and decide to terminate ourselves and infringe to the rights of other and bring a disaster, I believe this is a disaster to the nation, I am not sure what the world will say if this nation will say fails to look at particularly the rights of children. . . . And it is time that somebody speak for the voiceless, let us hold our religions steadfastly, but let us respect the rights of others'.

[101] Mr AC is on point in my opinion. 'Personhood should encompass the freedom to do everything which injures no one else, as soon as any part of a person's conduct affects prejudicially the interests of others, society has jurisdiction over it, and the question whether welfare will or will not be promoted by interfering with it becomes open discussion. But there is no room for entertaining any such question when a person's conduct affects the interests of no persons besides himself'. Glennon M J, A Constitutional Law Anthology, 1992, Anderson Publishing Co at 72.

[102] Mrs ES has a right to practice her religion or any religion for that matter. She also, as already stated, has a right to parenthood. All the doctors who attended to her, including doctors who filed affidavits in her application, agreed that in the condition she was, blood transfusion was the treatment appropriate to treat her ailment. There was no controversy or contest to the fact that her life hung in the balance. At that point her right to her religious beliefs and her right to parenthood were at crossroads. She was prepared even where death ensued to respect her religious beliefs but her application is silent on what would happen to her children if she died. I have accepted that Mr and Mrs ES had spoken about the children and that Mr S would have taken care of the children if she had died. But there was no evidence whether Mr S was working or not or what his financial position was and who was going to assist him in raising the children. It must be remembered that in the African context families are either of the female or male line of descent (matrilineal or patrilineal). If for example, the respondent's family were matrilineal, Mr S would have surrendered the children to the respondent's family, the family that so much wanted to save the life of Mrs ES. In that case, Mr S would have re-married and moved on with his life as if he never had children from a previous marriage. Mr AC made a point that the children would suffer if their

mother was no more. Mr AC particularly emphasised the condition of the newly born baby. He testified that for a week or more the baby had not felt the love of its mother. She could not breastfeed because of the condition she was in. Prof Pieper whose evidence is accurately summarised in para [32] above testified that a quick recovery (induced by blood transfusion) would probably lead to better bonding between Mrs ES and her premature newborn baby, who at that stage was being treated in an incubator. Clearly, a newborn have a significant special need for his or her mother. This is a clear case in my view given the foreign authorities referred to above where the rights of Mrs ES's newly born baby and its siblings were compelling to override her express wishes to refuse blood transfusion. The order to administer blood was justified under the circumstances albeit for different reasons.

[103] In *Kruger and Another v Minister of Correctional Services and Others* 1995(2) SA 803 (TPD) the President had passed a decree granting amnesty to imprisoned mothers with minor children. The decree was challenged by fathers with minor children as a potential violation of the equality clause. Some extracts of the President's affidavit motivating his decision to single out imprisoned mothers only, are reflected at 805F-I and 806B as follows:

‘With regard to the special remission to all mothers with minor dependent children under the age of 12 years, I was motivated predominantly by a concern for children who had been deprived of the nurturing and care which their mothers would ordinarily have provided . . . I respectfully draw attention to the fact that the well-being of young children has been of particular concern to me and was an important factor in identifying two of the three categories in the Presidential Act. Shortly before the signing of the Presidential Act I stated the following in a speech delivered on 16 June 1994:

> “Our policies must turn into reality the principle that every child deserves to have a decent home and be brought up in the loving care of a family. The terrible legacy of street children has to be attended to with urgency. A collective effort has to be launched by the Government, civil society and the private sector to ensure that every child is looked after, has sufficient nutrition and health care. The Government has already started taking steps in this regard.”

> I have an ongoing concern about the general plight of young children in South Africa. There have been many occasions upon which I have expressed this concern publicly'.

[104] Van Schalkwyk J dismissed the application holding partly that, '[I]t seems to me then that provided the executive has a plausible explanation for what has been done the Court will not interfere'.

[105] The concern about the wellbeing of children in Namibia is well documented in clauses on children and family in chapter three of the Constitution, the Children's Status Act 6 of 2006 and the Child Care and Protection Act 3 of 2015. This Court as the upper guardian of children should make the constitutionalising of children's rights a reality. A democratic society rests for its continuance, upon the healthy, well-rounded growth of young people into full maturity as

citizens, with all that implies, *Prince v Massachusetts*, 321 U.S. 158 (1944).

[106] The majority hold that 'the right to choose what can and cannot be done to one's body, whether one is a parent or not, is an inalienable human right. Were courts to hold that the right of parents to exercise this right would be limited in the best interest of children, the logical endpoint maybe that parents of young children should not be employed in the armed forces, that they should be prohibited from engaging in high risk sports, or publicly censured for consuming non-prescribed drugs and alcohol'. That 'the most extreme application of this principle might require a parent being compelled to undergo an operation for the purposes of organ donation if his or her child requires a kidney to survive. Even though as a society we recognise and promote the importance of families and relationships, this court is also compelled to protect the liberty, self-determination and dignity of the individual, especially in matters where medical treatment to one's own

person is concerned'. That 'the principle of patient autonomy must be the overriding principle that guides the courts in cases such as the one presently before court'.

[107] With greatest respect, the court's almost obsessive focus on the principle of patient autonomy is particularly hard to justify in the light of the circumstances of the case. I have no quarrel with the principle, it is settled law and requires no repetition. But where the right competes with other rights as were the case here, it may be limited. In as much as 'the concept of privacy embodies the moral fact that a person belongs to himself and not others nor to society as a whole', *Thornburgh v American College of Obstetricians & Gynecologists* 476 US at 777, n. 5 'parenthood alters so dramatically an individual's self-definition . . . .' *Bowers, Attorney General of Georgia v Hardwick et al*, 478 US 186, and 'we protect the family because it contributes so powerfully to the happiness of individuals . . . .' *Bowers, Attorney General of Georgia v Hardwick et al*, *supra*, Mr

AC's application as the majority correctly observed was 'well-meaning and bona fide' the court *a quo* was correct in holding in his favour.

[108] Those who engage in dangerous form of employment, sport or activity do so either, it is a career path and the only source of income for them and their families, or for patriotism, for entertainment, acclaim fame or for any other reason. But while they may appreciate the dangers associated with the activity, they do not wish to die, for if they so wished, their participation would be with the intention to commit suicide. On the argument of donation of organs by parents to save the life of a child, I do not see a reasonable court of justice endangering the life of one person to save that of the other by making such an order. But if such an order were to be made it would be influenced by the prevailing circumstances.

[109] The court concludes today that patient autonomy enjoys a preferred position in our law to the children's right to be cared for by their parents. I fear that the conclusion has risks and as Sullivan J observed in *Fosmire v Nicoleau*, *supra*, may ultimately prove to be the source of much mischief. I adopt the dissent opinion of Justice McDonald in Dubreuil, *supra*, as my own, when he said:

> 'The children's right to have a mother outweighs the mother's right to observe her religious beliefs. I suggest that parenthood, under some circumstances at least, can indeed deprive one of the right to live in accord with one's own beliefs. Parenthood requires many adjustments and often great sacrifice for the welfare of a person's children. Nearly every living creature of every species recognises the duty to nurture its offspring. Their lives are changed in doing so. Humans should not allow religious beliefs, no matter how deeply seated or appropriately held, to neglect this fundamental duty. Mothers do not abandon the nest'.

[110] I find that the right of Mrs ES's children in preventing their mother Mrs ES from abandoning them through death is sufficient

justification for having ordered the blood transfusion. As Justice Overton had stated in the *Wons* matter above, to justify, as a right of the free exercise of religion, a parent's right to abandon a minor child through death which is totally unnecessary, is in my view, neither a reasonable nor a logical interpretation of Articles 14(3) 15(1) and 21(c). The majority effectively condoned child abandonment if a parent's decision is made for religious reasons. Regrettably, I cannot support a judgment that endorses, as I believe this judgment does, the right to patient autonomy without equal recognition of the right of children to know and be cared for by their parents.

[111] Consequently I would have refused the order of the High Court dated 13 September 2012 for reasons given by the majority judgment and I would have upheld the order of the High Court dated 25 September 2012 dismissing Mrs ES's application and granting the counter-application of Mr AC for reasons given in my judgment.

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MAINGA, JA

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32. APPEARANCES

33.

34. APPELLANT: O R Daniel (with him A F Bodill)

35. Instructed by LorentzAngula Inc.

36.

37. RESPONDENTS: A W Corbett

38. Instructed by Du Plessis, De Wet & Co.