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Minors' consent to medical treatment

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Terms of Reference

In a letter to the Commission received on 14 August 2002, the Attorney General, the Hon R J Debus MP referred the following matter:

To inquire into and report on the laws relating to the consent of minors in New South Wales to medical treatment, with particular reference to:

(a) whether the rights and interests of minors and of parents and guardians are appropriately recognised;

(b) whether medical practitioners are adequately protected;

(c) whether codification and/or amendment of the law is necessary; and

(d) any related issues.

Participants

Division Members

Pursuant to section 12A of the *Law Reform Commission Act 1967* (NSW) the Chairperson of the Commission constituted a Division for the purpose of conducting the reference. The members of the Division are:
The Hon Justice Michael Adams
Associate Professor Jane Goodman-Delahunty
Master Joanne Harrison
Hon Justice David Hodgson
Hon Gordon Samuels AC CVO QC
Professor Michael Tilbury (Commissioner-in-Charge)

National Expert Advisory Panel

Ms Amanda Adrian	Former Commissioner, NSW Health Care Complaints Commission
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Professor Mary Chiarella	Chief Nursing Officer, NSW Department of Health
Professor John Devereux	Faculty of Law, The University of Queensland
Dr Michael Fairley	Sydney Children's Hospital
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Submissions

The Commission invites submissions on the issues relevant to this review, including but not limited to the issues raised in this Issues Paper.

Making a submission

There is no special form required for submissions. If it is inconvenient or impractical to make a written submission you may contact the Commission and either direct your comments to a Legal Officer over the telephone, or arrange to make your submission in person.

The closing date for submissions is 31 August, 2004.

All submissions and enquiries should be directed to:

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Confidentiality and use of submissions

In preparing further papers on this reference, the Commission will refer to submissions made in response to this Issues Paper. If you would like all or part of your submission to be treated as confidential, please indicate this in your submission. The Commission will respect requests for confidentiality when using submissions in later publications.

Copies of submissions made to the Commission will also normally be made available on request to other persons or organisations. Any request for a copy of a submission marked "confidential" will be determined in accordance with the *Freedom of Information Act 1989* (NSW).

Other publication formats

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Issues

Refer to the pages indicated below for a discussion of the issues listed.

Issue 1.1 (page 22)

Do you agree, or disagree, with the following definitions of key words and phrases in the Commission's terms of reference?

- "Minor": A person from birth to age 18. *(See paragraph 1.36)*
- "Parents or guardians": Any person or people who stand in the legal position of a parent to a young person, whether it be the natural parent, the adoptive parent, or the legal guardian. *(See paragraph 1.37)*
- "Consent": the agreement that is necessary to make lawful what would otherwise be a trespass to a young person's person, and includes the notion of refusal of medical treatment. *(See paragraph 1.38-1.43)*
- "Medical treatment": Any service provided by a registered medical practitioner, or under the ultimate supervision of a registered medical practitioner. *(See paragraph 1.44-1.48)*
- "Medical practitioner": Any person registered as a medical practitioner under the *Medical Practice Act 1992* (NSW). *(See paragraph 1.49)*

Issue 1.2 (page 23)

How should the terms "medical treatment" and "medical practitioners" be defined in the context of a discussion of young people's right to make decisions about their medical care?

Issue 2.1 (page 32

Should medical practitioners be offered a broader protection from civil and criminal liability when treating young people than that currently offered by s 49 of the *Minors (Property and Contracts) Act 1970* (NSW)?

Issue 2.2 (page 33)

Does s 49(2) of the *Minors (Property and Contracts) Act 1970* (NSW) offer any additional protection from liability for medical practitioners than that already provided by the common law?

Issue 2.3 (page 34)

Does s 49(1) of the *Minors (Property and Contracts) Act 1970* (NSW) offer any additional protection from liability for medical practitioners than that already provided by the common law?

Issue 2.4 (page 36)

Should young people and their parents have coexisting rights to consent to the medical treatment of the young person? If so, in what circumstances?

Issue 2.5 (page 43)

Should a different legal regime apply to young people aged 16 and over, than that which applies to young people below the age of 16, to determine when they can consent to or refuse medical treatment, and to determine who can consent to or refuse medical treatment on their behalf if they are not legally competent to make that decision themselves?

Issue 2.6 (page 47)

Should the law distinguish between the ability of young people, their parents or the courts to consent to the medical treatment of young people and to refuse to undergo such treatment?

Issue 3.1 (page 51)

In what situations, if any, should young people be able to make their own decisions about their medical care?

Issue 3.2 (page 56)

(a) Should the law assess a young person's competence to consent to medical treatment in terms of the individual young person's understanding of the nature and possible consequences of the proposed medical treatment, as put forward in Model One of the Commission's Options for Reform?

(b) Is there a more appropriate formulation of the test put forward in Model One? For example, should the focus be more on the reasoning process by which the young person reaches a decision about treatment, with an assessment of his or her ability to consider and weigh up various alternatives?

(c) Should the law spell out the level of understanding that a young person must demonstrate in order to be competent according to the test put forward in Model One and, if so, how?

(d) Would it be helpful to prescribe guidelines by which the treating medical practitioner can assess the individual patient's degree of understanding under this test?

Issue 3.3 (page 56)

(a) Does Model One of the Commission's Options for Reform place too much discretion in the medical practitioner's hands and too much faith in the medical practitioner's ability to assess the young person's level of maturity?

(b) Does Model One place too much emphasis on the young person's right to autonomy at the risk of exposing him or her to the consequences of a detrimental decision?

Issue 3.4 (page 57)

(a) Could a requirement for a second medical opinion in Model One of the Commission's Options for Reform become simply a "rubber stamp", where approval is granted as a matter of course?

(b) Would such a requirement place too great a burden on medical practitioners, particularly in more isolated, rural areas, to seek a second opinion?

(c) Would such a requirement discourage young people from seeking medical treatment if they knew that the details of their consultation were likely to be disclosed to another medical practitioner?

Issue 3.5 (page 57)

(a) Is it practical to include a safeguard in Model One of the Commission's Options for Reform that gives an "interested person" a right to challenge a medical practitioner's decision about competence in court?

(b) Is there any way in which parents, and other interested people, could be made aware of a medical practitioner's decision before the medical treatment is carried out without compromising the medical practitioner's duty of confidentiality to the young person?

(c) Could a provision, which allowed parents and others to challenge a medical practitioner's assessment of competence, discourage young people from seeking medical assistance?

(d) Are there other safeguards that could be included in Model One, which would be effective in limiting the power vested in the individual medical practitioner in determining a young person's competence to consent or refuse?

Issue 3.6 (page 58)

(a) If a young person is sufficiently mature to understand the nature and consequences of the medical treatment proposed, should that be enough to validate his or her consent, or refusal, according to Model One of the Commission's Options for Reform?

(b) Is a qualification justifiable that requires young people's decisions about their medical care to be in their own best interests before their consent or refusal becomes legally valid?

(c) If a young person's legal competence to consent, or refuse, is made subject to that consent or refusal being in his or her best interests, how are those best interests to be determined, and by whom?

Issue 3.7 (page 59)

How is Model One of the Commission's Options for Reform to be distinguished from the notion of "informed consent" in the law of medical negligence? Should a medical practitioner be required to disclose the "material risks" of a particular type of medical treatment in order to be satisfied of a young person's competence to consent?

Issue 3.8 (page 60)

(a) Is there any greater likelihood of error in assessing legal competence using a fixed age test, as in Model Two of the Commission's Options for Reform, than in a test that requires the treating medical practitioner to make a judgment about the maturity of an individual patient, as in Model One?

(b) Are concerns about denying young people below the cut-off age proper access to health care adequately met by formulating a list of medical procedures to which a person younger than the cut-off age can consent as exceptions to the general, fixed age rule?

(c) If Model Two were adopted, what would be an appropriate age to fix as the cut-off age? The most common choice in other jurisdictions is 16, although some jurisdictions have fixed the age at 14.

Issue 3.9 (page 61)

(a) Does Model Three of the Commission's Options for Reform find a suitable balance between young people's right to autonomy, parents' interests in protecting and guiding their children and the State's responsibility to protect its young?

(b) Is Model Three too complicated to be workable in practice?

Issue 3.10 (page 62)

Should the type of medical treatment in issue determine a young person's ability to consent to, or refuse, medical treatment, either as a principal or a subsidiary test for legal competence? If so, which types of treatment should a young person be automatically considered competent to consent to, or refuse?

Issue 3.11 (page 63)

(a) Should any or all of the following groups of young people, as listed in Model Five of the Commission's Options for Reform, be considered competent to consent to or refuse medical treatment, regardless of whether they meet the criteria in any general test for assessing legal competence?

- Young people who are married or living in a de facto relationship;
- Young people who are parents;
- Young people who live apart from their parents and manage their own financial affairs;
- Young people who are homeless.

(b) Are there any other groups of young people who should always be able to give personal consent or refusal to medical treatment?

(c) Should these groups of young people be able to consent to or refuse medical treatment as if they were adults, or should there be an additional requirement that the medical practitioner consider the treatment in question, or refusal of that treatment, to be in the patient's best interests?

Issue 3.12 (page 63)

(a) Are there any other models for reform that are not included in the five models set out in Chapter 3, which might be effective in determining young people's legal competence to make decisions about their medical care?

(b) Which, if any, features, or indicators, of the five models listed in Chapter 3, would you consider useful to retain in any alternative model for reform?

Issue 3.13 (page 66)

(a) Assuming that young people should be considered in some situations legally competent to refuse medical treatment, should the same test apply to decide a young person's legal competence to refuse as the test to determine competence to consent to treatment?

(b) If a different test should apply, how should a test to determine competence to refuse be formulated?

Issue 3.14 (page 69)

(a) Should a young person of any age be able to consent to any of the following four types of medical treatment without requiring parental consent:

- contraceptive advice and prescription (excluding permanent or long-lasting forms of contraception);
- treatment for sexually transmitted diseases;
- treatment for drug and alcohol abuse;
- mental health services?

(b) Should a young person of any age be able to consent to mental health treatment to prevent a risk of suicide, without requiring parental consent? Should a young person be able to consent to mental health treatment where there is no immediate risk of suicide, without parental consent?

(c) Should a young person be able to refuse any of the forms of treatment listed above in (a)?

(d) If the law recognises a young person's right to give personal consent to any of the forms of treatment listed in (a), should there be an additional requirement that the medical practitioner be satisfied that the treatment is in the young person's best interests?

(e) Should parents be able to consent to, or refuse, any of the four forms of treatment listed in (a), on behalf of their child? Should parents be able to veto a consent given by their child for any of these forms of treatment? Should a young person be able to veto a consent, or refusal, of his or her parents for any of these four forms of treatment?

Issue 3.15 (page 70)

(a) Should all young women below 18 be deemed competent to consent to a termination of pregnancy?

(b) Should all young women below 18 be deemed competent to refuse a termination?

(c) What legal role, if any, should the young woman's parents play in the decision whether or not to terminate her pregnancy?

Issue 3.16 (page 71)

(a) Should all pregnant young women below 18 be considered competent to consent to pregnancy-related health care?

(b) Should all pregnant young women below 18 be considered competent to refuse pregnancy-related health care?

(c) What role, if any, should the young woman's parents play in making decisions about her antenatal care?

Issue 4.1 (page 73)

Is there adequate provision in the current law for settling disputes between parents about their child's medical care?

Issue 4.2 (page 74)

Should medical practitioners be excused from liability in battery or assault for acting on the consent of one parent only?

Issue 4.3 (page 75)

(a) Should a caregiver or relative other than a young person's parents have authority to consent to or refuse medical treatment for the young person?

(b) If so, in what situations should the law recognise the right of someone other than a parent to make medical decisions for a young person?

(c) Is there adequate provision in the *Family Law Act 1975* (Cth) for the law to recognise the authority of someone other than a young person's parents to make decisions about that young person's medical treatment?

Issue 4.4 (page 80)

(a) Should the common law have any role in limiting the types of medical treatment to which parents can consent or would it be preferable, or even possible, to spell out in legislation the medical procedures for which authorisation from an external body is required, or at least to list in legislation the criteria for deciding whether a particular procedure requires such authorisation?

(b) Should legislation specify certain medical procedures that should not be carried out on a young person until the young person is legally competent to consent to it personally, unless there are sound medical reasons for carrying out the procedure before that time? For example, should legislation prohibit gender-assigning surgery on children with intersex conditions except when they are competent to consent to the surgery themselves?

Issue 4.5 (page 84)

(a) Should different rules apply to the types of medical treatment that require the consent of the Guardianship Tribunal and to the criteria by which the Tribunal decides whether or not to give its consent, for young people aged below 16, from young people aged 16 and above?

(b) Are the statutory provisions relating to "special medical treatment" under the *Children and Young Persons (Care and Protection) Act 1998* (NSW), and "special treatment" under the *Guardianship Act 1987* (NSW), sufficiently clear to operate effectively in practice?

Issue 4.6 (page 86)

Does s 10 of the *Human Tissue Act 1983* (NSW) offer adequate safeguards to protect the health and well-being of the child?

Issue 4.7 (page 92)

(a) Is the current system for the authorisation of medical treatment for a young person in the Guardianship Tribunal, the Family Court or the Supreme Court working in practice?

(b) Are any of the following options preferable to the current system for deciding cases involving the medical treatment of young people, and why or why not?

Option A: The Family Court has sole jurisdiction to authorise or refuse medical procedures requiring external authorisation.

Option B: The NSW Guardianship Tribunal has sole jurisdiction to authorise or refuse medical procedures requiring external authorisation.

Option C: A co-ordinated system is established in which both the Family Court and the Guardianship Tribunal have jurisdiction to hear such cases, but the current uncertainties and duplications are worked out in some way.

(c) If any of these options are preferred to the current system, what role, if any, should the Supreme Court of New South Wales play in hearing cases involving the medical treatment of young people?

Issue 4.8 (page 94)

(a) In guiding the court or tribunal's decision whether or not to authorise certain medical treatment for a young person, should legislation provide for a broad discretion, with a general reference to the young person's best interests or welfare, or should it spell out a specific set of criteria that must be taken into account?

(b) Should legislation focus on specific types of medical treatment and apply special rules to making decisions about those procedures or should it set down criteria to be applied generally to all types of medical treatment requiring external authorisation?

Issue 4.9 (page 95)

In cases where a young person is not legally competent to consent to or refuse treatment, should the decision to carry out or refuse certain medical treatment ever rest with an external body, such as a court or tribunal, rather than with the young person's parents?

Issue 4.10 (page 97)

(a) In cases where a young person is legally competent to consent to, or refuse, certain medical treatment, should the law restrict that young person's ability to consent to or refuse the treatment and require authorisation for the treatment from an external body, such as a court or tribunal?

(b) If so, should the same criteria apply to determining the types of medical treatment for which external authorisation is required as apply to determining the types of medical treatment to which a parent cannot consent to or refuse?

(c) Should the same procedures apply for obtaining such external authorisation as apply in the case of parents seeking authorisation?

Issue 5.1 (page 103)

(a) Does s 174 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) operate effectively in its present form? In particular, is s 174 sufficiently comprehensive and clear about the situations in which young people can be provided with emergency medical treatment without a preliminary requirement for consent, or should general statutory guidelines be made for the guidance of those involved in the emergency medical treatment of young people?

(b) Should parents or young people be able to refuse emergency medical treatment (of their child)? If so, in what circumstances?

(c) Generally, should the law regarding medical emergencies be different for young people than for adults in the same situation?

Issue 5.2 (page 105)

Should clearer guidelines be given to medical practitioners as to when they have to respond to emergency situations involving young people who are not their patients?

Issue 5.3 (page 107)

Does Part 8 of the *Civil Liability Act 2002* (NSW) sufficiently protect first responders in emergencies from civil liability? For example, does Part 8 make sufficiently clear that medical practitioners and the public are not liable for assault and battery for emergency health care treatment? Should first responders be protected from liability for assisting an injured person below 18 years, who refuses, or whose parent refuses, emergency assistance?

Issue 5.4 (page 113)

(a) Should a child or young person ever be forced to undergo a medical examination against their will, and without their parent's consent?

(b) If so, in what circumstances should a child or young person be forced to undergo a medical examination? What type of medical examination should they be forced to undergo against their will?

(c) Is the present law covering medical examinations in cases of suspected child abuse sufficient?

(d) Should medical examinations under s 173 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) be more aligned with the consensual approach taken to medical examinations of children and young people under Children's Court "assessment orders" (s 53 of the *Children and Young Persons (Care and Protection) Act 1998*)? Is there a reason why a s 173 medical examination should be different?

Issue 5.5 (page 115)

Should s 22 of the *Public Health Act 1991* (NSW) have specific provisions governing young people with a category 4 or 5 contagious disease?

Issue 5.6 (page 116)

(a) Should there be greater clarity and consistency across educational and other institutions caring for young person, as to any requirement/s for parental consent/s to minor medical treatments for their children, such as the administering of first aid or non-prescription medications?

(b) Should educational and other institutions be required first to obtain a young person's consent, in the case of an 'older' young person, before providing minor medical treatment? If so, how should such a young person be defined?

(c) Should legislation define exactly what is meant by "minor" medical treatment

Issue 6.1 (page 124)

For young people below 14 years old who have mental illnesses, should the objection of one parent be sufficient to bar their voluntary admission in a psychiatric hospital? Alternatively, should there be other factors to consider: for example, the child's level of understanding concerning his or her proposed hospitalisation, the opinion of medical practitioner(s) who have been treating the young person, the wishes of the other parent and the child's best interests?

Issue 6.2 (page 125)

Should the provisions regarding the right of young people to consent to voluntary admission for psychiatric treatments in hospitals be the same as the general rules on young people's competence to consent to medical treatment?

Issue 6.3 (page 131)

(a) Should young people be considered potentially competent to consent to Electro Convulsive Therapy (ECT)?

(b) Should the provisions of the *Mental Health Act 1990* (NSW) concerning young people's competence to consent to ECT, and treatment in the absence of such consent, be the same as those for psychosurgery?

Issue 6.4 (page 132)

Should special medical treatment in the *Mental Health Act 1990* (NSW) include those treatments listed in the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and the *Guardianship Act 1987* (NSW)?

Issue 6.5 (page 132)

Should the Mental Health Review Tribunal have the authority to consent to the performance of special medical treatment on patients below 16 years old?

Issue 6.6 (page 134)

(a) Are there issues particular to young people with intellectual disabilities that should be taken into account as regards consent to, and refusal of, medical treatment while they are in out-of-home care?

(b) Are there types of medical treatment/therapy particularly relevant to this group of young people that require special rules on consent?

Issue 7.1 (page 136)

Are there any other groups of young people, besides those discussed in Chapters 6 and 7, that require special consideration in formulating a legal framework for making decisions about their medical treatment?

Issue 7.2 (page 139)

Is the legislative framework governing consent to medical treatment for children and young people in out-of-home care sufficiently clear?

Issue 7.3 (page 141)

Are there issues particular to young people from a non-English speaking background that should be taken into account in formulating a legal model to govern consent to, and refusal of, medical treatment for young people?

Issue 7.4 (page 142)

Are there issues particular to Indigenous young people that should be taken into account in formulating a legal model to govern consent to, and refusal of, medical treatment for young people?

Issue 7.5 (page 145)

(a) In practice, do medical practitioners generally treat homeless young people based on their consent alone?

(b) What steps (if any) do medical practitioners take to treat a homeless young person who refuses medical treatment?

(c) Should there be special provisions in the law to deal with consent to medical treatment for homeless young people? If so, what should these provisions be?

Issue 7.6 (page 147)

Is the existing law sufficiently clear as to the rights of young people, and others, in respect of the medical treatment of young people in juvenile detention centres?

Issue 7.7 (page 149)

(a) Should there be special provision in legislation to allow parents who are below the age of 18 to consent to and refuse medical treatment for their child?

(b) Should there be special provision in legislation, additional to existing provisions, to allow someone other than a child's parent to consent to or refuse medical treatment if the parent is not competent to consent or refuse?

Issue 8.1 (page 156)

Should specific guidelines be developed to assist medical practitioners in discharging their duty to inform under-age patients about the material risks involved in a proposed medical treatment?

Issue 8.2 (page 156)

Do the duties to obtain a patient's consent and to warn the patient of material risks of a proposed treatment create confusion in practice about what is required of medical practitioners when dealing with under-age patients?

Issue 8.3 (page 161)

Should legislation expressly provide that, where consent is a legal prerequisite for the provision of medical treatment, failure by a medical practitioner to obtain a valid consent is a ground for disciplinary action?

Issue 8.4 (page 162)

(a) Should the law exonerate a medical practitioner from liability and/or disciplinary action for making an honest and reasonable mistake about a young patient's competence to consent to medical treatment?

(b) Should the law exonerate a medical practitioner from liability and/or disciplinary action for making an honest and reasonable mistake about whether or not medical treatment is in the best interests of a young person?

Issue 8.5 (page 164)

(a) Is the current law adequate in imposing liability on medical practitioners for treating young people without a valid consent (where consent is legally required), where the medical treatment in question does not involve any physical contact?

(b) Should the law impose liability on medical practitioners for treating young people without the requisite consent, where the medical treatment in question does not involve any physical contact?

Issue 9.1 (page 177)

(a) Should young people have the right to keep their health information confidential from their parents?

(b) If so, should such a right be confined to situations where a young person can validly consent to their medical treatment? Or should it extend to situations where the young person, while not competent to consent to the treatment in question, had an understanding of the concept of secrecy and gave information to the medical practitioner with an expectation that it would not be disclosed?

(c) What should be the significance of the nature of the health information? Should a young person's right to keep their health information confidential from their parents apply only to certain classes of health information, for example those relating to reproduction and sexual health?

Issue 9.2 (page 178)

(a) What should be the test in determining whether or not a young person can give a valid consent to disclose his or her health information?

(b) Should young people who are competent to consent to medical treatment automatically be competent to consent to the disclosure of the health information obtained from that particular treatment?

(c) Should young people who are not competent to consent to medical treatment be able to provide a valid consent to the disclosure of their health information? If so, in what circumstances?

(d) Should the nature of the health information affect the response to any of these issues?

Issue 9.3 (page 179)

(a) Where a young person cannot consent to disclosure of his or her health information, should the young person's parents have the authority to do so?

(b) If so, should there be any limitations on the exercise of such authority?

Issue 9.4 (page 181)

(a) Should non-consensual disclosure of a young person's health information be permitted in any circumstances other than those listed in the *Health Records and Information Privacy Act 2002* (NSW)?

(b) Should the *Health Records and Information Privacy Act 2002* (NSW) impose any additional limitations or controls on non-consensual disclosure of a young person's health information?

Issue 9.5 (page 182)

Should the mandatory reporting requirement contained in s 27 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) apply also to 16 and 17 year olds?

Issue 9.6 (page 183)

Are there other situations that should be added to the list in s 23 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW)?

Issue 9.7 (page 187)

(a) Should the *Freedom of Information Act 1989* (NSW) contain additional limitations on access to medical records by a young person, such as those found in the NSW Premier's Department's *Freedom of Information Procedure Manual*?

(b) Is the "unreasonable" disclosure provision in the *Freedom of Information Act 1989* (NSW) a sufficient control on parental access to medical records?

Issue 9.8 (page 188)

(a) Should the *Private Hospitals Regulation 1996* (NSW) contain any additional limits on the right of young people to access their clinical records? For example, should the ability to request access be limited by a test of capacity?

(b) Should the *Private Hospitals Regulation 1996* (NSW) contain additional grounds of refusal to grant access to a young person's parent, in their capacity as a patient's representative? For example, should access by a parent be dependent upon access being in the under-age patient's best interests or some other test?

Issue 9.9 (page 190)

(a) Should the right of access to medical records, conferred by the *Health Records and Information Privacy Act 2002* (NSW), be extended to all young people?

(b) If not, is the statutory test of capacity an appropriate limitation on access or would some other test be more appropriate?

(c) Should the *Health Records and Information Privacy Act 2002* (NSW) contain any additional limitations on the exercise of the right of access by those young people who have that right?

(d) Should parents have an independent right of access to their children's medical records in circumstances where the young person is capable of exercising his or her own right of access? If so, under what circumstances?

Issue 9.10 (page 191)

Is the law dealing with the retention of young people's health information adequate?

Issue 10.1 (page 195)

(a) Is the law that governs the consent of young people to medical treatment obscure?

(b) Should the law that governs the consent of young people to medical treatment be codified?

(c) If not, should the law that governs the consent of young people to medical treatment be consolidated?

1. Introduction

- Making decisions about medical treatment: key concerns
- The aims of this issues paper
- Young people's health concerns
- Young people's decision-making capacity
- Scope of current regulation and State intervention
- Rights and interests at stake
- Medicare: a practical obstacle to medical care?
- Definitions
- Structure of the paper

MAKING DECISIONS ABOUT MEDICAL TREATMENT: KEY CONCERNS

1.1 When can young people, below the age of 18, make decisions about their medical care by themselves? When *should* young people be able to make decisions about their medical care by themselves? Who should be able to make decisions about a young person's medical care on the young person's behalf? What should be the legal liability of medical practitioners who treat young people without a valid consent?

1.2 These are the questions central to the Law Reform Commission's reference. The terms of reference are:

> To inquire into and to report on the laws relating to the consent of minors in New South Wales to medical treatment, with particular reference to:
>
> (a) whether the rights and interests of minors and of parents and guardians are appropriately recognised;
>
> (b) whether medical practitioners are adequately protected;
>
> (c) whether codification and/or amendment of the law is necessary; and
>
> (d) any related issues.

1.3 This Issues Paper considers the law relating to consent to medical treatment of people aged below 18 ("young people"). It covers four broad areas:

- the legal competence of young people to consent to, and refuse, medical treatment;
- the legal framework governing consent to, and refusal of, medical treatment of young people in situations where young people are not legally competent to make that decision themselves;
- the situations in which a medical practitioner can legally treat a young person without consent;
- implications for maintaining patient confidentiality when treating a patient under 18.

1.4 This introductory chapter provides some context for a subsequent discussion of the medical treatment of young people: it notes some of the major health concerns of young people in our community; it refers to the scientific and empirical literature dealing with young people's decision-making capacity; it considers the interests and rights of those involved in the process of making decisions about a young person's medical care; it outlines the extent of current regulation of decision-making for young people's medical treatment; and it makes brief reference to problems for young people in gaining access to the Medicare system as a practical obstacle to health care. It seeks to define the scope of this reference by identifying who and what are included within the terms “young person”, “parent”, “consent”, “medical treatment” and “medical practitioner”. Chapter 1 also sets out the aims of this Issues Paper, and the process of public consultation that will follow its release.

1.5 Underlying the discussion in Chapter 1 and, indeed, the entire Issues Paper, are two fundamental concerns: why is it important to scrutinise the law governing consent to the medical treatment of young people; and what should legal reform be seeking to achieve in this area? The Commission hopes to put forward some tentative answers to these questions in this Paper and to provoke responses from the public to assist both in identifying issues relevant to young people’s consent to medical treatment and in determining which direction legal reform, if needed, should take.

THE AIMS OF THIS ISSUES PAPER

1.6 This Issues Paper aims to provide a summary of the main issues relating to the law governing the consent of young people to medical treatment. The Commission has sought to identify appropriate parameters for the reference, and the main areas of interest and concern within those parameters. Rather than providing an in-depth discussion of the law and its underlying policies, this Paper aims to act as a springboard for further community consultation and subsequent, more detailed commentary by the Commission.

1.7 Each chapter of this Paper poses one or more questions, seeking your views in response. These questions appear in bold and are referred to as Issues 1, 2, 3, and so on. For details on how to make a submission to the Commission in response to this Issues Paper, and the date by which to do so, see page vii. Following the release of this Paper, the Commission will continue its process of community consultation which, in addition to reviewing submissions received from interested members of the public, will include meeting with groups and individuals in the community who have particular expertise, experience or interest in this area. This process of community consultation will assist us in ultimately determining whether, and to what extent, legal reform is necessary, and making recommendations as to the form and direction such reform should take.

YOUNG PEOPLE’S HEALTH CONCERNS

1.8 What are some of the typical health concerns of our young people in relation to which the question of who should have the legal right to consent to or refuse medical treatment may be controversial? This section seeks to provide some examples of such health concerns, both to stimulate debate about the law governing consent to medical treatment and to illustrate that the health concerns of young people are real, significant and various, requiring a clear legal framework by which medical practitioners can provide care with relative certainty of the law, and young people can have their health concerns met in appropriate ways.

1.9 For the purpose of this discussion, young people can be grouped into two broad categories: adolescents and younger, pre-adolescent children. The term "adolescents" is used here to refer to young people who have entered puberty and who are below 18.[1] The health concerns of particular significance to each group generally vary and give rise to different considerations in formulating a legal framework to determine who can make decisions about their medical care.

Adolescents

1.10 In the past, the question of whether a young person could legally consent to or refuse medical treatment has typically attracted attention in relation to matters involving adolescent health.[2] Adolescents face

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1. There is no single, uniform definition of the term, "adolescent". Agencies and organisations dealing with teenagers have adopted various definitions. For example, the World Health Organisation defines an "adolescent" as a person between the ages of 10 and 19, that is, someone in the second decade of life: see World Health Organisation, "Adolescent health and development" in "Overview of child and adolescent health" (as at 28 April 2004) «http://www.who.int/child-adolescent-health/OVERVIEW/AHD/adh_over.htm». The Adolescent Clinics at The Children's Hospital at Westmead define an "adolescent" as a person between the ages of 12 and 16: see The Children's Hospital at Westmead, "Adolescent clinics" (as at 28 April 2004) «http://www.chw.edu.au/prof/clinics/adolescent_clinics.htm». For the purposes of our discussion, the Law Reform Commission has not defined "adolescence" according to a particular chronological age, but rather as the time characterised by the physical, and accompanying emotional and mental, changes of puberty, and limited to those young people below the age of 18, that is, below the age of full legal capacity as an adult.
2. For example, the English case which settled the current common law test for a young person's competence to consent, *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, involved a dispute about whether or not teenage girls could consent to receiving contraceptive advice and prescription for the Pill. Other cases have involved, for example, treatment of young people with anorexia nervosa (see *Director General, NSW Department of Community Services v Y and Z, Parents of X* [1999] NSWSC 644; *Re W (a minor) (medical treatment)* [1992] 4 All ER 627) and termination of pregnancy (see *K v Minister for Youth and Community Services; Re Infant "K"* (1982) 8 Fam LR 250).

particular health concerns relevant to the physical, mental and emotional developments of puberty. These concerns include:[3]

- *A heightened preoccupation with body image and the physical changes to their bodies.* Adolescents may seek medical treatment and advice for the changes their bodies undergo in puberty. For some, increased concern for their physical attractiveness may lead to, for example, development of an eating disorder, or even a desire for cosmetic surgery.[4]
- *Increased awareness of sexuality.* Adolescents usually become curious about sex and their own sexuality. Some become sexually active in their teenage years. They may seek medical advice and treatment for contraception, sexually transmitted diseases, or pregnancy.
- *Experimentation with drugs and alcohol.* Some adolescents may begin to experiment with drugs and alcohol. Some may have problems with substance addiction, and may need treatment for the physical and mental effects of addiction.[5]

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[3] See NSW Centre for the Advancement of Adolescent Health, *Access to health care among NSW adolescents: Phase 1* (Research Report, Sydney, 2002) at 23-25 and, generally, D Bennett and L Rowe, *What to do when your children turn into teenagers* (Doubleday, Sydney, 2003).

[4] According to figures from the 1998 National Survey of Mental Health and Wellbeing, in 1998, 47% of females aged 13-17 were exercising to control weight, 26% were dieting to control weight, and 3% of females in this age group were vomiting or using laxatives to lose weight: see L Moon, P Meyer and J Grau, *Australia's young people: their health and wellbeing 1999* (Australian Institute of Health and Welfare, Canberra, 1999); Australian Bureau of Statistics, "Selected risks faced by teenagers" *Australian social trends* (Commonwealth of Australia, Canberra, 2002) at 61. It has been estimated that, in females in the "at risk" age group of 15 to 20, anorexia nervosa affects between one and two of every 1,000: T Bartholomew and S Paxton, "General practitioners' perspectives regarding competence and confidentiality in an adolescent with suspected anorexia nervosa: legal and ethical considerations" (2003) 10 *Journal of Law and Medicine* 308 at 316. Anorexia nervosa has been noted as the third most common chronic illness in Australian adolescents (after obesity and asthma), particularly prevalent in young women, but with increasing prevalence in young men: see D Bennett and L Rowe, *What to do when your children turn into teenagers* (Doubleday, Sydney, 2003) at 324.

[5] In 1998, the Australian Institute of Health and Welfare carried out a survey, the National Drug Strategy Household Survey: see P Adhikari and A Summerill, *1998 National drug strategy household survey: detailed findings* (Drug Statistics Series No. 6, Australian Institute of Health and Welfare, Canberra, 1999). According to the survey, the drugs most commonly reported as available by adolescents between the ages of 14 and 19 years were: alcohol (82%), tobacco (69%), marijuana (48%), and painkillers (40%). 33% of males in that age group, and 27% of females, were reported to drink alcohol on at least one day per week; 16% of both males and

- *Onset of mental illness, including depression.* The mental health of Australian adolescents has been the subject of much public discussion in recent years,[6] with depression and the threat of suicide posing serious risks to the lives of many young people. Adolescence is also a time when about 75 percent of mental disorders first become apparent.[7] Adolescents may seek counselling, and other forms of treatment, including medication, to address concerns with their mental health.

1.11 Adolescents may be reluctant to share their health concerns with their parents. Adolescence is often characterised by a desire for privacy, greater independence from parents, and a degree of conflict with parents and other authority figures. At the same time, parents will usually be anxious to retain some control and influence over their child's physical and mental well-being. For this group of young people, facing the types of health concerns outlined above, questions of who can consent to or refuse medical treatment raise considerations of ensuring access to medical services, recognising the growing maturity of the adolescent, and promoting the young person's best interests.

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females smoked nicotine daily, or on most days; 45% of both males and females in that age group had tried marijuana. The 2001 survey revealed similar results: one in five teenagers (aged 14-19) smoked tobacco in 2001, with 15.1% smoking daily; one in three males and one in four females aged 14-19 consumed alcohol weekly; and more than one third of teenagers aged 14-19 had used illicit drugs: see Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey – First Results* (Drug Statistics Series No 9, Canberra, 2002).

[6] For example, in 1995, the Commonwealth government developed the National Youth Suicide Prevention Strategy, and allocated government funding specifically to the Strategy for the period 1995-1999. The Strategy aimed to provide a coordinated approach to youth suicide prevention throughout Australia, and set up a number of programs to achieve its goals: see Australian Department of Health and Ageing, Mental Health and Special Programs Branch (as at 28 April 2004) «www.mentalhealth.gov.au/sp/nysps/about.htm». In Australia, in 1998, there were 446 deaths from suicide in the 15-24 years age group, and young men comprised 364 of these deaths. For young men aged 15-19, the rate of suicide in this year was 17.2 per 100,000, and for young women aged 15-19, it was 5.5 per 100,000. It is estimated that the overall suicide rate among Aboriginal and Torres Strait Islander communities may be four times higher than in the non-indigenous population: see P Mitchell, *Valuing young lives: evaluation of the National Youth Suicide Prevention Strategy* (Australian Institute of Family Studies, Commonwealth of Australia, 2000) at 24-26.

[7] See D Bennett and L Rowe, *What to do when your children turn into teenagers* (Doubleday, Sydney, 2003) at 299.

Younger children

1.12 It is more difficult to generalise about the typical types of health concerns of younger, pre-adolescent children. Obviously, young children do not yet usually face the health concerns typically associated with puberty.[8] Instead, they are likely to require medical treatment, from time to time, for a wide range of childhood injuries and illnesses, varying from, for example, the common cold, to ear infections, to gastroenteritis, from cuts, to bruises, to broken limbs. They may require regular management of chronic health conditions, such as asthma, juvenile diabetes or eczema. As they develop, they may require treatment for learning or behavioural problems. Parents may seek to immunise their young children against a number of illnesses for which vaccines are now available, such as measles, mumps, chickenpox and hepatitis B. Apart from these more everyday health concerns, there are other health concerns which are more serious and may require decisions about life-saving treatment or invasive and irreversible treatment. Young children may also be found to be medically suited to blood or tissue donation, to benefit, for example, another family member, and the question then arises of who should have the authority to consent to or refuse such a donation.

1.13 Of course, the health concerns outlined above are not limited to young children. They can also affect the general population. The difference for young children is that, because of their immaturity, they are usually voiceless in the way their health concerns are addressed. This vulnerability makes it important to ensure that their welfare is protected and their best interests promoted.

YOUNG PEOPLE'S DECISION-MAKING CAPACITY

1.14 The capacity of young people to make their own decisions about their medical care has been the subject of psychological theories and empirical research.[9] Piaget[10] developed a model of young people's cognitive

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[8] Of course, some pre-pubescent children may face problems more usually associated with adolescents, such as alcohol and substance abuse.

[9] For a discussion of the literature in this area, see, for example, L Bunney, "The capacity of competent minors to consent to and refuse medical treatment" (1997) 5 *Journal of Law and Medicine* 52 at 60-61; A Newman, "Adolescent consent to routine medical and surgical treatment: a proposal to simplify the law of teenage medical decision-making" (2001) *Journal of Legal Medicine* 501 at 518-520; P Parkinson, "Children's rights and doctors' immunities: the implications of the High Court's decision in *Re Marion*" (1992) 6 *Australian Journal of Family Law* 101 at 106.

development, which asserted that the capacity to make an intelligent choice generally appears in a child between the ages of 11 and 14. At this stage of their cognitive development, children have the ability to deal with abstractions, use deductive and inductive reasoning, apply reason to hypothetical situations and think about the future. They can therefore consider different options and their consequences. In their empirical study, Weithorn and Campbell[11] compared the decision-making capacity of a group of children aged 9 to 14 with a group of adults aged 18 to 21. The 14 year olds were found to demonstrate a level of competence equivalent to the adults.[12] The 9 year olds had significantly less developed skills in understanding and reasoning but despite this, did not differ significantly from the adults in the final choices they made about medical treatment. The study concluded that, despite their poorer understanding and failure to consider fully many of the critical elements of disclosed information, the 9 year olds tended to make clear and sensible treatment preferences, similar to the adults within the sample group.

1.15 While these studies provide some support for the assertion that, at least by the age of 14, young people have attained the same level of cognitive development as adults to make medical treatment choices, other writers have emphasised that young people's decision-making capacity must also be judged according to their "social development".[13] Young people may not have developed an internal capability for free, deliberate choice, which results not just from a level of cognitive maturity, but also from emotional development and a sense of distinct "personhood".[14] Research suggests that, in early adolescence, young people have a greater tendency than at any other time toward conformity, with the risk of deferential responses to requests for consent being at its greatest until the ages 15-17.[15] Each young person's decision-making capacity should be assessed with reference to the range of his or her experiences, and individual qualities, such as his or her abilities and confidence, relational style with

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[10] See J Piaget and B Inhelder, *The psychology of the child* (Basic Books, New York, 1969). See also E Susman, "Participation in biomedical research: the consent process as viewed by children, adolescents, young adults and physicians" (1992) 121 *Journal of Pediatrics* 547.

[11] L A Weithorn and S B Campbell, "The competency of children and adolescents to make informed treatment decisions" (1983) 9 *Child Development* 285.

[12] Competence was assessed according to capabilities for: inferential understanding, factual understanding, reasoning, reasonable outcome and evidence of choice.

[13] See M McCabe, "Involving children in medical decision making: developmental and clinical considerations" (1996) 21 *Journal of Pediatric Psychology* 505 at 509.

[14] See L Roberts, "Informed consent and the capacity for voluntarism" (2002) 159 *American Journal of Psychiatry* 705.

[15] See T Grisso and L Vierling, "Minors' consent to treatment: a developmental perspective" (1978) 9 *Professional Psychology* 412.

authority and emotional state. A young person's decision-making capacity will also be affected by external factors, such as the nature and circumstances of the particular decision, the nature of the information provided to the young person and the way in which it is communicated, and the expectations of the adults involved in the decision.[16] Cauffman and Steinberg argue that, when determining young people's competence, it is not sufficient simply to consider their cognitive differences and similarities with adults, but also their maturity of judgment. They claim that adolescents are more likely to differ from adults in their sense of responsibility (autonomy, identity and self-reliance), their perspective (sense of morality and context) and their temperance (regulation of emotion, avoidance of extremes and non-impulsivity). However, the way in which these differences affect the young person's maturity of judgment has not been sufficiently subjected to empirical research to make any considered assessment of their decision-making capacity in respect of medical treatment.[17]

SCOPE OF CURRENT REGULATION AND STATE INTERVENTION

1.16 At present, there is no single legal framework in New South Wales to regulate the rights and roles of young people, parents, medical practitioners and other interested parties in making decisions about young people's medical treatment. Legislation applies to some aspects of this decision-making process. The relevant pieces of legislation are:[18]

- *Minors (Property and Contracts) Act 1970* (NSW);
- *Children and Young Persons (Care and Protection) Act 1998* (NSW);
- *Guardianship Act 1987* (NSW); and
- *Family Law Act 1975* (Cth).

1.17 The scope of current legislative regulation is limited. The legislation says nothing about the rights of young people or their parents to make medical decisions or at least to be involved in such decisions, nor the legal obligations and rights of medical practitioners. It has much more specific aims. For instance, s 49 of the *Minors (Property and Contracts) Act 1970* is not concerned with establishing a general framework for the rights of young people to make medical decisions, based on a particular policy

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16. See P Alderson, *Children's consent to surgery* (Open University Press, Buckingham, 1993) at 193; G Koocher and D de Maso, "Children's competence to consent to medical procedures" (1990) 7 *Pediatrician* 68.
17. E Cauffman and L Steinberg, "The cognitive and affective influences on adolescent decision-making" (1995) 68 *Temple Law Review* 1763 at 1788.
18. See Chapter 2 and 4 for a more detailed discussion of this legislation.

position on what such rights should be. Its primary concern is with ensuring that medical practitioners are protected from liability in certain situations. Similarly, the three remaining pieces of legislation, listed above, do not aim to map out a framework for making decisions about young people's medical treatment. Their aim is to place limits on the types of medical treatment to which young people and their parents can consent, and to provide for the intervention of the State for those types of treatment, through several of its courts and tribunals, specifically the NSW Guardianship Tribunal, the Family Court of Australia and the Supreme Court of New South Wales, as well as, though perhaps with less direct involvement, the Children's Court (through the State child protection legislation) and the Mental Health Review Tribunal.

1.18 The common law (judge-made law) reflects greater consideration than current legislation of the rights and responsibilities of young people and parents in the process of making decisions about young people's medical treatment. It has developed a test for determining young people's legal competence to make their own medical decisions, following the courts' consideration of the rights of parents and their children.[19] However, it has not yet developed to the extent of delineating clearly the lines of liability for the medical profession, nor necessarily providing young patients and parents with remedies to enforce their rights in respect of all types of treatment.

1.19 The law assumes that adults are competent to make decisions about their medical treatment, whether it be to consent to, or refuse, such treatment.[20] That assumption is based on the principles of self-determination and autonomy, that is, the notion that individuals, of adult age, have the right to choose how they live and what should be done with their own bodies. That right is absolute, even if the decision made by a particular individual about his or her own medical care is not generally considered to promote his or her best interests.[21] People below the age of 18 neither enjoy that same assumption nor the same recognition of their right to self-determination. Current regulation of the decision-making process for the medical treatment of young people is too limited in its aims to consider, in any meaningful way, whether, and in what circumstances, the continued curtailment of that right can be justified.

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[19] See Chapter 2.

[20] Of course, that assumption does not apply when the adult patient's capacity to understand is somehow impaired, for example, by reason of an intellectual disability.

[21] See *Re T (adult: refusal of medical treatment)* [1992] 4 All ER 649; *Re B (adult: refusal of medical treatment)* [2002] 2 All ER 449.

RIGHTS AND INTERESTS AT STAKE

1.20 What should the law be aiming to achieve in regulating the ability of young people and others to make decisions about a young person's medical treatment? In the broadest sense, the State has in interest in ensuring that the medical treatment of young people promotes their best interests. More particularly, it could be argued that the law should aim to achieve, at the least, the following:

- It should ensure that young people have ready access to appropriate medical care;
- It should recognise and protect young people's rights to participate in decisions affecting them and to exercise some control over their own health care relative to their level of maturity;
- It should protect young people from detrimental decisions that may harm them;
- It should recognise the role of parents and the State in participating in decisions affecting their child's welfare and in determining what is in his or her best interests, and promote the community's interest in encouraging parents to take responsibility for their child's well-being;
- It should provide the medical profession with a workable, clear and consistent framework for treating young people in order to provide them with the best possible care.

1.21 Australia has recognised, both internationally and in its own domestic law, that young people have certain rights that should be protected. These rights include: a right to a good standard of health, a right to have access to health care facilities and the right of young people to participate in decisions affecting them.

1.22 The United Nations *Convention on the Rights of the Child*[22] acknowledges these rights and represents a promise by its signatories, including Australia, to protect and promote them. Article 24(1) states that:

> States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

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[22] "Child" is defined in the Convention as a person aged below 18: see Art 1. The Convention was ratified by Australia on 17 December 1990.

1.23 Article 12(1) provides that:

> States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

1.24 At the same time, the Convention also recognises the role of parents, as well as other family and community members, in providing young people with guidance and direction in the exercise of their rights:

> States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.[23]

1.25 The United Nations Committee on the Rights of the Child has recently given specific consideration to the needs of adolescents and has claimed that signatory States should take additional steps to protect their rights, as enshrined in the *Convention on the Rights of the Child*.[24] While acknowledging the continuing role of parents in making decisions about adolescents' medical care, the Committee has urged countries to recognise in their domestic law the possibility that the maturing adolescent may be able to give personal consent for medical treatment:

> Before consent is given by parents, adolescents need to be given a chance to express freely their views and they should be given due weight, in accordance with article 12 of the Convention. However, if the adolescent is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself, while informing the parents, if this is in the "best interest of the child" (article 3).[25]

1.26 Consistent with this emphasis on the increasing autonomy of the maturing adolescent, the Committee has also underlined the importance of maintaining the confidentiality of adolescents' medical information.[26]

1.27 In Australia, federal legislation gives the Human Rights and Equal Opportunity Commission the responsibility of ensuring that federal legislation is not inconsistent with the rights enshrined in the *Convention*

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[23] See Art 5.

[24] United Nations Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child* (CRC/GC/2003/4, 2003).

[25] United Nations Committee on the Rights of the Child at para 32.

[26] United Nations Committee on the Rights of the Child at para 33.

on the Rights of the Child (among other instruments),[27] of promoting an understanding and public discussion of those rights and of reporting on any action that Australia needs to take to comply with the provisions set out in the Convention.[28]

1.28 At a State level, New South Wales has given express recognition in legislation to the importance of protecting and promoting the safety and well-being of young people, while at the same time acknowledging their right to participate in decisions that affect them. The New South Wales Commission for Children and Young People is a government body set up to protect the interests of young people in the provision of government and non-government services and the implementation of legislation and government policies. Its work is governed by three statutory principles, as provided in s 10 of the *Commission for Children and Young People Act 1998* (NSW). These are:

> (a) the safety, welfare and well-being of children are the paramount consideration;
>
> (b) the views of children are to be given serious consideration and taken into account;
>
> (c) a co-operative relationship between children and their families and community is important for the safety, welfare and well-being of children.

1.29 As is clear from the discussion above, there has been increasing recognition in recent years, both internationally and domestically, of children and young people as people with rights, while at the same time a continuing emphasis on the role, responsibilities and interests of parents

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[27] The specific provisions of the *Convention on the Rights of the Child* have not been formally made part of our domestic law. Australian law recognises the rights enshrined in the Convention in so far as the Commonwealth Attorney General declared, on 22 December 1992, that the *Convention on the Rights of the Child* was an international instrument relating to human rights and freedoms for the purpose of s 47 of the *Human Rights and Equal Opportunity Commission Act 1986* (Cth). That declaration came into effect on 13 January 1993, and is still in force: Commonwealth of Australia Gazette (No. GN 1, 13 January 1993) at 85-107.

[28] See the functions of the Human Rights and Equal Opportunity Commission, set out in s 11 of the *Human Rights and Equal Opportunity Commission Act 1986* (Cth), specifically s 11(1)(e), (f), (g), (j) and (k). Section 11 of the Act requires the Commission to monitor (to a limited extent) Australia's compliance with certain "human rights". "Human rights" are defined in s 3 of the Act to include rights recognised or declared by any "relevant international instrument", which in turn is defined in s 3 as an instrument declared under s 47 of the Act. The *Convention on the Rights of the Child* is an international instrument declared to be an international instrument according to s 47: see Commonwealth of Australia Gazette (No. GN 1, 13 January 1993) at 85-107.

and families in caring and making decisions about their children's welfare. A legal framework devised to regulate the area of young people's consent to medical treatment must find a way to recognise and balance these rights and interests.

MEDICARE: A PRACTICAL OBSTACLE TO MEDICAL CARE?

1.30 It is pointless to consider reform to the decision-making processes concerning young people's medical treatment, without also taking into account practical obstacles that stand in the way of young people gaining ready access to appropriate health care. One of the most obvious, and most significant, obstacles arises from possible problems for young people in making use of the Medicare system. Many young people, with no significant sources of income, are unlikely to be able to seek medical treatment, independently of their parents, unless such treatment is free. There may be some matters for which young people, especially teenagers, do not want to seek medical advice and treatment unless they can do so without involving their parents. Ready access to the Medicare system is important in such situations if these young people are to seek out appropriate medical assistance.

1.31 There are no legislative restrictions on the age at which a person can make use of the bulk-billing health care system. However, the Health Insurance Commission has an internal policy that allows only people aged 15 and above to hold a Medicare card in their own name. Young people below that age must usually use their family's general Medicare card. There is some flexibility in the policy to allow people below 15 to hold their own Medicare cards in some situations, for example, young people who attend boarding schools or otherwise live away from home. However, most young people below the age of 15, who wish to see a medical practitioner and be bulk-billed, must take their family's Medicare card. This may be awkward for them if they do not want their parents to know about the consultation.

1.32 Having said that, there is no legislative or administrative requirement that a patient actually present his or her Medicare card at the medical practitioner's practice in order to be bulk-billed. All that is required is the patient's Medicare number. A young person could, for example, copy out his or her Medicare number from the family Medicare card and present the number to the medical practitioner. There is also a Medicare "provider hotline" number which medical practices can telephone to obtain or confirm a particular patient's Medicare number. In theory, therefore, a young person below the age of 15 could still make use of the Medicare system without involving his or her parents. However, many young people may not know that they can receive free health care without presenting their Medicare card to the medical practitioner. Moreover, it may be a business decision of the particular medical practice not to bulk-bill patients unless they present their Medicare card at the time of the consultation. Medical practices may also vary in their internal policies concerning the age at which they will allow patients to sign Medicare vouchers for themselves, rather than requiring a parent to sign on the child's behalf.

1.33 Any reforms to the law which are aimed at providing young people with easier access to the health care system will be incomplete unless consideration is also given to possible changes to the Medicare system to allow young people to make greater use of the bulk-billing system independently of their parents. However, any such changes to Medicare can only be made at the federal level, and therefore lie beyond the scope of the NSW Law Reform Commission's role. For this reason, the Commission does not discuss the Medicare system in any detail in this Issues Paper. We have simply raised it in this introductory chapter as a matter that will impinge, in a practical way, on any reforms that we ultimately recommend.

DEFINITIONS

1.34 The terms of the Commission's reference turn on several key words and phrases:

- "minor";
- "parents and guardians";
- "consent";
- "medical treatment"; and
- "medical practitioners".

1.35 The scope of this reference is limited by the ways in which these words are defined. Below is a discussion of possible meanings and provisional definitions that the Commission has put forward. Some of these definitions we consider to be fairly uncontroversial. Others may attract more attention and disagreement. The definitions that we suggest are a preliminary attempt to set parameters for further discussion and we welcome comments on them. To this end, Issues 1.1 and 1.2 below seek your views on the definitions that we have suggested.

"Minor"

1.36 "Minor" means a person from birth to age 18 (which is the age at which, in New South Wales, a person acquires the legal status of an adult).[29] When a person reaches the age of 18, he or she is completely free to consent to, or refuse, medical treatment, provided that he or she is not incompetent for some reason (other than age), such as mental incapacity. The Commission uses the term "young person" instead of "minor" in this Issues Paper, as "young person" is more commonly used in everyday language, whereas "minor" tends to be a more legalistic term.

"Parents and guardians"

1.37 This phrase refers to any person or people who stand in the legal position of a parent to a young person, whether they be the natural parents, the adoptive parents or have been appointed the young person's legal guardians.[30] This definition does not include other people who may take on a role in raising a child, but who do not have any legal status as a parent or legal guardian of that child, for example, a grandparent or other member of the young person's extended family. In Chapter 4, at para 4.4-4.5, the Commission discusses the question of whether people other than parents should have a legal right to participate in making decisions about the medical care of a young person.

"Consent"

1.38 What is meant by "consent" in the context of providing medical treatment to young people? The few legislative provisions in New South Wales dealing with consent in relation to young people's medical treatment do not provide any definitions of the term, "consent".[31] The common law has

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[29] See *Minors (Property and Contracts) Act 1970* (NSW) s 9.

[30] For legislation regulating the adoption of children and/or appointment of legal guardians, see *Adoption Act 2000* (NSW) Pt 9; *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 79, Ch 10 (appointment of Children's Guardian for children and young people in out-of-home care); *Guardianship Act 1987* (NSW) s 9 forward (applies to young people aged 16 and over, in certain circumstances); *Family Law Act* 1975 (Cth) s 61D, 64B, 64C; *Jurisdiction of Courts (Cross-Vesting) Act 1987* (Cth) s 4(1); see also cases asserting the preservation of the parens patriae jurisdiction of the NSW Supreme Court to make orders regarding the welfare of children: eg *Director-General, NSW Department of Community Services v Y* [1999] NSWSC 644 (Austin J); *Re Jessica* [2001] NSWSC 1207 (Hamilton J).

[31] There is no definition of "consent" in the *Minors (Property and Contracts) Act 1970*(NSW), *Children and Young Persons (Care and Protection) Act 1998*(NSW) or *Guardianship Act 1987*(NSW). Similarly, the South Australian legislation, which

developed a notion of consent arising out of an (adult) patient's right to self-determination or autonomy: each person has a right to be free of unwanted bodily contact and to decide whether such contact should occur. Medical treatment is usually[32] only lawful if the adult patient has agreed, or consented, to it, in the exercise of his or her right to personal autonomy.[33] The absence of consent has particular legal ramifications: medical practitioners who carry out medical treatment involving bodily contact without a legally valid consent (where such is required) are potentially liable in tort for trespass to the person, either as a battery, an assault or false imprisonment. In this way, the law has developed a notion of consent, as it relates to medical treatment, as the assent, or agreement, to physical contact that is necessary in order to obviate an action in trespass, in recognition of each person's right to personal autonomy. The patient must be advised in broad terms of the nature of the treatment and agree to it.[34]

1.39 "Consent" relating to medical treatment has a different shade of meaning when the courts talk of a patient's "informed consent" to particular medical treatment. "Informed consent" is an American term[35] which the Australian High Court has criticised as a misleading way to describe a medical practitioner's duty to disclose to a patient the material risks of a particular medical procedure.[36] A risk is material, and therefore required to be disclosed to the patient, if a reasonable person, in the patient's position, would attach significance to it, or if the medical practitioner is, or should reasonably be, aware that the particular patient would be likely to attach significance to it. Failure to disclose all the material risks of a particular treatment does not affect the validity of the

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regulates young people's competence to consent to medical treatment, does not define the term "consent": see *Consent to Medical Treatment and Palliative Care Act 1995* (SA). There is, however, legislation in British Columbia, Canada, which deals with the ability of young people to consent to medical treatment and defines "consent" in terms of requiring the health care provider to explain, and be satisfied that the young person understands, the nature and consequences, and the reasonably foreseeable benefits and risks, of the health care: see *Infants Act* RSBC 1996 c. 223 s 17.

[32] For situations in which medical treatment may be lawfully carried out without either the patient's or his or her parent's consent, see Chapter 5.

[33] See *Re T (Adult: refusal of medical treatment)* [1992] 4 All ER 649; *Re W (a minor) (medical treatment)* [1992] 4 All ER 627 (CA); *Marion's case* (1992) 175 CLR 218 at 222-223; see also L Bunney, "The capacity of competent minors to consent to and refuse medical treatment" (1997) 5 *Journal of Law and Medicine* 52 at 54; D Mendelson, "Historical evolution and modern implications of concepts of consent to, and refusal of, medical treatment in the law of trespass" (1996) 17 *Journal of Legal Medicine* 1 at 1-2.

[34] See *Rogers v Whitaker* (1992) 175 CLR 479.

[35] See *Canterbury v Spence* 464 F. 2d 772 (D.C. Cir. 1972).

[36] See *Rogers v Whitaker* (1992) 175 CLR 479.

consent given by the patient to the treatment, although the High Court has recognised that, in reality, a patient's choice to undergo, or not undergo, treatment is meaningless unless it has been made on the basis of all relevant information and advice. Instead, a medical practitioner's failure to disclose signifies a breach of his or her duty of care owed to the patient. Failure to disclose, or obtain "informed consent", therefore, gives rise to liability in negligence, not in trespass.

1.40 In the law relating to the medical treatment of young people, the distinction is blurred between the notion of consent as an agreement to contact necessary to obviate an action in trespass, and "informed" consent as a decision made following disclosure of all material risks. In *Marion's* case,[37] the High Court endorsed a test aimed at assessing a young person's competence to consent to medical treatment, based upon whether the young person understood the nature and consequences of the treatment. This test was applied to assess the validity of the young person's consent, as used in the first sense of the word, that is, to determine whether there was a legally recognisable agreement to contact necessary to avoid liability, on the medical practitioner's part, in trespass.[38] At the same time, the majority of the High Court spoke of a young person's competence to give "informed consent",[39] rather than simply competence to consent, and the test put forward to determine that competence seems to include elements from the notion of "informed" consent, as used in the second sense of the word, that is, an agreement following disclosure of the material risks of the proposed treatment. Certainly, the requirement for a young person to understand not just the nature of the proposed treatment, but also its consequences, appears to place a greater burden on the extent of the young person's understanding in order to be deemed competent to give a valid consent, and on the amount of information disclosed by the medical practitioner in order to obtain a valid consent to avoid liability in trespass, than ordinarily applies in the case of treating adult patients.

1.41 The end result is that, when dealing with young people's medical treatment, the law is not clear in its definition of consent, appearing to merge, to some extent at least, the two meanings of consent which it

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[37] See *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218. See Chapter 2 at para 2.7-2.14 for a discussion of *Marion's* case.

[38] See the majority in *Department of Health and Community Services (NT) v JWB (Marion's case)* at 232-235.

[39] See, for example, *Department of Health and Community Services (NT) v JWB (Marion's case)* at 237, 239, 240, 250. See L Bunney, "The capacity of competent minors to consent to and refuse medical treatment" (1997) 5 *Journal of Law and Medicine* 52 at 54-55.

otherwise keeps distinct in the context of medical treatment for adult patients. Unlike adults, the consent of a young person necessary to avoid an action in trespass requires an agreement based not just on an understanding of the broad nature of the treatment, but also of the consequences of the treatment. Whether or not an understanding of the "consequences" amounts to an understanding of the "material risks", as used in the concept of "informed consent", is open to question. It is also open to question whether the information which a medical practitioner has a duty to disclose to a young patient, in order to avoid liability in negligence, differs in any way from the information which must be disclosed to an adult patient, given that the young patient must already be aware of, and understand, the "consequences" of the treatment in order to be considered competent to "consent" to it, so as to avoid a possible action in trespass.

1.42 One other point is worth noting in seeking to define the term, "consent". In paragraph 1.38, the Commission referred to the historical development of the notion of consent, arising out of the courts' recognition of people's right to self-determination and autonomy. Medical treatment involving bodily contact was considered to infringe that right to personal autonomy, and to amount to a trespass, unless it had been consented to. The difficulty in this rationale for the practice of modern medicine is that not all types of medical treatment involve physical contact. For example, counselling, or the simple prescription of medication, does not necessarily involve any bodily contact. In such situations, what does it mean to require a patient's "consent" to treatment? "Consent" as an agreement necessary to obviate an action in trespass has no real meaning in this context, because there is no physical trespass to the patient's person. Is "consent" limited here to mean a decision based on full disclosure of the nature and the material risks of the treatment, so as to avoid liability, on the medical practitioner's part, in negligence? In Chapter 8, the Commission discusses more fully the problems of traditional lines of liability for medical treatment that does not involve physical contact.

1.43 Having highlighted here the blurring of the boundaries between "consent" and "informed consent" in the context of the medical treatment of young people, the Commission will tend to use "consent" in this Issues Paper as meaning the agreement that is necessary to make lawful what would otherwise be a trespass to a young person's person. In considering the law relating to consent in this sense, we also consider the law relating to the *refusal* of medical treatment. At the same time, we are aware of and make continuing references to, the difficulties of distinguishing this notion of consent from the notion that is usually associated with the law of negligence, of an agreement based on the disclosure of all material risks.

"Medical treatment"

1.44 It is difficult to settle on a definition of "medical treatment". The word "medical" normally connotes the involvement of a medical practitioner, or other paramedical professional, such as a nurse, in the performance of orthodox, mainstream medical procedures. Below are some examples, taken from various legislative provisions and proposed provisions, of this kind of narrow view of "medical" in the phrase, "medical treatment":

> "Medical treatment" means treatment or procedures administered or carried out by a medical practitioner in the course of medical or surgical practice or by a dentist in the course of dental practice and includes the prescription or supply of drugs.[40]
>
> "Medical treatment" includes any medical or surgical procedure, operation, or examination, and any prophylactic, palliative, or rehabilitative care normally carried out by or under the supervision of a medical practitioner.[41]
>
> "Health care" means treatment by a qualified medical or dental practitioner in the course of his practice, and includes … treatment given by any person pursuant to directions given in the course of practice by a qualified medical or dental practitioner …[42]

> "Medical treatment" means:
>
> (i) treatment by a medical practitioner in the course of the practice of medicine or surgery, or
>
> (ii) treatment by any person pursuant to directions given in the course of the practice of medicine or surgery by a medical practitioner.[43]

1.45 On the other hand, there are now a large number of widely accepted, "alternative" health services that do not fall within the notion of "medical" services as traditionally understood, but which nevertheless aim to benefit a person's health and well-being. Such services include, for example, acupuncture, osteopathy, chiropractic treatment or naturopathy. Similarly, services provided by, for example, physiotherapists, psychologists or nutritionists, would not normally be considered to fall within the notion of "medical" treatment, but have as their aim the benefit to a person's health. It could be argued that, while these types of services would not usually be understood to be "medical" treatment, the same principles are at stake in terms of a young person's right to bodily integrity, and the compromise of that right for the benefit of that person's health. Following this reasoning, a broad definition could be adopted, widening the terms of the reference

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[40] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4.

[41] *Guardianship Act 1987* (NSW) s 33.

[42] Alberta Institute of Law Research and Reform, *Consent of Minors to Health Care* (Report, 1975) Recommendation 9.

[43] *Minors (Property and Contracts) Act 1970* (NSW) s 49(4).

beyond services that are strictly termed "medical". Examples of such a broad definition include:

> … care provided to young people by all those who profess to be in the business of improving or maintaining the health of others.[44]
>
> "Health care" means any care, treatment, advice, service or goods provided in respect of the physical or mental health of a person.[45]

1.46 Similarly, the word "treatment" in the phrase "medical treatment" is open to a number of interpretations. For example, should it be confined to conduct that includes some kind of physical contact with the patient, for which consent would be necessary to avoid potential liability for trespass? Or, should it extend to conduct that does not include any physical contact, such as counselling, advice or the provision of information? Should it be confined to the provision of a service that could be considered "therapeutic" to the patient's health, that is, given for the purpose of curing or alleviating an injury, disease or illness, or should it extend to treatment that is "non-therapeutic", if that term can be defined in any meaningful way?[46] Should it include, for example, cosmetic surgery, or blood or tissue donation?

1.47 There does not seem to be any neat, obvious way in which to define the phrase, "medical treatment". At this stage, the Commission has decided to adopt a narrow interpretation of "medical" as a starting point to open the way for public discussion and consultation. In this Issues Paper, therefore, we use the term "medical treatment" to apply to services provided by registered medical practitioners or under the ultimate supervision of a registered medical practitioner. We are fully aware that there are other sorts of services that are aimed at providing a benefit to a person's health and for which the issue of who has a right to consent is also controversial. However, given that the terms of reference specifically speak of "medical" treatment and "medical practitioners", and given that this Issues Paper represents only the preliminary stage of discussion of this area, we have chosen to begin with a narrow view of the phrase. We are inclined to expand the definition of "medical treatment" beyond a focus on services provided by medical practitioners, or those working under medical practitioners, and we would be interested in your suggestions as to how "medical treatment" should be defined. Issue 1.2 below invites your comments on this point.

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[44] Queensland Law Reform Commission, *Consent to Health Care of Young People* (Report 51, 1996) at 17-18.

[45] *Health Care Liability Act 2001* (NSW) s 4(1).

[46] Note the discussion of the distinction between "therapeutic" and "non-therapeutic" sterilisation in *Marion's case*: *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218 at 250. See Chapter 4 at para 4.13 for further discussion.

1.48 As for the meaning of "treatment", we have chosen, at this stage, to include all the sorts of services that medical practitioners provide. This includes treatment requiring no physical contact, such as the provision of advice, information or counselling, and also includes treatment that might not strictly be considered to cure or alleviate an injury or illness. However, at least at this stage, the Commission has decided not to include within the concept of "treatment" any procedures that form part of a clinical trial or medical research. While medical research ultimately aims to benefit the health of its recipients and the community at large, we consider it to be something broader than the notion of "treatment" as that term is used in the terms of reference. However, we are aware that there are issues of concern relating to young people and consent to medical research; at present, uncertainties in the law may be having a stultifying effect on the advancement of medical research, and may also be resulting in many drugs being available on the market the effects of which have not been properly tested on children. It is an area which the Commission may need to revisit upon further community consultation.

"Medical practitioners"

1.49 Following on from the Commission's preliminary interpretation of the phrase, "medical treatment", we have taken a fairly narrow view of the phrase "medical practitioners" to refer only to persons registered as a medical practitioner under the *Medical Practice Act 1992* (NSW). However, as we noted in paragraph 1.47 above, we adopt these narrow definitions of "medical treatment" and "medical practitioner" as starting points only, and welcome suggestions for preferable ways of defining them.

Issue 1.1

Do you agree, or disagree, with the following definitions of key words and phrases in the Commission's terms of reference?

- "Minor": A person from birth to age 18. *(See paragraph 1.36)*
- "Parents or guardians": Any person or people who stand in the legal position of a parent to a young person, whether it be the natural parent, the adoptive parent, or the legal guardian. *(See paragraph 1.37)*
- "Consent": The agreement that is necessary to make lawful what would otherwise be a trespass to a young person's person, and includes the notion of refusal of medical treatment. *(See paragraph 1.38-1.43)*
- "Medical treatment": Any service provided by a registered medical practitioner, or under the ultimate supervision of a registered medical practitioner. *(See paragraph 1.44-1.48)*
- "Medical practitioner": Any person registered as a medical practitioner under the *Medical Practice Act 1992* (NSW). *(See paragraph 1.49)*

Issue 1.2

How should the terms "medical treatment" and "medical practitioners" be defined in the context of a discussion of young people's right to make decisions about their medical care?

STRUCTURE OF THIS PAPER

1.50 This Issues Paper adopts the following structure.

1.51 Chapter 2 summarises the current law, both common law and statutory provisions, determining when young people can legally consent to, and refuse, medical treatment themselves.

1.52 Chapter 3 puts forward suggestions for reform of the current law governing young people's competence to make their own medical decisions. It discusses various alternative tests for determining when a young person can consent to and refuse medical treatment.

1.53 Chapter 4 discusses the law governing consent to, and refusal of, medical treatment for young people who are not legally competent to consent or refuse themselves. It focuses particularly on the role of parents in making decisions about their child's medical care.

1.54 Chapter 5 discusses the law governing when a medical practitioner can legally treat a young person without consent, that is, without either the consent of the young person, his or her parents, or some other third party, such as a court or tribunal.

1.55 Chapter 6 discusses the legal framework for making decisions about medical care for young people with mental illnesses and/or intellectual disabilities.

1.56 Chapter 7 discusses the legal framework for making decisions about medical care for other groups of young people who also have special needs, namely young people in out-of-home care, homeless young people, young people from non-English speaking backgrounds, young people who are Aboriginal or Torres Strait Islander, and young people whose parents are not competent to make medical decisions.

1.57 Chapter 8 sets out the various grounds of legal liability for medical practitioners who treat young people without a legally valid consent, where such consent is required by law, and the protection that is currently offered to medical practitioners in such situations.

1.58 Chapter 9 discusses issues concerning patient confidentiality that arise when a medical practitioner treats a person below the age of 18.

1.59 Chapter 10 considers the need for consolidation or codification of the law relating to the consent or refusal of medical treatment for young people.

1.60 Each chapter contains issues which relate to the discussion specific to that chapter, and which invite your response.

2.

Young people's capacity to make medical decisions – the current law

- Overview
- The common law
- Section 49 of the Minors (Property and Contracts) Act 1970
- Best interests as a paramount consideration
- Part 5 of the Guardianship Act 1987
- Refusing medical treatment

OVERVIEW

2.1 This chapter sets out the current law governing the circumstances in which young people can consent to, and refuse, medical treatment.

2.2 As a general rule,[1] a medical practitioner cannot treat an adult (that is a person above 18 years of age) without a valid consent from the patient. Without such consent, the medical practitioner may face liability for, at the least, trespass to the person.[2] An adult's consent is only valid if he or she is competent to consent. The law generally considers adults to be competent to consent, unless it can be shown that a particular individual's capacity to understand is affected in some way, for example, by reason of mental illness or an intellectual disability. The law relating to the ability of young people to consent to medical treatment is much more complex.

2.3 In New South Wales, the current law determining a young person's competence to consent to medical treatment is found in rules derived from:

- the common law;
- s 49 of the *Minors (Property and Contracts) Act 1970* (NSW); and
- Part 5 of the *Guardianship Act 1987* (NSW) (for young people aged 16 and over).

2.4 This chapter focuses on the rules found in these three sources. The rules may differ depending on whether the issue in question is one of competence to *consent* to medical treatment or one of competence to *refuse* treatment. This chapter first addresses capacity to consent,[3] before discussing the principles governing refusal to consent.[4]

2.5 There are other sources of rules affecting young people's competence to consent that apply in particular circumstances. These are discussed in other chapters of this Paper. They include:

- The *Children and Young Persons (Care and* Protection*) Act 1998* (NSW), which has provisions relating to emergency treatments, special medical treatments, children in need of care and protection and young people in out-of-home care.[5]

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[1] See Chapter 5 for a discussion on the medical treatment of young people without consent.

[2] See Chapter 8 for a discussion on the liabilities of medical practitioners.

[3] See para 2.7-2.46.

[4] See para 2.47-2.53.

[5] See Chapters 4, 5, 6 and 7.

- The *Mental Health Act 1990* (NSW), which applies to young people with mental illnesses in psychiatric hospitals.[6]
- The *Human Tissue Act 1983* (NSW), which relates to consent to the donation from a young person's body of specified regenerative tissue for the purpose of transplantation to the body of a parent, brother or sister of the young person.[7]
- Section 67ZC of the *Family Law Act 1975* (Cth), which deals with the Family Court's jurisdiction to make orders relating to the welfare of young people.[8]

2.6 The law relating to young people's competence to consent is obscure, complicated and piecemeal.[9] The current law results from several, disparate legislative initiatives and the separate progression of the common law. The way in which the common law interacts with the legislative provisions is unclear. The law embraces neither a coherent policy for making decisions about young people's medical care, nor a clear legal framework within which the medical profession can work. In Chapter 10, we raise the issue whether the laws that govern the consent of young people to medical treatment should be codified or consolidated to achieve clarity and consistency.

THE COMMON LAW

The *Gillick*-competence test

2.7 A young person under 18 years of age is legally competent to consent to medical treatment if he or she is capable of understanding the nature and consequences of that treatment. The High Court of Australia settled this common law test for determining a young person's competence in a case commonly known as *Marion's* case. The majority of the Court held that:

> A minor is capable of giving informed consent when he or she achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.[10]

The majority in *Marion's* case followed a decision of the English House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority*.[11] In

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[6] See Chapter 6.

[7] See Chapter 4.

[8] See Chapter 4.

[9] See generally L Skene, *Law and medical practice: rights, duties, claims and defences* (2nd edition, LexisNexis Butterworths, Sydney, 2004) Ch 4.

[10] *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218 at 237-238 (Mason CJ, Dawson, Toohey, and Gaudron JJ).

[11] [1986] AC 112.

Gillick, it was held that a young girl was competent to consent to contraceptive advice and treatment if she had a sufficient understanding and intelligence to enable her to understand fully what was proposed.[12]

2.8 The test focuses on an assessment of the individual young person's level of maturity and understanding in relation to the treatment proposed. This means that, before the age of 18 (when a young person legally becomes an adult), there is no fixed age at which it is possible to say, in advance of such an assessment, that a young person is automatically capable of consenting to medical treatment generally, or to specific types of medical treatment. Thus, while a young person of, say, 10 years of age may have the necessary intelligence and understanding of what is proposed to consent to the administration of a course of antibiotics to treat a sore throat, he or she may not, at the same time, possess sufficient understanding to consent to the removal of his or her tonsils in the case of acute tonsillitis. In short, before the age of majority, competence to consent operates on a continuum which ranges from the point at which a young person is clearly able to consent to the medical treatment proposed to that at which he or she is clearly unable to do so.

2.9 The test may prove difficult for medical practitioners, with whom the assessment of *Gillick*-competence initially rests, to apply in practice. The imprecision of the test places a significant onus on that assessment.[13] Medical practitioners sued for providing medical treatment to a young person without consent bear the onus of proving that they believed that the young person was of sufficient maturity and understanding to consent to the treatment in question.[14]

2.10 The justification for the *Gillick* test is that it accords with experience and psychology in recognising that the point at which a young person has capacity to consent to particular medical treatment varies with each individual and cannot be constrained artificially by a fixed-aged test.[15] Further, the flexibility of the test allows the law to develop in accordance with social experience.[16] And the heavy responsibility that the test places on medical practitioners is acceptable because the responsibility is in the hands of a "learned and highly trained profession regulated by statute and

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[12] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 at 188-189 (Lord Scarman).

[13] *Re Alex (Hormonal Treatment for Gender Identity Dysphoria)* [2004] FamCA 297 (13 April 2004) at [155] per Nicholson CJ.

[14] See, for example, L Skene, *Law and medical practice: rights, duties, claims and defences* (2nd edition, LexisNexis Butterworths, Sydney, 2004) at para 4.19.

[15] *Marion's* case at 237-238.

[16] *Gillick* at 191.

governed by a strict ethical code which is vigorously enforced".[17] Lord Scarman said in *Gillick*:

> The truth may well be that the rights of parents and children in this sensitive area are better protected by professional standards of the medical profession than by "a priori" legal lines of division between capacity and lack of capacity to consent since any such general dividing line is sure to produce in some cases injustice, hardship and injury to health.[18]

The level of understanding required

2.11 The High Court, in *Marion's* case, did not elaborate on the level of understanding a young person must possess to be considered competent to consent to specific medical treatment. The majority of the Court stated merely that the young person should understand "fully what is proposed", without explaining how to judge that understanding.

2.12 In *Gillick*, Lord Scarman, referring to a young person's ability to access contraceptive advice, stated that it would not be enough that the young person understood the nature of the advice given: he or she must also have a sufficient maturity to understand what is involved.[19] This emphasis on maturity to understand the nature and effects of proposed treatment has been stressed in subsequent cases.[20] Indeed, in the context of contraceptive advice, Lord Scarman was of the view that:

> There are moral and family questions, especially [the young person's] relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that she is able to appraise these factors before he can safely proceed upon the basis that she has at law capacity to consent to contraceptive treatment. And it further follows that ordinarily the proper course will be for him … first to seek to persuade the girl to bring her parents into consultation, and if she refuses, not to prescribe contraceptive treatment unless he is satisfied that her circumstances are such that he ought to proceed without parental knowledge and consent.[21]

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[17] *Gillick* at 191.

[18] *Gillick* at 191.

[19] *Gillick* at 189 (Lord Scarman).

[20] *Re Alex* at [168] ("grave nature and effects of proposed treatment").

[21] *Gillick* at 189.

Some commentators have described this level of understanding as a capacity to exercise a "wise choice".[22]

2.13 In contrast, Lord Fraser, in *Gillick*, said that a young person can consent to medical treatment if he or she understands what is proposed and is capable of expressing his or her own wishes.[23] Lord Fraser did not expressly require a capacity to understand the moral and emotional ramifications of the contraceptive treatment in issue in that case. However, Lord Fraser pointed out that the young person's right to consent is subject to the medical practitioner's judgment as to whether or not the medical treatment is in the young person's best interests.[24]

2.14 When considering possible reforms to the way in which young people's competence to consent is determined, any proposals for reform of the *Gillick*-competence test may need to spell out the level of understanding that is required for the young person to be deemed competent. This is an issue that is considered as part of the discussion of possible legal reforms in Chapter 3.

SECTION 49 OF THE MINORS (PROPERTY AND CONTRACTS) ACT 1970

2.15 In New South Wales, the common law test that determines a young person's competence to consent according to the individual's level of maturity is subject to s 49 of the *Minors (Property and Contracts) Act 1970* (NSW), which provides:

> (1) Where medical treatment or dental treatment of a minor aged less than sixteen years is carried out with the prior consent of a parent or guardian of the person of the minor, the consent has effect in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, the minor were aged twenty-one years or upwards and had authorised the giving of the consent.
>
> (2) Where medical treatment or dental treatment of a minor aged fourteen years or upwards is carried out with the prior consent of the minor, his or her consent has effect in relation to a claim by him or her for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, he or she were aged twenty-one years or upwards.
>
> (3) This section does not affect:

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22. P Parkinson, "Children's rights and doctors' immunities: the implications of the High Court's decision in *Re Marion*" (1992) 6 *Australian Journal of Family Law* 101 at 111.
23. *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 at 169.
24. *Gillick* at 173-174 (Lord Fraser).

> (a) such operation as a consent may have otherwise than as provided by this section, or
>
> (b) the circumstances in which medical treatment or dental treatment may be justified in the absence of consent.
>
> (4) In this section:
>
> ***dental treatment*** means:
>
> (i) treatment by a dentist registered under the *Dentists Act 1934* in the course of the practice of dentistry, or
>
> (ii) treatment by any person pursuant to directions given in the course of the practice of dentistry by a dentist so registered, and
>
> ***medical treatment*** means:
>
> (i) treatment by a medical practitioner in the course of the practice of medicine or surgery, or
>
> (ii) treatment by any person pursuant to directions given in the course of the practice of medicine or surgery by a medical practitioner.

Purpose of s 49 – protection from liability

2.16 The purpose of s 49 is to provide limited protection from civil liability to "persons acting with reasonable care and consent" (usually medical practitioners) in the treatment of young people.[25] It states that such a person cannot be sued in battery or assault for treating a young person, if the person obtains consent from:

- the young person's parent or guardian if the young person is aged below 16; or
- the young person if the young person is aged 14 or over.

2.17 Section 49 does not, in terms, confer a general capacity on young people to consent to (or refuse) medical treatment. Nor does it offer medical practitioners protection from criminal liability[26] or from civil actions other than battery or assault (for example, false imprisonment). Section 49 may be contrasted with the more encompassing South Australian legislation that provides:[27]

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[25] New South Wales Law Reform Commission, *Infancy in relation to contracts and property* (Report 6, 1969), Appendix G (Notes on Proposed Bill) at para 44; NSW, *Parliamentary Debates (Hansard)* Legislative Assembly, 11 August 1970 at 5275 (Assistant Minister's Second Reading Speech to *Minors (Property and Contracts) Bill*). See also *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311 at 321-322 (Helsham CJ in Eq).

[26] The wording in subsections (1) and (2), "a claim … for assault or battery", implies civil proceedings. Further, s 49 is part of an Act dealing predominantly with various civil acts and proceedings involving people below the age of 18.

[27] *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6.

> A person on or over 16 years of age may make decisions about his or her own medical treatment as validly and effectively as an adult.

Issue 2.1

Should medical practitioners be offered a broader protection from civil and criminal liability when treating young people than that currently offered by s 49 of the *Minors (Property and Contracts) Act 1970* (NSW)?

Interaction of s 49 and the common law

2.18 The relationship between s 49 and the common law is subject to a number of differing interpretations. In discussing that relationship, it is essential to bear in mind two factors. First, s 49 was enacted more than twenty years before the *Gillick* test of young people's competence to consent to medical treatment was accepted by the High Court in *Marion's* case. Secondly, s 49(3)(a) stipulates that s 49 does not affect the operation that consent otherwise has. Thus the common law remains relevant to the operation of consent except in so far as s 49(1) and (2) apply.

2.19 The interaction of s 49 and the common law needs to be considered in relation to the medical treatment of:

- young people below 14 years of age.
- young people aged 14 years and over;
- young people below 16 years of age; and
- young people aged 16 and over.

Young people below 14 years of age

2.20 Section 49 makes no specific mention of young people below the age of 14. For young people in this age group, the common law (as expounded in *Marion's* case) must operate to determine their competence to consent to the particular medical treatment proposed.

Young people aged 14 and over

2.21 Section 49(2) provides that a medical practitioner is protected from civil liability for battery or assault for treating a young person aged 14 and over if the young person consents to the treatment. If the young person is *Gillick*-competent, the subsection is merely confirmatory of the common law. But what if the young person is not *Gillick*-competent? Does the subsection provide an immunity from liability in battery or assault to a medical practitioner who has treated a "consenting" young person above the age of 14 even if the young person does not understand fully what is proposed?

2.22 A reading of the subsection, as well as some English case law,[28] suggests an affirmative answer to this question, which gives s 49(2) an operation independent of the common law. However, this interpretation of the subsection is open to doubt for at least three reasons. First, the English case law is concerned with the interpretation of a statute that is differently structured and worded to that in New South Wales.[29] Secondly, the subsection assumes that the young person's consent is validly given or effective, and this merely begs the question of capacity to consent that is addressed in *Gillick* and *Marion*. Thirdly, and as already noted, the purpose of the section is to provide a limited defence to civil liability, not to confer a general capacity to consent on young people aged 14 and over.[30]

2.23 These doubts suggest a second interpretation: that s 49(2) merely confirms that young people aged 14 and over have the ability to consent to medical treatment, provided that they are *Gillick*-competent.[31] On this view, a medical practitioner could not rely on the consent of a young person aged 14 and over for protection from liability unless the young person is *Gillick*-competent. If so, s 49(2) would appear to add nothing to the common law.

Issue 2.2

Does s 49(2) of the *Minors (Property and Contracts) Act 1970* (NSW) offer any additional protection from liability for medical practitioners than that already provided by the common law?

Young people below 16 years of age

2.24 Section 49(1) allows a parent or a guardian to consent to the medical treatment of a young person who is below 16 years of age as if the young person were 21 years of age and had authorised the giving of consent. Such consent has effect in relation to a claim by the young person for assault or battery in respect of anything done in the course of the treatment. Clearly, if the young person is not *Gillick*-competent, s 49(1) adds nothing to the common law.

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[28] Especially *Re W (A Minor)* [1993] Fam 64 at 77 (*Gillick*-competence presumed or irrelevant).

[29] *Family Law Reform Act 1969* (UK) s 8(1) (which avoids the "overlap" between ss 49(1) and (2) where the young person is between 14 and 16 years of age, and which says that an "effective consent" makes the consent of a parent or guardian unnecessary).

[30] See para 2.16-2.17.

[31] See *Gillick v West Norfolk* AHA [1986] AC 112 at 167 per Lord Fraser (*Family Law Reform Act 1969* (UK) s 8(1) is "merely for the avoidance of doubt").

2.25 On the other hand, if the young person is *Gillick* competent, s 49(1) does qualify the common law if, as seems to be the case,[32] the rule at common law is that the authority of a parent with respect to particular medical treatment comes to an end once the young person achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. The effect of s 49(1) is then to confer a power on the parent or guardian the power that they would not otherwise have to consent to the medical treatment of a *Gillick*-competent young person, the consent operating as a defence to any claim in battery or assault brought by the young person in respect of anything done in the course of the treatment.

2.26 An alternative, but probably minority, view of the common law, supported by Justice Deane in *Marion's case*,[33] is that a young person's achievement of *Gillick*-competence does not necessarily result in the young person's parents losing the power to consent to medical treatment on behalf of the young person. If so, there would be a "transitional period" in which the ability to consent to the treatment of a young person is shared between that person and his or her parents. Section 49(1) would, on this view, add nothing to the common law. Indeed, the common law would be wider than s 49(1) since, at common law, the power of parents or guardians to consent to the medical treatment of *Gillick*-competent young persons is limited neither to young persons below the age of 16 nor to the context of actions for assault and battery.

Issue 2.3

Does s 49(1) of the *Minors (Property and Contracts) Act 1970* (NSW) offer any additional protection from liability for medical practitioners than that already provided by the common law?

Young people aged 16 and over

2.27 The common law and s 49(2) are both capable of application to persons aged 16 and over. In addition, young people aged 16 and over may be subject to the provisions of the *Guardianship Act*.[34] There are also special procedures to which only a court, or another body, such as the

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[32] See *Marion's* case (1992) 175 CLR 218 at 237 per Mason CJ, Dawson, Toohey and Gaudron JJ (referring to Lord Scarman in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 at 184, 189); at 316-317 per McHugh J dissenting. See further para 2.31.

[33] *Marion's* case at 294 per Deane J (relationship between minor and parents will ordinarily pass through a transitional stage in which authority is shared). See also *Re R* [1991] Fam 11 at 22-25; *Re W (A Minor)* [1993] Fam 64 at 74-79; *Re S* [1995] 1 FCR 604.

[34] See para 2.35-2.46.

Guardianship Tribunal, can consent. These situations are discussed in Chapter 4.

Overlapping rights of young persons and their parents

2.28 Section 49(1) of the *Minors (Property and Contracts) Act 1970* (NSW) and, on one view, the common law seem to allow for the simultaneous existence and operation of parents' and young people's rights to consent to medical treatment, but only in the case of the legislation where the young person is aged below 16 years of age.[35] The coexistence of these rights obviously presents no problem in so far as the young person fully understands particular types of treatment (to which he or she may therefore consent) but not others (to which his or her parent must consent).

2.29 However, s 49(1) also creates the possibility that a parent may consent to medical treatment to which the young person is also competent (in the *Gillick* sense) to consent. In such cases, the consent of either the parent or the competent young person exonerates the medical practitioner (or other defendant) from liability in battery or assault in respect of the treatment in question.[36] It is important to appreciate that s 49(1) does no more than this. In particular, it probably does not give the parents a veto on the consent of the young person (or vice versa).[37] Rather, where a *Gillick*-competent young person's attitude to consent to particular medical treatment differs from that of his or her parents who are also competent to consent to that treatment, the conflict will be resolved in one of the following ways:

- by the medical practitioner exercising professional judgment to refuse treatment or to administer treatment relying on either the consent of the parent or young person;
- by an application by an interested person for a judicial determination of whether or not the treatment is in the young person's best interests;[38]
- ultimately, by the ability to administer treatment against the wishes of the young person after such a judicial determination.[39]

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[35] See para 2.24.

[36] Especially in *Re R* [1991] Fam 11 at 22-25; *Re W* [1993] Fam 64 at 74-79 (though the statements are, strictly, obiter dicta).

[37] Especially in *Re R* [1992] Fam 11 at 23; *Re W* [1993] Fam 64 at 83-84. The dicta of Helsham CJ in Eq in *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311 at 321 are to the contrary.

[38] See especially *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311; *Re R* [1991] Fam 11; *Re W (A Minor)* [1993] Fam 64; and the cases on refusal at para 2.53. On the ability of the courts to interfere to protect the young person's best interests, see para 2.32-2.34.

2.30 In favour of this approach is the admittedly paternalistic argument that the coexistence of the young person's and parents' rights to consent can operate to protect the best interests of the young person before he or she reaches majority.[40] To give young people and their parents coexisting rights to consent to medical treatment means that unresolved conflicts between the wishes of a competent young person and those of his or her parents in relation to proposed medical treatment are generally resolvable ultimately by litigation, in which the best interests of the child will be the primary consideration.[41]

2.31 It is, however, arguable that, in such cases, a preferable course is simply to allow the wishes of the *Gillick*-competent young person to prevail over those of his or her parents. This would seem to be the position at common law.[42] *Gillick* suggests that once young people have sufficient maturity to consent to the medical treatment proposed, their parents' right to consent to medical treatment on their behalf ceases.[43] In *Gillick*, Lord Scarman said that:

> [P]arental rights are derived from parental duty and exist only so long as they are needed for the protection of the person and property of the child … as a matter of law, the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.[44]

This seems to accord with the High Court's view of the law in *Marion's* case.[45]

Issue 2.4

Should young people and their parents have coexisting rights to consent to the medical treatment of the young person? If so, in what circumstances?

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39. See *Re B* [1997]1 FCR 618.
40. See para 3.41-3.42.
41. See para 2.32-2.34.
42. This position may conflict with the "alternative" view of the common law identified in para 2.26.
43. L Skene, *Law and medical practice: rights, duties, claims and defences* (2nd edition, LexisNexis Butterworths, Sydney, 2004) at para 4.26-4.27.
44. *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 at 184, 188 – 189 (Lord Scarman).
45. *Marion's* case (1992) 175 CLR 218 at 237. See also at 316-317 (McHugh J dissenting). But see at 294 (Deane J).

BEST INTERESTS AS A PARAMOUNT CONSIDERATION

2.32 A court, exercising its parens patriae or welfare jurisdiction, can always make decisions for the benefit of young people under 18 years of age. The young person's best interests are objectively ascertained.[46]

2.33 The Commission has already pointed out that a parent of a young person under 18 years of age can consent to the medical treatment of that person where he or she is not *Gillick*-competent[47] and, with more limited effect, where the young person is under the age of 16 and *Gillick*-competent.[48] While it may be assumed that parents exercise their authority in this respect in the best interests of the child, it is clear that parental authority is not absolute and may be overridden by a court acting in the young person's best interests both where the person is not *Gillick*-competent[49] and where he or she is.[50]

2.34 The same is true where a young person under 18 years of age has himself or herself consented to medical treatment. The court can override that consent whether the person is *Gillick*-competent or not.[51] This is because the court has a welfare or parens patriae jurisdiction in respect of young people. That jurisdiction is exercised in the best interests of young people, and (while generally supervisory of the exercise of the care and control of young people by parents and guardians) is wider than the powers of a parent.[52] In practice, the cases involving decisions about a young person's medical treatment that have come before the courts have been concerned with young people who refuse to give consent. It is clearly the law that a court can override a young person's refusal to give consent to medical treatment where the refusal is not in the young person's best interests.[53]

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[46] *Marion's* case at 240, 316

[47] See para 2.20-2.27.

[48] See para 2.24.

[49] *Re Alex* [2004] Fam CA 297 (13 April 2004) at [153]. Consider also *Re Elizabeth* (1989) 96 FLR 248.

[50] *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311. Consider also *Re E* [1992] 2 FCR 219; *Re S* [1995] 1 FCR 604 (in both of which the court indicated that it would have overridden the young person's refusal to consent had the young person been *Gillick*-competent, effectively also overruling the parent's wishes).

[51] See *Re W (A Minor)* [1993] Fam 64 at 84 (point 6)(Lord Donaldson MR). And consider *Re Alex* at [173].

[52] *Marion's* case at 258-259.

[53] See para 2.53.

PART 5 OF THE GUARDIANSHIP ACT 1987

2.35 A separate set of rules appears to govern consent to medical treatment for people, aged 16 and over, who are incompetent to consent themselves and are covered by Part 5 of the *Guardianship Act 1987* (NSW). As a whole, the *Guardianship Act 1987* deals with adult people[54] who are not competent to make decisions themselves about aspects of their lives, if, for example, they suffer from a disability that requires them to be cared for or supervised. However, Part 5 of the *Guardianship Act 1987*, dealing with consent to medical (and dental) treatment, is not restricted to people suffering from a disability. It expressly applies to any person, 16 and over, who is incapable of understanding the general nature and effect of the proposed treatment, or is incapable of indicating whether or not he or she consents or does not consent to the treatment being carried out.[55] A 16 year old could, theoretically at least, come within the scope of Part 5, if he or she were incapable of understanding the nature and effect of the treatment, not because of a disability, but because of his or her immaturity (although it may be unlikely that a young person of this age, with average abilities and intelligence, would be found too immature to understand the issues in question).

2.36 Consequently, the following framework governs consent to treatment for young people aged 16 and over:

- If a young person aged 16 or above is incapable of understanding the nature and effect of the proposed medical treatment, that young person is brought within the framework of Part 5 of the *Guardianship Act 1987* (NSW). Among other things, Part 5 specifies the people who can then consent to medical treatment on the young person's behalf.
- Young people aged 16 and above who *are* capable of understanding the general nature and effect of the treatment in question do not come within the scope of Part 5. Consequently, the common law rules apply to them: as they are capable of understanding the nature and effect of the proposed treatment, they will be legally competent to consent to the treatment themselves, following the common law test set out in *Gillick*.
- Part 5 of the *Guardianship Act 1987* does not deal with the right to refuse medical treatment. The common law rules governing a young person's right to refuse treatment, as discussed below,[56] apply equally to young people aged 16 and above.

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[54] A guardianship order may be made under the *Guardianship Act 1987* in respect of a person aged 16 and above: see s 9(2).

[55] *Guardianship Act 1987* (NSW) s 33(2).

[56] See para 2.47-2.53.

The framework under the *Guardianship Act*

2.37 Part 5 of the *Guardianship Act 1987* (NSW) provides a legislative framework for consent to the medical treatment of people, aged 16 and over (including adults), who are not capable of consenting themselves. The framework applies to a "patient" who is of or above the age of 16 years, and "who is incapable of giving consent to the carrying out of medical or dental treatment."[57] The legislation defines a person as incapable of giving consent if he or she is incapable of understanding the general nature and effect of the proposed treatment, or is incapable of indicating whether or not he or she consents, or does not consent, to the treatment being carried out.[58] The term "patient" is not defined in the Act. As noted above, it seems likely that, in most cases, those young people to whom Part 5 will apply will have an impairment or disability of some kind beyond mere immaturity, which will prevent them from giving personal consent. However, there is no reason to believe, on the wording of the legislation, that Part 5 is intended not to apply to young people who are incompetent simply because of their immaturity, however unlikely this scenario is.

2.38 The term "medical treatment" is defined in the *Guardianship Act* as "medical treatment (including any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care) normally carried out by or under the supervision of a medical practitioner", but does not include a number of procedures, such as first-aid medical treatment and any non-intrusive examination made for diagnostic purposes.[59] Presumably, if there were any forms of medical treatment that did not fall within this legislative definition, Part 5 of the *Guardianship Act* would not apply, and instead the common law would operate to determine those people who could consent to the treatment in question.[60]

2.39 For medical treatment that is covered by Part 5, the framework set up by the legislation divides medical treatment into three categories: minor treatment, major treatment and special treatment. "Minor treatment" is defined as treatment that is not special treatment or major treatment (or treatment in the course of a clinical trial).[61] In general terms, "major

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[57] *Guardianship Act 1987* (NSW) s 34(1)(b).

[58] *Guardianship Act 1987* (NSW) s 33(2).

[59] *Guardianship Act 1987* (NSW) s 33(1).

[60] Section 46(5) of the *Guardianship Act 1987* (NSW) provides that the Guardianship Tribunal, a person responsible or a guardian, can consent to medical treatment expressly excluded from the definition of that term in the same way as they can consent to treatment falling within the legislative definition. However, it does not make any provision for consent to treatment that is not expressly excluded from the definition, but simply does not come within the definition.

[61] *Guardianship Act 1987* (NSW) s 33(1).

treatment" is defined[62] as treatment, not including special treatment, that involves:

- the administration of a long-acting injectable hormonal substance for the purpose of contraception or menstrual regulation;
- the administration of a drug of addiction;
- the administration of a general anaesthetic or other sedation, except in certain instances;
- treatment used for the purpose of eliminating menstruation;
- the administration of a restricted substance for the purpose of affecting the central nervous system, except in certain instances;
- treatment that involves a substantial risk (that is, more than a mere possibility) to the patient of death, brain damage, paralysis, permanent loss of function of an organ or limb, permanent and disfiguring scarring, exacerbation of the condition being treated, an unusually long period of recovery, a detrimental change of personality, or a high level of pain or stress;
- testing for HIV.

2.40 "Special treatment" is generally defined as:[63]

- treatment intended or reasonably likely to render the person permanently infertile;
- new treatment that has not yet gained the support of a substantial number of medical practitioners practising in the area;
- the administration of a drug of addiction over a period of more than 10 days in any period of 30 days, except in certain instances;
- treatment carried out for the purpose of terminating pregnancy;
- a vasectomy or tubal occlusion;
- treatment involving the use of an aversive stimulus.

2.41 For young people aged 16 to 18, who are incapable of giving consent as defined in Part 5, their parent, or person with parental responsibility, can consent to minor or major treatment being carried out on the young person. If the young person is in care, the Director General or the Minister of Youth and Community Services can give consent for minor or major

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[62] See *Guardianship Act 1987* (NSW) s 33(1); *Guardianship Regulation 2000* (NSW) cl 8.

[63] *Guardianship Act 1987* (NSW) s 33(1); *Guardianship Regulation 2000* (NSW) cl 6.

treatment.[64] The Guardianship Tribunal can also give consent for minor or major treatment for young people to whom Part 5 applies.[65]

2.42 In relation to special treatment, as defined in the legislation, consent for such treatment must generally be obtained from the Guardianship Tribunal before it can be carried out on a young person aged 16 to 18 to whom this legislative framework applies.[66] In deciding whether or not to consent to the medical treatment in question, the Tribunal must take into account a number of considerations, including the patient's and the parents' views.[67]

2.43 There is provision within the framework set up in Part 5 for medical treatment to be carried out without consent, in situations of urgency, where the treatment amounts to a minor treatment and there is no parent, or the parent cannot be contacted or is unable to make a decision about consent, and the patient does not object to the minor treatment in question.[68]

2.44 There are two limitations on the power of parents or guardians to consent to minor or major medical treatment under the *Guardianship Act 1987* (NSW).[69] First, parents or guardians cannot give consent to treatment that is to be carried out for any purpose other than that of promoting or maintaining the health and well-being of the patient. Secondly, parents or guardians cannot give consent if the person carrying out or supervising the treatment is aware, or ought reasonably to be aware, that the patient objects to the carrying out of the treatment. This second limitation gives patients a power to veto a decision made on their behalf to have medical treatment carried out.

2.45 A patient's objection to the medical treatment in question is to be disregarded if the patient has minimal or no understanding of what the treatment entails, and the treatment will cause no distress or reasonably tolerable and transitory distress, or if the Tribunal has authorised the medical treatment, despite the patient's objection. The Tribunal can only override such an objection if it is satisfied that the objection is made

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[64] *Guardianship Act 1987* (NSW) s 36, 33A(2), 33.

[65] *Guardianship Act 1987* (NSW) s 36(1)(b). Part 5 also provides for consent to be given to "clinical trials", and generally requires that the Guardianship Tribunal give such consent: see s 45AA, 45AB.

[66] *Guardianship Act 1987* (NSW) 36(1)(b). There is provision in s 36(2) for the guardian of a patient to consent to the carrying out of continuing or further special treatment if the Tribunal has previously given consent to this. The Commission discusses these provisions relating to special treatment in Chapter 4 at paragraph 4.21-4.22.

[67] *Guardianship Act 1987* (NSW) s 44.

[68] *Guardianship Act 1987* (NSW) s 37.

[69] *Guardianship Act 1987* (NSW) s 46.

because of the patient's lack of understanding of the nature of, or reason for, the treatment.[70]

2.46 In general, the practical effect of the separate regime under Part 5 of the *Guardianship Act* is the same as that of the rules applying to consent for young people aged below 16 who are incompetent to consent themselves. In both cases, it will usually be the young person's parents who have the power to consent on their child's behalf. However, there are several differences worth noting:

- Part 5 of the *Guardianship Act* constitutes a fairly cohesive regime which sets up mechanisms for the provision of medical and dental treatment for people aged 16 and over who are not competent to make decisions about their own medical care. It follows certain policy directions, namely to ensure that people within this group are not deprived of necessary medical and dental treatment, and that any medical treatment carried out is done for the purpose of promoting the person's health and well-being.[71] In contrast, there is no single cohesive framework governing consent to medical treatment for young people aged below 16. Instead, consent to the medical treatment of young people who are below 16 and who lack capacity to consent, is governed by a combination of the common law, s 49 of the *Minors (Property and Contracts) Act 1970* (NSW), and the *Children and Young Persons (Care and Protection) Act 1998* (NSW). Because of the piecemeal nature of the rules governing consent for under 16-year-olds, there is no overall policy approach to imposing restrictions on the power to consent for this group of young people.
- For young people aged 16 and over who lack capacity to consent, the Guardianship Tribunal can consent to any type of medical treatment (falling within the legislative definition), even if parents are also legally entitled to consent to that type of treatment. Therefore, if parents would not give their consent to a certain type of treatment, a medical practitioner could apply to the Guardianship Tribunal for its consent to the treatment, if the medical practitioner considered that it was in the young person's best interests to do so. For young people below 16, there is no such express provision for the Guardianship Tribunal (or other body) to authorise medical treatment in situations where parents will not consent. However, the parens patriae jurisdiction of the Supreme Court gives that court the power to authorise medical treatment that is in the child's best interests, even if the parents will not consent. It is likely too that the Family Court of

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[70] *Guardianship Act 1987* (NSW) s 46A.

[71] See *Guardianship Act 1987* (NSW) s 32.

Australia could hear such an application.[72] These mechanisms are not as straightforward as those set up by Part 5.

- The types of treatment that are considered "special" and require tribunal authorisation, rather than a parent's consent, are slightly different for people aged 16 and over than for people aged below 16. These are discussed in Chapter 4.

Issue 2.5

Should a different legal regime apply to young people aged 16 and over, than that which applies to young people below the age of 16, to determine when they can consent to or refuse medical treatment, and to determine who can consent to or refuse medical treatment on their behalf if they are not legally competent to make that decision themselves?

REFUSING MEDICAL TREATMENT

2.47 Neither s 49 of the *Minors (Property and Contracts) Act 1970* (NSW) nor Part 5 of the *Guardianship Act 1987* (NSW) deals expressly with a young person's ability to refuse medical treatment. The matter is, therefore, generally governed by the common law.

2.48 For competent adults, the power to consent to treatment includes the right to refuse treatment. This right is premised on the right of each individual to autonomy and personal integrity. In the words of Justice Cardozo: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body".[73] Hence, a competent adult has an absolute right to refuse medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death.[74] The rules that apply to young people under 18 years of age are, however, quite different.

2.49 First, the ability of parents to consent to the medical treatment of a young person can operate on that person's refusal of medical treatment even where the young person is *Gillick*-competent. In *R (A Minor) (Wardship: Consent to Treatment)*, the English Court of Appeal examined the issue whether a young person who has achieved a sufficient understanding and intelligence to enable him or her to understand fully the treatment that is proposed could refuse treatment. The Court was of the view that the refusal of treatment by a *Gillick*-competent young person, although an important factor in the medical practitioner's decision whether

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[72] See para 4.24.

[73] *Schloendorff v Society of New York Hospital* (1914) 105 NE 92 at 93.

[74] *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871 at 904-905 (Lord Templeman); *Re T (Adult: Refusal of Treatment* [1992] 2 FLR 458 at 460 (Lord Donaldson MR).

or not to treat, did not hinder the ability of that young person's parents to give an effective consent to that treatment.[75] This approach has since been reiterated in a number of English cases.[76] The approach is supported by s 49(1) of the *Minors (Property and Contracts) Act 1970* (NSW) which, while not giving parents a veto on the *consent* to medical treatment of a *Gillick*-competent young person,[77] has the effect that the consent of a parent or guardian to the treatment of a *Gillick*-competent young person under 16 years of age provides a defence to an action in battery or assault where that young person has *refused* medical treatment.[78]

2.50 Secondly, the court may become involved in its parens patriae jurisdiction. When a court is asked to authorise the medical treatment of a young person, it starts from the position that the young person's opinion should be acted on unless the balance is strongly against this.[79] In practice, a young person's wish not to undergo medical treatment may be overridden by the courts if:

- the young person lacks sufficient understanding to appreciate the consequences of the refusal; or
- the refusal is not in the young person's best interests.

Lack of full understanding, intelligence and maturity

2.51 A young person's refusal of medical treatment may be overridden if the young person is considered not to be *Gillick*-competent.[80] The courts approach the assessment of a young person's competence to refuse treatment by analysing the young person's capacity to comprehend and

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[75] *In re R (A Minor) (Wardship: Consent to Treatment)* [1991] WLR 592 at 601 (Lord Donaldson MR). The young person in this case was, however, found not to be *Gillick*-competent.

[76] See *Re W (A Minor)* [1993] Fam 64 at 81 (Lord Donaldson MR); *Re S (A Minor) (Refusal of Medical Treatment)* [1995] 1 FCR 604 at 608-609 (Johnson J); *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180; *Re B (A Minor) (Treatment and Secure Accommodation)* [1997] 1 FCR 618 at 628-629 (Cazalet J).

[77] See para 2.29.

[78] See *Re W (A Minor)* [1993} Fam 64 at 84; *Re K, W and H (Minors) (Medical Treatment)* [1993] 1 FLR 854. The position at common law is unclear: consider para 2.25-2.26, 2.31.

[79] *Re S (A Minor) (Refusal of Medical Treatment)* [1995] 1 FCR 604.

[80] *Re W (A Minor)* [1993] Fam 64; *Re S (A Minor) (Refusal of Medical Treatment)* [1995] 1 FCR 604; *Re B (A Minor) (Treatment and Secure Accommodation)* [1997] FCR 618; *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180.

retain treatment information, to believe it and to weigh it in the balance to arrive at a choice.[81]

Case study

A, a 15 year old boy, was hospitalised for leukaemia. Conventional treatment involved the administration of four drugs, which in turn necessitated the administration of blood transfusions from time to time. There was an 80% to 90% chance of full remission if this treatment were adopted. The child and his family were Jehovah's Witnesses and it was contrary to their religion to permit blood transfusions. As the child, supported by his parents, indicated his refusal of a blood transfusion, the hospital adopted an alternative course of treatment, which gave a 60% chance of remission. Within two weeks, A's condition had deteriorated to the extent that his life was threatened. The hospital sought the leave of the court to treat A as they considered necessary, including the transfusion of blood.

One issue was whether A was of sufficient understanding and intelligence and maturity to give an informed refusal of the proposed treatment. The court found A of sufficient intelligence to be able to make decisions about his well-being and was impressed by his calm assertion that he would refuse treatment well knowing that he may die as a result. However, the court found that he did not have a full understanding of the whole implication of what the refusal of treatment involved. He did not have a sufficient understanding of the pain he had yet to suffer, of the fear he would be undergoing, of the distress not only occasioned by that fear but also – and importantly – the distress he would suffer as he, a loving son, helplessly watched his family's distress. He might have some concept of the fact that he would die if untreated, but the court found that he did not have the ability to turn his mind to the manner of his death and the extent of his and his family's suffering.

The court held that A's welfare dictated that the hospital be at liberty to treat him with the administration of further drugs and consequently with the administration of blood and blood products.[82]

Was the level of understanding, intelligence and maturity required in this case too high?

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[81] *Re C (Refusal of Medical Treatment* [1994] 1 FLR 31 at 36 (Thorpe J). This case, which involved an adult, has been applied to minors: see *Re B (A Minor) (Treatment and Secure Accommodation)* [1997] FCR 618 at 625 (Cazalet J).

[82] *Re E (A Minor) (Wardship: Medical Treatment)* [1992] 2 FCR 219. See also *Re S (A Minor) (Refusal of Medical Treatment)* [1995] 1 FCR 604.

2.52 In assessing a young person's competence, the court will take into account the extent to which that competence is affected by illness, medication, false assumptions, misinformation or by influence of another. Hence, the courts have held that anorexia nervosa is an illness that can affect a young person's competence, providing a basis for overriding the young person's refusal to consent to treatment.[83]

The young person's best interests

2.53 A court can override a young person's refusal of medical treatment in its welfare jurisdiction.[84] The court's discretion to override a young person's refusal of treatment can be exercised only if the refusal is contrary to the young person's best interests. Courts often use this discretion in circumstances where a refusal of treatment will in all probability lead to the death of the child or to severe or permanent injury.[85] The court can override a refusal of treatment, notwithstanding the fact that the child or young person is "*Gillick*-competent".[86]

Case study

M, a 15 year old girl, suffered a heart failure. Despite medical treatment, her medical condition deteriorated to an extent that the medical practitioners concluded that the only course of action to save her life was heart transplantation. As she refused to give her consent to the operation, the hospital applied to the court for leave to carry out the operation. Below are extracts of the interview M had with a solicitor who acted on behalf of the court:

"First knew I needed a transplant on Wednesday. I understand what a heart transplant means, procedure explained…checkups…tablets for the rest of my life. I feel depressed about that. I am only fifteen and don't want to take tablets for the rest of my life…It's all happened quickly…if I don't get the operation I will die. I really don't want a transplant – I am not happy with it - I don't want to die. It's hard to take it all in. I feel selfish. If I had the transplant, I wouldn't be happy. If I were to die my family would be sad. If I had children and they were old enough my age, I would go with whatever is best – what they want I would not let them die. Death is final I know I can't change my mind. I don't want to die, but I would rather die than have the transplant and have someone else's heart, I would rather die

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[83] *Re W (A Minor)* [1993] Fam 64 at 81 (Lord Donaldson MR).

[84] *Re W (A Minor)* [1993] Fam 64 at 81 (Lord Donaldson MR); *Re M (Medical Treatment: Consent)* [1999] 2 FLR 1997.

[85] *Re W (A Minor)* [1993] Fam 64 at 88 (Balcombe LJ).

[86] *In re R (A Minor) (Wardship: Consent to Treatment)* [1991] WLR 592 at 602 (Lord Donaldson MR). The minor in this case was, however, found not to be *Gillick*-competent.

with fifteen years of my own heart. If I had someone else's heart, I would be different from anybody else – being dead would not make me different from anyone else. I would feel different with someone else's heart, that's enough reason not to have a heart transplant, even if it saved my life. I don't want to write the Judge a letter."

The solicitor who interviewed M expressed the view that she was an intelligent 15 year old whose wishes should carry considerable weight. However, he was also of the view that M felt overwhelmed by her situation and the decision she was being asked to make.

The court noted the risks involved during and after a heart transplant operation. There was also a risk that M would harbour for the rest of her life a deep resentment of what had been done to her. However, those risks had to be balanced with the certainty of death if no operation was made. The court ruled that it was in M's best interests to have a heart transplant operation.[87]

Issue 2.6

Should the law distinguish between the ability of young people, their parents or the courts to consent to the medical treatment of young people and to refuse to undergo such treatment?

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[87] *Re M (Child: refusal of medical treatment)* [1999] 2 FCR 577.

3.

Young people's capacity to make medical decisions – models for reform

- Should young people be able to make decisions about their own medical care?
- Choosing a model to decide competence
- The right to refuse medical treatment: should different rules apply?
- Treating certain types of conditions
- Treatment requiring court authorisation

3.1 Chapter 2 summarises the current law governing the legal competence of a person below 18 to consent to, or refuse, medical treatment for himself or herself. The current law is, arguably, unclear and uncertain in a number of respects, lacking a considered and coherent policy direction. Rather than providing a general framework by which to determine young people's competence, the current law has much more specific aims and limited scope.

3.2 In this chapter, the Commission considers various models for legal reform that could be adopted to replace or build upon the existing law. These models would aim to replace what is a fairly piecemeal area of the law with a more cohesive framework that reflects a particular policy stand as regards the rights and interests of young people, their families and the medical profession.

3.3 The models for reform that are discussed below vary in their policy positions, as well as the extent to which they seek to replace and reform the existing law. Ultimately, the decision whether or not to replace the current law, and the particular model that is chosen to replace it, should depend on the policies on which the model is based, and its workability in practice.

SHOULD YOUNG PEOPLE BE ABLE TO MAKE DECISIONS ABOUT THEIR OWN MEDICAL CARE?

3.4 Should a person below 18 be able to consent to, or refuse, his or her own medical treatment? This question is fundamental to any discussion of possible legal reform and the response that is considered most appropriate will guide the direction that such reform will take.[1]

3.5 There are at least three grounds for arguing that young people should, in some situations at least, be considered legally competent to consent to and refuse medical treatment:[2]

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[1] Leanne Bunney describes three general approaches which currently reflect the community's views of the medical treatment of children: libertarian (in favour of young people exercising adult rights as soon as they are able to); protectionist (in favour of protecting the young person's "best interests"); and parentalist (in favour of the adult closest to the child, usually the parent, having sole control over the child until the child reaches legal maturity): see L Bunney, "The capacity of competent minors to consent to and refuse medical treatment" (1997) 5 *Journal of Law and Medicine* 52 at 52.

[2] See Queensland Law Reform Commission, *Consent to medical treatment of young people* (Discussion Paper, WP 44, 1995) at 81; Law Reform Commission of Western Australia, *Medical treatment for minors* (Discussion Paper, Project 77, 1988) at

- Some young people may be capable of maturing and developing to a degree that they can, and should, be considered to have the capacity of adults to understand and make decisions about their own health care.
- The law in this area should be in line with the modern view of children as young people with rights, including a right to their own bodily integrity and a right to control, or at the least to participate in, decisions affecting their bodies. The perception of children as "chattels" of their parents or their father, over whom parents may exercise complete control, is outmoded and inappropriate.
- It is in young people's best interests to allow them ready access to health care and treatment when needed. In some instances, particularly for matters relevant to adolescent health, young people may not seek medical assistance if they have to involve their parents in the process. It may be necessary to recognise as valid the young person's consent in order to treat him or her.

3.6 One or all of these grounds could provide a basis to justify a legal framework recognising young people's competence to make decisions about their health care. Which of these grounds is given priority, or how they are balanced, will affect the framework that is formulated. For example, if priority is given to the first two arguments, then the law should deny a young person the right to give a personal consent or refusal to medical treatment only to the extent that is necessary to protect them from the consequences of a decision made when they do not have sufficient maturity to give an informed consent or refusal. Once they are sufficiently mature, they should be recognised as autonomous individuals with the same right to make their own decisions as adults. If, on the other hand, priority is given to the third argument, then the law should only recognise as valid a young person's consent or refusal to the extent that this benefits the young person's health and well-being, with less focus on the maturity of the individual.

Issue 3.1

In what situations, if any, should young people be able to make their own decisions about their medical care?

CHOOSING A MODEL TO DECIDE COMPETENCE

3.7 The Commission puts forward below five possible tests, or models, for deciding when a young person should be considered legally competent to

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para 3.8-3.11; A Bainham, *The judge and the competent minor* (1992) 108 *Law Quarterly Review* 194 at 196.

consent to, or refuse, a particular type of medical treatment. We have set out the basic principles of each model and raised issues of concern about each. We are interested in your comments, both generally about each model and about the specific issues raised. A table, summarising the features of each model, as well as its advantages and disadvantages, appears in Appendix A, to help you compare and weigh up the options. As well, there may be other models that we have not considered and that have merit as a means of determining when a young person should be able to give personal consent or refusal to medical treatment. We welcome your suggestions for other such models.

3.8 In considering possible options for reform, it may be helpful to imagine how each model would apply in practice to assess a young patient's legal competence. Here are some situations in which the question of whether young people should be able to consent to treatment may provoke various responses and to which the application of the models suggested below may prove to be more, or less, workable than the existing law:

- A young woman wishes to have cosmetic surgery performed, such as a breast enlargement.
- A young person seeks treatment for depression, including counselling and prescription of anti-depressants.
- A young person suffering from leukaemia wishes to decide for himself or herself the treatment program, rather than allowing his or her parents to decide.
- A young woman seeks a prescription for the Pill.

A note on the right to refuse treatment

3.9 It is questionable whether a young person's right to refuse medical treatment should be treated separately and differently from the right to consent, and whether a different legal framework should govern any such right to refuse. The Commission considers this question below, at paragraph 3.35-3.43. For the moment, the five suggested models for reform that follow are formulated in terms of deciding both whether a young person can consent to and refuse treatment. It may be that these models are ultimately considered appropriate only as a means of determining the issue of consent and that different rules are considered desirable to apply to determining if and when a young person can give a valid refusal of medical treatment.

Model One: Assess consent according to each young person's capacity to understand

"Understanding the nature and possible consequences"

3.10 This model encapsulates the common law approach to deciding competence to consent, as reflected in the *Gillick* test.[3] It determines legal competence to consent on an individual, case-by-case basis: a young person may give a valid consent or refusal if he or she is capable of understanding the nature and possible consequences of the treatment. It allows the treating medical practitioner to judge the maturity of each individual and recognises that young people mature at different rates, with varying degrees of understanding about different types of treatment.

3.11 This model has several variations. A young person could give a legal consent or refusal to medical treatment if:

- the treating medical practitioner were satisfied that the young person understood the nature and possible consequences of the treatment;[4] or

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[3] See Chapter 2 at para 2.7-2.14.

[4] The Queensland Law Reform Commission endorsed this variation. It recommended that a young person's competence to consent be judged according to whether or not he or she understood the nature and consequences of the health care, and communicated his or her decision in some way: see Queensland Law Reform Commission, *Consent to health care of young people* (Report 51, December 1996) Vol 2 at 201. See also the Scottish Law Commission, which recommended that a person below the age of 16 have capacity to consent to medical treatment if he or she were capable of understanding the nature and consequences of the treatment proposed: Scottish Law Commission, *Report on the legal capacity and responsibility of minors and pupils* (Scot Law Com No.110, HMSO, Edinburgh, 1987) at para 3.83. The Law Reform Commission of Manitoba also endorsed the application of the mature minor rule (that is, an assessment of a young person's competence to consent according to his or her ability to understand the medical treatment in question), but considered that the common law was sufficiently clear without the need for further legislative clarification: see Manitoba Law Reform Commission, *Minors' consent to health care* (Report 91, 1995) recommendations 1 and 2. The Law Reform Commission of Hong Kong also expressed support for the application of the mature minor rule: see Hong Kong Law Reform Commission, *Young persons - effects of age in civil law* (Topic 11, 1986) at para 5.5.5.

[5] See *Consent to Medical Treatment and Palliative Care Act 1995* (SA s 12(b)(i)), which provides for a young person below the age of 16 to consent to medical treatment if capable of understanding the nature, consequences and risks of the treatment, and if the treatment is in the best interests of the young person's health and well-being. In British Columbia, Canada, s 17 of the *Infants Act* RSBC 1996 c. 223 makes similar provision for the validity of a young person's consent to be subject to the medical treatment being in his or her best interests. The Uniform

- the treating medical practitioner were satisfied that the young person understood the nature and possible consequences of the treatment and the medical practitioner were satisfied that the treatment was in the young person's best interests;[5] or
- the treating medical practitioner were satisfied that the young person understood the nature and consequences of the treatment, where there was a presumption of maturity over a specified age, such as 13, and the possibility of maturity under that age if it could be proved to the medical practitioner's satisfaction;[6] or
- the treating medical practitioner were satisfied according to one of the above tests, and that opinion was supported by written approval from a second medical practitioner.[7]

What level of understanding should be required?

3.12 What do we mean by "understanding" the nature and possible consequences of a particular type of treatment? Should this test for competence require simply that a young person reach a certain level of cognitive development to appreciate the procedure that is involved or is

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Law Conference of Canada also recommended a Uniform Act for Canada governing the capacity of young people to consent to medical treatment. According to its scheme, a mature young person's capacity to consent would be limited by the requirement that the medical treatment be in the young person's best interests: see Canada, Uniform Law Conference, *Proceedings of the fifty-seventh annual meeting of the uniform law conference of Canada* (1975) Appendix N.

[6] See the Law Reform Commission of Western Australia, which proposed a statutory scheme that confirmed the common law right of young people to consent to medical treatment if they were mature, and that regarded young people aged between 13 and 16 as presumptively mature, and young people below the age of 13 as potentially mature if that maturity could be established to the medical practitioner's satisfaction: see Law Reform Commission of Western Australia, *Medical treatment for minors* (Discussion Paper, Project No. 77, 1988) at para 5.9-5.17.

[7] See *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 12(b)(ii) and the recommendation of the Uniform Law Conference of Canada in *Proceedings of the fifty-seventh annual meeting of the uniform law conference of Canada* (1975) Appendix N. The Queensland Law Reform Commission ultimately rejected as impracticable any such requirement for a second medical practitioner's opinion: see Queensland Law Reform Commission, *Consent to health care of young people* (Report 51, December 1996) Volume 2 at 257-258.

there some higher level of understanding that should be required? Is a single test for competence possible in view of the variety of medical procedures that might be the subject of consideration in any particular situation? The Commission has already noted[8] that the current common law is not clear about the level of understanding that a young person must demonstrate under the *Gillick* test in order to be legally competent to consent to medical treatment: should the young person have to demonstrate a high level of understanding, so as to be able to exercise a "wise choice", understanding not just the nature of the treatment proposed, but also the moral, emotional and family ramifications of the treatment, or should he or she only have to demonstrate a lower level of understanding, one which considers simply the nature of the medical treatment proposed? Should the young person demonstrate not only the cognitive skills to make an intelligent choice about the proposed treatment, but also have the social or emotional maturity to make a "voluntary" decision, reasonably free from influences such as pressure from peers, the desire to conform or to defer to authority?[9]

3.13 For instance, in the example outlined in paragraph 3.8 of the young woman seeking cosmetic surgery, should she be considered legally competent to consent to the surgery if she has the cognitive skills to understand the procedure and the risks involved? Should the treating medical practitioner also be questioning her level of social and emotional maturity, and her ability to decide independently of a normal adolescent preoccupation with body image and conformity with peers? Is it possible to identify, with any real certainty, a particular point in a young person's development as the threshold past which that young person should be considered legally competent to make decisions about health care?

3.14 It has been suggested[10] that guidelines should be formulated to help medical practitioners assess young people's capacity to understand in a clear, consistent manner, with reference to specified and clearly articulated criteria. The use of guidelines would, firstly, provide the medical profession with an objective standard to enable them to assess young people consistently; and secondly, ensure that medical practitioners provide objective, behaviourally based observations of any incapacitations of a particular patient, which would then be available for subsequent scrutiny by, for example, a court.

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[8] See para 2.11-2.14.

[9]. See the discussion of the development of young people's decision-making skills in Chapter 1, at paragraph 1.14-1.15.

[10] See L Bunney, "The capacity of competent minors to consent to and refuse medical treatment" (1997) 5 *Journal of Law and Medicine* 52 at 61, 80.

Issue 3.2

(a) Should the law assess a young person's competence to consent to medical treatment in terms of the individual young person's understanding of the nature and possible consequences of the proposed medical treatment, as put forward in Model One of the Commission's Options for Reform?

(b) Is there a more appropriate formulation of the test put forward in Model One? For example, should the focus be more on the reasoning process by which the young person reaches a decision about treatment, with an assessment of his or her ability to consider and weigh up various alternatives?

(c) Should the law spell out the level of understanding that a young person must demonstrate in order to be competent according to the test put forward in Model One and, if so, how?

(d) Would it be helpful to prescribe guidelines by which the treating medical practitioner can assess the individual patient's degree of understanding under this test?

Finding appropriate safeguards against a medical practitioner's error in judgment

3.15 Model One carries the risk that a medical practitioner will make a mistake about an individual patient's level of maturity. As we noted in the paragraph above, it may not be easy in practice to identify a point at which a young person can be said to pass a specified threshold of maturity to make him or her legally competent to make a decision about a particular medical matter, and it is a question on which medical practitioners might reasonably disagree. There are other factors that might also affect a medical practitioner's ability to make a fair assessment of a young person's competence, such as the medical practitioner's own cultural values and his or her exposure to and experience in treating young patients. The medical practitioner's judgment may go unchallenged or may not be challenged until after the consequences of that judgment have been felt.

Issue 3.3

(a) Does Model One of the Commission's Options for Reform place too much discretion in the medical practitioner's hands and too much faith in the medical practitioner's ability to assess the young person's level of maturity?

(b) Does Model One place too much emphasis on the young person's right to autonomy at the risk of exposing him or her to the consequences of a detrimental decision?

3.16 Safeguards could be put in place to check the exercise of the medical practitioner's discretion. For example, the requirement for written support from a second medical practitioner, appearing above as the fourth variation of this model,[11] is one such safeguard.

Issue 3.4

(a) Could a requirement for a second medical opinion in Model One of the Commission's Options for Reform become simply a "rubber stamp", where approval is granted as a matter of course?

(b) Would such a requirement place too great a burden on medical practitioners, particularly in more isolated, rural areas, to seek a second opinion?

(c) Would such a requirement discourage young people from seeking medical treatment if they knew that the details of their consultation were likely to be disclosed to another medical practitioner?

3.17 Another safeguard that has been previously suggested[12] is provision for a person with "sufficient interest", including a young person or parent, to apply to a judge to challenge the medical practitioner's decision about the young person's maturity in order either to prohibit the proposed medical treatment or to allow it to take place.

Issue 3.5

(a) Is it practical to include a safeguard in Model One of the Commission's Options for Reform that gives an "interested person" a right to challenge a medical practitioner's decision about competence in court?

(b) Is there any way in which parents, and other interested people, could be made aware of a medical practitioner's decision before the medical treatment is carried out without compromising the medical practitioner's duty of confidentiality to the young person?

(c) Could a provision, which allowed parents and others to challenge a medical practitioner's assessment of competence, discourage young people from seeking medical assistance?

(d) Are there other safeguards that could be included in Model One, which would be effective in limiting the power vested in the individual medical practitioner in determining a young person's competence to consent or refuse?

A requirement to consider the young person's best interests?

3.18 The second variation of this test includes a welfare provision. That is, the medical practitioner must be satisfied that the treatment in question is

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[11] See para 3.11 above.

[12] See Saskatchewan Law Reform Commission, *Proposals for a Consent of Minors to Health Care Act* (Report to the Attorney General, February 1980) Chapter 7 at 12-13, Appendix D.

in the young person's best interests before relying on the (competent) young person's consent, or refusal.

Issue 3.6

(a) If a young person is sufficiently mature to understand the nature and consequences of the medical treatment proposed, should that be enough to validate his or her consent, or refusal, according to Model One of the Commission's Options for Reform?

(b) Is a qualification justifiable that requires young people's decisions about their medical care to be in their own best interests before their consent or refusal becomes legally valid?

(c) If a young person's legal competence to consent, or refuse, is made subject to that consent or refusal being in his or her best interests, how are those best interests to be determined, and by whom?

Distinguishing between "consent" and "informed consent"

3.19 In Chapter 1,[13] the Commission referred to two legal doctrines relating to the notion of consent to medical treatment. The first requires a patient's legally valid consent in order to negate what would otherwise amount to a trespass to the person; the second requires that a patient's consent be based on an informed decision, following a disclosure by the medical practitioner of all the material risks involved in the proposed treatment. In general, at least in the context of treating adult patients, it seems that a consent is legally valid to avoid liability in trespass if it is given by a competent patient who understands the general nature of the procedure that is proposed. Failure to disclose all the material risks to the patient does not invalidate the patient's consent so as to give rise to liability in trespass, but instead exposes the medical practitioner to possible liability in negligence.

3.20 The Commission noted in Chapter 1 that in the current law governing young people's competence to consent to medical treatment, there appears, to some extent at least, a convergence of these two doctrines. Under the *Gillick* test, a young person is competent to consent to treatment, so as to negate what would otherwise be a trespass, if he or she understands the nature *and* the possible consequences of the treatment. Presumably, this would require the treating medical practitioner to disclose not only the general nature of the treatment, but also its possible consequences, including the risks inherent with the procedure. It is not clear how this impacts, if at all, on a medical practitioner's duty to disclose all material risks so as to avoid liability in negligence.

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[13] See para 1.38-1.43.

3.21 Model One adopts, to a great extent, the common law test for assessing a young person's competence under the *Gillick* test. If this model is determined to be the preferred option, it may be desirable to consider how it is to interact with the notion of "informed consent" in the law of medical negligence.

Issue 3.7

How is Model One of the Commission's Options for Reform to be distinguished from the notion of "informed consent" in the law of medical negligence? Should a medical practitioner be required to disclose the "material risks" of a particular type of medical treatment in order to be satisfied of a young person's competence to consent?

Model Two: Assess consent by fixing a general cut-off age

3.22 This model fixes a general age at which a young person is considered legally competent to consent to or refuse medical treatment. All young people of that age are then able to give personal consent or refusal, without the need to obtain parental approval of that decision (unless incapacitated for some reason other than minority, such as an intellectual disability). All young people under that fixed age require their parents' consent, or authorisation from the State, to obtain medical treatment, and their parents generally have sole right to refuse medical treatment for them, subject to the courts' power to intervene. This general rule could be made subject to certain exceptions. For example, different rules could apply to decisions about treating certain types of medical conditions, as discussed at paragraph 3.27-3.29 below.

3.23 This model[14] has the advantage of certainty for medical practitioners. It removes any discretion from the medical practitioner to make a judgment about the maturity of an individual patient. It avoids the risk that a medical practitioner will sometimes make mistakes in assessing a young person's competence to consent, and that young people with insufficient understanding may consequently consent to health care without their parents' knowledge or guidance. The model does not allow for the possibility that certain individuals may be mature enough to make a decision about their health care at a younger age. It also carries the risk that young people below the cut-off age will be deprived of medical

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[14] For further discussion of a fixed-age rule to determine competence, see A Newman, "Adolescent consent to routine medical and surgical treatment: a proposal to simplify the law of teenage medical decision-making" (2001) 22 *Journal of Legal Medicine* 501.

treatment because they do not want to consult with their parents about the medical condition in question. This model gives priority to the need to protect immature young people from making detrimental decisions over the desire to give mature young people the right to autonomy and proper access to health care.

Issue 3.8

(a) Is there any greater likelihood of error in assessing legal competence using a fixed age test, as in Model Two of the Commission's Options for Reform, than in a test that requires the treating medical practitioner to make a judgment about the maturity of an individual patient, as in Model One?
(b) Are concerns about denying young people below the cut-off age proper access to health care adequately met by formulating a list of medical procedures to which a person younger than the cut-off age can consent as exceptions to the general, fixed age rule?
(c) If Model Two were adopted, what would be an appropriate age to fix as the cut-off age? The most common choice in other jurisdictions is 16, although some jurisdictions have fixed the age at 14.[15]

Model Three: Assess consent according to the young person's age *and* capacity to understand

3.24 This model combines an age-based test and a capacity-based test. Young people over a certain age can give a valid consent or refusal to medical treatment if the treating medical practitioner is satisfied that they understand the nature and consequences of the treatment. Young people under that age cannot give a valid consent or refusal, and medical practitioners cannot generally treat them without the parents' consent.

3.25 Here is one formulation of this approach:

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[15] For example, in South Australia, a person of or over 16 years of age is able to make decisions about his or her own medical treatment as if he or she were an adult: see *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6. See also *Family Law Reform Act 1969* (UK) s 8, following a recommendation of the Committee on the Age of Majority: see England and Wales, *Report of the committee on the age of majority* (Cmnd 3342, HMSO, London, 1967) at para 474-484. Similarly, law reform bodies elsewhere have recommended adoption of a legislative scheme that regards young people aged 16 and above as if they had the legal competence of adults in terms of making decisions about their medical treatment: see Saskatchewan Law Reform Commission, *Proposals for a Consent of Minors to Health Care Act* (Report to the Attorney General, 1980) Appendix D; Law Reform Commission of Western Australia, *Medical treatment for minors* (Discussion Paper, Project No. 77, 1988) at para 5.11-5.13; Scottish Law Commission, *Legal capacity and responsibility of minors and pupils* (Report, Scot Law Com No. 110, Edinburgh, HMSO, 1987) at para 3.62.

- Young people aged 16 and over can legally consent to medical treatment as if they were adults.
- Young people between 12 and 15 can legally consent to medical treatment if they understand the nature and consequences of the treatment. The young person's consent is still valid even if one or both parents object to or refuse the treatment. Parents of a child between 12 and 15 can legally consent to medical treatment for their child. Their consent is still valid even if the child objects to or refuses the treatment, except for certain types of treatment that cannot be performed over the young person's objection, such as termination of pregnancy.
- Young people under 12 cannot legally consent to, or refuse, their own medical treatment. Medical practitioners can generally treat a child under 12 if the child's parents consent to the treatment and the treatment is in the best interests of the child.

3.26 This approach seeks to strike a balance between flexibility and the need to protect immature young people from the consequences of detrimental decisions about their health care. It recognises that some individuals below a certain age may in fact be mature enough to make their own decisions about medical treatment. However, it also recognises the possibility that medical practitioners may make mistakes in assessing competence, and goes some way in protecting young people from those mistakes.

Issue 3.9

(a) Does Model Three of the Commission's Options for Reform find a suitable balance between young people's right to autonomy, parents' interests in protecting and guiding their children and the State's responsibility to protect its young?
(b) Is Model Three too complicated to be workable in practice?

Model Four: Assess consent according to the type of medical treatment

3.27 This model determines a young person's legal competence to give personal consent or refusal, according to the type of medical treatment that is in question. For example, the law could stipulate that a young person, of any age, could give a personal consent to, or refusal of, treatment in respect of one or more of the following:

- contraception;
- termination of pregnancy;

- pregnancy-related health care;
- sexually transmitted diseases;
- drug or alcohol abuse;
- mental health services.

3.28 If desired, legislation giving effect to this model could include an additional provision that the treatment sought (or refused) be in the young person's best interests: that is, a young person could consent to, or refuse, treatment relating to one of the above, if it were in the young person's best interests that the treatment be carried out (or not carried out, as the case may be).

3.29 This model could operate either as a principal test for deciding legal competence, or in addition to a principal test. For example, legal competence to consent could be judged according to a fixed age test (or any other of the models discussed), with the additional provision that a young person of any age could give personal consent to treatment for one of a list of prescribed conditions. The issue here is whether there are certain types of treatment to which a young person of any age should always be able to give a personal consent or refusal, for public policy reasons, regardless of whatever other rules apply generally to decide legal competence to consent. The Commission gives separate consideration to this question at paragraphs 3.44-3.54 below.

Issue 3.10

Should the type of medical treatment in issue determine a young person's ability to consent to, or refuse, medical treatment, either as a principal or a subsidiary test for legal competence? If so, which types of treatment should a young person be automatically considered competent to consent to, or refuse?

Model Five: Assess consent according to specific groups of young people

3.30 According to this model, young people can make their own decisions about their health care if they fall within one of a list of categories, such as:

- young people who are married or living in a de facto relationship;
- young people who are themselves parents;
- young people who live apart from their parents and manage their own financial affairs;
- homeless young people.

3.31 Again, this model can be put forward either as a principal test for determining legal competence, or in addition to a principal test. For example, a young person who is below the fixed age for consent in a fixed age model could still give personal consent if he or she fell into one of the above categories.

Issue 3.11

(a) Should any or all of the following groups of young people, as listed in Model Five of the Commission's Options for Reform, be considered competent to consent to or refuse medical treatment, regardless of whether they meet the criteria in any general test for assessing legal competence?

- Young people who are married or living in a de facto relationship;
- Young people who are parents;
- Young people who live apart from their parents and manage their own financial affairs;
- Young people who are homeless.

(b) Are there any other groups of young people who should always be able to give personal consent or refusal to medical treatment?

(c) Should these groups of young people be able to consent to or refuse medical treatment as if they were adults, or should there be an additional requirement that the medical practitioner consider the treatment in question, or refusal of that treatment, to be in the patient's best interests?

Formulating an alternative model: Selecting indicators from each proposed model for reform

3.32 It may be that no single model of the five set out above is considered suitable as the sole means of deciding a young person's legal competence to consent. Instead, each model may contain features that are considered useful as indicators by which to assess competence. Ultimately, the model that is chosen may be a collection of indicators from all, or some, of these models.

Issue 3.12

(a) Are there any other models for reform that are not included in the five models set out in Chapter 3, which might be effective in determining young people's legal competence to make decisions about their medical care?

(b) Which, if any, features, or indicators, of the five models listed in Chapter 3, would you consider useful to retain in any alternative model for reform?

The role of parents in the proposed model for reform

3.33 Consideration needs to be given to the role that parents should play within any proposed model for reform to the law governing young people's right to consent to and refuse medical treatment. The current law in New South Wales is unclear on the interaction between parents' and young people's rights to consent, and how to resolve possible conflict between a parent and child.[16]

3.34 It may be desirable to clarify the role and rights of parents in participating in decisions about their children's medical care once their children are legally competent to consent to, and refuse, medical treatment themselves. Should parents retain power to make medical decisions on their child's behalf in this situation or should any such power cease as soon as their child becomes legally competent to make those decisions? This question has already been raised in Chapter 2, in Issue 2.4, and the Commission invites your response.

THE RIGHT TO REFUSE MEDICAL TREATMENT: SHOULD DIFFERENT RULES APPLY?

3.35 As the Commission noted in Chapter 2, at paragraphs 2.47-2.53, it is not clear whether, under current law, a mature young person has a right to refuse medical treatment in the same way as he or she has a right to consent to it.

3.36 Should a person under 18 have a right to refuse medical treatment and, if so, when should he or she be able to do so? The following are controversial situations in which these questions may arise:

- A young person with anorexia refuses treatment for the disease.
- A young person with a mental illness or behavioural disorder refuses treatment, in particular refuses prescribed medication.
- A young person suffering from substance addiction refuses treatment, including counselling.
- A young woman refuses to terminate her pregnancy.
- A young person refuses a particular treatment that is preferred by the treating medical practitioner and/or parents, and chooses a different treatment option.

3.37 Some of these examples are complicated by the fact that there are factors additional to the person's age that may have an effect on his or her capacity to understand the consequences of refusing treatment. How should medical practitioners assess the capacity of a young person who suffers from a mental illness or eating disorder: are they to determine first

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[16] See Chapter 2 at para 2.28-2.31.

whether the young person has the maturity of an adult, and if so, then judge their capacity to refuse treatment according to the standards used to determine legal capacity of an adult with a mental illness, or is a two-staged determination of this sort completely artificial and impossible to carry out in practice?

3.38 The question of a young person's right to refuse also highlights problems in maintaining patient confidentiality when treating young people. Where a young person refuses treatment that the medical practitioner considers to be in his or her best interest, and the parents are unaware of the young person's health problem or condition, can and should the medical practitioner breach patient confidentiality to inform the parents of the young person's refusal? This is an issue that is discussed in Chapter 9.[17]

Reason for recognising a right to refuse

3.39 The main reason for recognising a young person's right to refuse medical treatment is straightforward. If young people are judged to be sufficiently mature, according to whatever test of maturity is formulated, why should they not be able to refuse medical treatment in the same way that a mature young person is able to consent to medical treatment and in the same way that an adult has a right to refuse treatment? If the law recognises the rights of adults to bodily integrity and control over their own health care, it is discriminatory and unjustifiably paternalistic to deny the same rights to young people who have the mental capacity to make rational decisions for themselves.

Reasons for rejecting a right to refuse

3.40 The following are possible reasons for denying young people a right to refuse medical treatment.

3.41 In most cases, the provision of medical treatment is aimed at benefiting a young person and the refusal of such treatment would be considered, at least in the eyes of the general public, to be to the young person's detriment. If the primary motivation in recognising young people's right to *consent* to medical treatment is to allow them better access to health care, that same concern does not apply to allow them a right to refuse treatment and in fact argues against such a right. At the beginning of this chapter, the Commission referred to three grounds for justifying a

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[17] See para 9.15-9.18.

young person's right to consent: recognition of young people's ability to mature; recognition of their right to bodily integrity and control over their own health care; and a desire to allow them ready access to medical care. A legal framework that denies young people a right to refuse medical treatment gives priority to the third consideration over the first two considerations.

3.42 It may also be argued that the level of maturity that is needed to appreciate what is involved in refusing medical treatment is different from, and possibly higher than, the level of maturity required in consenting to treatment.[18] Is the reasoning process of the average adolescent, for example, able to appreciate fully the long-term consequences of a decision to refuse treatment?

3.43 Of course, instead of rejecting altogether a young person's right to refuse, a different test, or a more stringent test, could apply to deciding a young person's capacity to refuse treatment than the test to decide his or her capacity to consent to it. Whether it would be practical or workable to have two different tests operating at the same time is open to question. The Commission has already asked, in Issue 2.6, whether young people should ever be considered legally competent to refuse medical treatment. Issue 3.13 seeks your views on the test that should be applied to determine competence to refuse, assuming a right to refuse should be afforded.

Issue 3.13

(a) Assuming that young people should be considered in some situations legally competent to refuse medical treatment, should the same test apply to decide a young person's legal competence to refuse as the test to determine competence to consent to treatment?
(b) If a different test should apply, how should a test to determine competence to refuse be formulated?

TREATING CERTAIN TYPES OF CONDITIONS

3.44 In paragraph 3.27-3.29, the Commission discussed a possible model for deciding consent (and possibly refusal) according to the type of medical condition that was involved. We noted that this model could be used as the primary model for deciding a young person's competence to consent to medical treatment, or as a model additional to another primary model. The fundamental question is whether, regardless of whatever general test is

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[18] This was a view put forward by the Queensland Law Reform Commission: see Queensland Law Reform Commission, *Consent to health care of young people* (Report 51, 1996) Volume 1 at 79.

used to decide legal competence to consent and/or refuse, there are certain types of conditions for which a young person should always have the right to refuse or consent to treatment, without the need to obtain a parent's consent or support.

3.45 We have already suggested a list of conditions and treatment that might fall within this special category of cases. These are:

- contraceptive advice and prescription (excluding permanent or long-lasting forms of contraception);
- sexually transmitted diseases;
- drug and alcohol abuse;
- mental health services;
- termination of pregnancy; and
- pregnancy-related health care.

Contraceptive advice, STDs, substance addiction and mental health services

3.46 In relation to these four conditions and treatment, it could be said that it is in both the interests of the young person and of the general community to allow a young person ready access to treatment, and that a young person of any age should be able to consent to such treatment without first obtaining parental authorisation. Should young people of any age, who are sexually active, have access to contraception, both for their own well-being, in preventing unwanted pregnancies, and for the sake of the community, which may indirectly share the costs of raising an unplanned child? The Commission does not intend to include within this list those forms of contraception that are permanent or long-lasting, such as sterilisation or injectable hormones. These types of medical procedures currently require special authorisation from a court or tribunal and we consider them separately in Chapter 4.

3.47 It is in the interests of the community, as well as the individual, to treat a sexually transmitted disease to prevent further infection. It can also be argued that a young person of any age who suffers from substance addiction should be able to seek treatment for that addiction for his or her own welfare, as well as the interests of the community in reducing the incidence of substance addiction and social problems that follow such addiction.

3.48 Perhaps more controversially would be to allow young people of any age ready access to mental health treatment, without the requirement first to obtain parental consent (and perhaps even without parents' knowledge). Certainly, there is a strong argument for allowing young people ready access to treatment if they suffer from depression, where treatment is likely to prevent a possible suicide. Access to mental health services without parental consent could be limited to these more extreme cases of suicide risk.[19] However, such a limitation may not be practical: it will not necessarily be readily apparent to a medical practitioner, on first meeting with a young person, whether or not that person poses a suicide risk. More fundamentally, it could be argued that young people of any age who are in a state of mental distress should be able to seek help, whether or not they want to tell their parents about the problem first in order to gain their consent for treatment. On the other hand, parents may be concerned that their children are, for instance, receiving counselling and possibly being prescribed drugs without their knowledge or authorisation. Towards the beginning of this Chapter,[20] the Commission cited situations in which the question whether a young person should have a right to consent to treatment might provoke differing responses. One of these situations was of a young person suffering from depression. Should that young person be given the right to consent to counselling, and possibly to medication such as anti-depressants, regardless of whether he or she passes any legal test for competence, or should his or her parents be involved in the decision of whether, and how, to treat the depression?

3.49 There are grounds for arguing that it is in the public interest to allow medical practitioners to treat young people for these four conditions based solely on the young person's consent, without the need to obtain parental consent and, perhaps, despite parental objection. The same justification does not apply to allowing young people of all ages the right to refuse treatment for these four conditions. In fact, the public interest argument provides a ground for arguing that young people of any age should not have a right to refuse treatment for these conditions, regardless of whatever general right to refuse medical treatment is recognised.

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19. This was recommended by the Queensland Law Reform Commission: see Queensland Law Reform Commission, *Consent to health care of young people* (Report 51, 1996) Volume 1 at 116 (although the Queensland Law Reform Commission did note that, since much psychiatric and psychological treatment did not involve any physical contact, liability in trespass for treating without a valid consent would not usually arise).
20. See para 3.8.

Issue 3.14

(a) Should a young person of any age be able to consent to any of the following four types of medical treatment without requiring parental consent:

- contraceptive advice and prescription (excluding permanent or long-lasting forms of contraception);
- treatment for sexually transmitted diseases;
- treatment for drug and alcohol abuse;
- mental health services?

(b) Should a young person of any age be able to consent to mental health treatment to prevent a risk of suicide, without requiring parental consent? Should a young person be able to consent to mental health treatment where there is no immediate risk of suicide, without parental consent?

(c) Should a young person be able to refuse any of the forms of treatment listed above in (a)?

(d) If the law recognises a young person's right to give personal consent to any of the forms of treatment listed in (a), should there be an additional requirement that the medical practitioner be satisfied that the treatment is in the young person's best interests?

(e) Should parents be able to consent to, or refuse, any of the four forms of treatment listed in (a), on behalf of their child? Should parents be able to veto a consent given by their child for any of these forms of treatment? Should a young person be able to veto a consent, or refusal, of his or her parents for any of these four forms of treatment?

Termination of pregnancy

3.50 At present, a pregnancy can be lawfully terminated if there is a valid consent and the termination is necessary to protect the woman from serious danger to her physical and mental health.[21] Presumably, under current law, only a young woman who is considered mature according to the *Gillick* test is able to give a valid consent to a termination. A young woman who does not meet this standard would therefore need to obtain her parents' consent before a legal abortion could be performed. It is uncertain in what circumstances a young woman might refuse a termination of her pregnancy if her parents had consented to the termination.

3.51 For a young woman, the decision to terminate a pregnancy is one that, ideally, should be made with the guidance and advice, or at least the knowledge of, a parent. On the other hand, young women who are not

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[21] See *R v Wald* (1971) 3 NSWDCR 25. See also *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311.

considered legally competent to give personal consent may simply resort to "backyard abortions" rather than inform their parents of the pregnancy, at great risk to their health. It may also seem paradoxical that a young woman can be considered not to be sufficiently mature to have the capacity to consent to an abortion but, failing that termination, is deemed sufficiently mature to give birth and possibly raise a child.

3.52 As for a young woman's right to refuse an abortion, it seems in some way an invidious violation of a woman's right to bodily integrity and right to choose to impose an unwanted termination on her. At the same time, parents and other adults may have grounds for concern that, because of the young woman's immaturity, she does not properly appreciate the demands of giving birth and raising a child.

Issue 3.15

(a) Should all young women below 18 be deemed competent to consent to a termination of pregnancy?

(b) Should all young women below 18 be deemed competent to refuse a termination?

(c) What legal role, if any, should the young woman's parents play in the decision whether or not to terminate her pregnancy?

Pregnancy-related health care

3.53 Should a pregnant woman who is below the age of 18 be able to give personal consent or refusal to pregnancy-related health care, or should the general test for determining competence to consent and refuse apply to this situation? For example, should a pregnant young woman be able to give personal consent to tests and ultrasounds that are routinely carried out to monitor the health of the foetus? Should a pregnant young woman have the right to refuse such tests? Should a young woman be considered competent to give personal consent or refusal to medical assistance in giving birth, such as consenting to or refusing a caesarean birth?

3.54 On the one hand, a woman who is sufficiently mature to have a child could be considered sufficiently mature to make decisions about her antenatal care. On the other hand, parenthood does not necessarily connote maturity and an immature young woman may make decisions about her health care that are detrimental not only to herself but also to the foetus.

Issue 3.16

(a) Should all pregnant women below 18 be considered competent to consent to pregnancy-related health care?
(b) Should all pregnant women below 18 be considered competent to refuse pregnancy-related health care?
(c) What role, if any, should the young woman's parents play in making decisions about her antenatal care?

TREATMENT REQUIRING COURT AUTHORISATION

3.55 There are currently statutory provisions requiring court authorisation before certain types of treatment can be carried out on a person under 18, whether or not that person is generally considered competent to give personal consent to medical treatment. The Commission defers discussion of these provisions to Chapter 4.

4.

Making decisions about medical care for young people who are not competent to decide for themselves

- Overview
- When parents disagree
- Recognizing the involvement of other family members or caregivers
- Medical treatment requiring authorisation by a court or tribunal

OVERVIEW

4.1 This chapter considers the situation where young people are not legally competent to consent to, or refuse, medical treatment themselves. In such cases, it is generally the young person's parents who consent or refuse, on the young person's behalf, and medical practitioners generally seek the parents' consent, or refusal, before treating (or not treating).[1] The Commission has identified three main questions about the role of parents in making medical decisions for young people who are not legally competent to make those decisions for themselves:

- What should happen when parents disagree about whether to consent to or refuse medical treatment for their child?
- Should family members other than parents be legally entitled to participate in the decision-making process regarding the child's medical treatment?
- Should there be limits on the parents' ability (or that of any other family member, or the legally competent young person) to consent to or refuse medical treatment for their child, and if so, where should those limits lie? That is, are there some medical decisions that should not be able to be made solely by the parents (or a competent young person), but that should require some authorisation from an external body, such as from a court?

WHEN PARENTS DISAGREE

4.2 When a child is not legally competent to consent to or refuse medical treatment, parents must usually make that decision on the child's behalf. What should happen, then, if parents cannot agree about the appropriate decision to make? As a general rule, both parents of a child have responsibility for the child, whether or not the child lives with that particular parent.[2] When parents cannot agree about whether to consent to

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1. The situations in which medical practitioners may treat young people without first obtaining consent from either the young person or the parents are discussed in Chapter 5.
2. See *Family Law Act 1975* (Cth) s 61B, 61C. See also eg *Gillick v West Norfolk Area Health Authority* [1986] AC 112; *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218. The exercise of parental responsibility can be affected or curtailed by an order of a court: see *Family Law Act 1975* (Cth) s 61C(3). Alternatively, the powers that a parent may exercise in respect of his or her child may be varied upon agreement between the parents in a parenting plan: see *Family Law Act 1975* (Cth) s 63C.

or refuse medical treatment for their child, there is currently provision for the final decision to be made by a court. The Family Court has jurisdiction to make orders about the welfare of a child, including orders concerning the child's medical care.[3] Indeed, the Family Court has issued guidelines on medical procedures for children, outlining "special medical procedures" for which Family Court authorisation must first be sought. The guidelines list as one such special medical procedure, a significant procedure about which parents disagree.[4] It is possible that the Supreme Court of New South Wales retains a limited jurisdiction over children's medical treatment.[5] There is also general provision in Chapter 4 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) for the Director-General of the Department of Community Services to take action to protect the safety, welfare, and well-being of a child or young person. Such action can include development of a care plan for the child or young person, in consultation with the parents, as well as use of alternative dispute resolution to resolve problems arising from the care of a child or young person.[6] These general provisions could be relied on to resolve disputes between parents about their child's medical care, where there was concern that such a dispute was affecting the child's welfare.

Issue 4.1

Is there adequate provision in the current law for settling disputes between parents about their child's medical care?

4.3 The statutory provisions that expressly deal with parents' power to consent to medical treatment confer that power on a parent, in the singular. Section 49(1) of the *Minors (Property and Contracts) Act 1970* (NSW)[7] enables a medical practitioner to rely on the consent of "a parent or guardian" of a young person aged below 16. The section makes no reference to a situation where one parent consents, and the other does not consent, to the proposed treatment. In such an event, it can be assumed that a medical practitioner could legally rely on the consent of one parent, in the face of

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[3] See *Family Law Act 1975* (Cth) s 67ZC, 68B (empowers the Family Court to order injunctions for the welfare of a child). See para 4.24-4.25 for a more detailed discussion of the welfare jurisdiction of the Family Court.

[4] See Family Court of Australia, *A Question of Right Treatment, The Family Court and Special Medical Procedures for Children – An Introductory Guide* (1998) (Victorian version) at viii (as at 9 March 2004) «www.familycourt.gov.au/html/medical_procedures.html».

[5] See para 4.28-4.33 about the constitutional uncertainties surrounding the jurisdictional limits of the Family Court and the parens patriae jurisdiction of the Supreme Court, particularly in relation to the welfare of ex-nuptial children.

[6] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 37.

[7] See paragraphs 2.15-2.17 for a summary of the operation of s 49.

the other's opposition, and it would be up to the opposing parent to take action such as seeking an injunction in the Family Court. For people aged 16 and over, who cannot give personal consent, s 36 of the *Guardianship Act 1987* (NSW)[8] allows consent for minor or major treatment to be given by "the person responsible" who, in the case of a "child" (that is, someone below the age of 18),[9] is the person with parental responsibility for the child.[10] As with children below the age of 16, it seems that a medical practitioner could legally rely on the consent of one parent, even if the other parent opposes the treatment.

Issue 4.2

Should medical practitioners be excused from liability in battery or assault for acting on the consent of one parent only?

RECOGNISING THE INVOLVEMENT OF OTHER FAMILY MEMBERS OR CAREGIVERS

4.4 In general,[11] it is the responsibility of parents to make decisions about their child's medical care (except in cases where medical treatment must be authorised by a court), as part of the exercise of their parental responsibility.[12] It has been suggested[13] that this approach does not take account of Aboriginal and Torres Strait Islander cultural traditions and their emphasis on the role of the extended family and kinship group in raising children. Similarly, the traditions of some groups of people from non-English speaking backgrounds may place greater emphasis on the involvement of the extended family. It is also possible to imagine situations where, for many different reasons, children are raised or cared for by family members other than their parents, without formal adoption arrangements being entered into. In such situations, should family members and other caregivers have a legal right to consent to or refuse medical treatment on behalf of the child or should they at least have a legal entitlement to be involved in the decision-making process?

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8. See paragraphs 2.35-2.46 for a summary of the operation of Part 5 of the *Guardianship Act 1987* (NSW).
9. See *Guardianship Act 1987* (NSW) s 3(1).
10. *Guardianship Act 1987* (NSW) s 33A(2).
11. The exercise of power under parental responsibility is subject to any contrary order of a court: see *Family Law Act 1975* (Cth) s 61C(3).
12. See *Family Law Act 1975* (Cth) s 61B, 61C(1); *Gillick v West Norfolk Area Health Authority* [1986] AC 112; *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218.
13. See Commissioner for Children and Young People, *Submission* (February 2001) at para 22.01-22.02.

4.5 There is some suggestion that, at common law, a person can be found to stand "in loco parentis" to a child and have responsibility for the care of the child.[14] For example, a person, such as a grandparent, may take over the care of the child and become, in effect, a foster parent, though without any formal arrangements being made. It is questionable, however, whether a person in this position would have the authority to give a legal consent or refusal in respect of the child's medical treatment.[15] In some jurisdictions, legislation makes some provision for a person who has been acting in the place of a parent to consent to medical treatment for a child.[16] There are provisions in the *Family Law Act 1975* (Cth) for the Family Court to make a specific issues order concerning a child in favour of a person other than the child's parents. A specific issues order can confer any aspect of parental responsibility on a person, including responsibility for the long-term or the day-to-day care, welfare and development of the child.[17] Arguably, such an order could include responsibility for making certain medical decisions, or medical decisions generally, for a child.

Issue 4.3

(a) Should a caregiver or relative other than a young person's parents have authority to consent to or refuse medical treatment for the young person?
(b) If so, in what situations should the law recognise the right of someone other than a parent to make medical decisions for a young person?
(c) Is there adequate provision in the *Family Law Act 1975* (Cth) for the law to recognise the authority of someone other than a young person's parents to make decisions about that young person's medical treatment?

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[14] See *Fowkes v Pascoe* (1875) 10 Ch App 343; *Nash v Commissioner for Railways* [1963] SR (NSW) 357; *Re Schneider and Secretary to the Department of Social Security* (1986) ASSC 92-085.

[15] There are no cases dealing with this specific question. For a more detailed discussion of the notion of "in loco parentis", see Queensland Law Reform Commission, *Consent to health care of young people* (Report 51, 1996) Vol 2 at 331-333.

[16] See *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4 (a "parent" is defined to include a person in loco parentis); *Guardianship Act 1968* (NZ) s 25(3)(b) and (c) (if there is no guardian in New Zealand, or the guardian is not capable of consenting, consent can be given by a person in New Zealand who has been acting in the place of a parent); *Children Act 1989* (UK) s 2(9) (a parent can arrange for some or all aspects of his or her parental responsibility to be met by one or more persons acting on the parent's behalf) and s 3(5) (a person who has the care of a child, though not having parental responsibility for the child, may do what is reasonable to safeguard or promote the child's welfare).

[17] See *Family Law Act 1975* (Cth) s 64B(6), 64C, 65G. There are certain requirements that must be met before the Court will make a parenting order in favour of a person other than the child's parents: see s 65G.

MEDICAL TREATMENT REQUIRING AUTHORISATION BY A COURT OR TRIBUNAL

4.6 Parents do not have an unlimited power to consent to and refuse all types of medical treatment for their children. There are certain types of medical procedures that cannot be performed on a young person unless a court, or tribunal, has authorised the procedure. Similarly, in certain situations, a court can order a particular medical procedure to be carried out on a child despite a parent's refusal of the treatment. In New South Wales, the final decision about whether, and how, to treat a child in certain situations lies not with the parents but with either:

- the Supreme Court of New South Wales;
- the New South Wales Guardianship Tribunal; or
- the Family Court of Australia.

4.7 There is also scope for the Children's Court to become involved in a child's medical care if, through the State child protection legislation, the child is considered to be in need of care and protection on the basis of medical neglect. The child may be removed from his or her parents' care and placed in the care of the Department of Community Services.[18]

4.8 In addition to legislation requiring court or tribunal authorisation, the common law imposes limits on parents' ability to make medical decisions for their children and requires that certain types of treatment be authorised by a court. The common law principles are outlined below, at paragraphs 4.11-4.15.

4.9 There is a great deal of uncertainty surrounding this area of the law governing consent to medical treatment of young people. There is also suggestion that the law as it stands is failing in its aim to provide adequate safeguards to protect children's right to bodily integrity and ensure that serious medical procedures are only authorised if they are in a child's best interests.[19] The implementation of a coherent framework, following a

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[18] See *Children and Young Persons (Care and Protection) Act 1998* (NSW), especially s 34, 43, 46, 48, 49, 61, 71(1)(d), 72, 79(1)(b).

[19] See K Murray, "Medical procedures – is the law effective?", paper presented at the 3rd National Family Court Conference (Melbourne, 20-24 October 1998) at 1-2; S Brady and S Grover, *The sterilisation of girls and young women in Australia: a legal, medical and social context* (Human Rights and Equal Opportunity Commission, 1997) at 58-59. Brady and Grover state that, from the time of the High Court's decision in *Marion's case*, in 1992, until 1997, courts and tribunals have authorised a total of 17 sterilisations of young women. This figure compares with data collected by the Health Insurance Commission, which shows that at least 1045 young women have been sterilised between 1992 and 1997. The authors

considered and consistent policy approach, may provide greater protection of young people's rights, as well as give both parents and medical practitioners greater certainty as to their roles and responsibilities.[20] Any attempt to formulate such a framework must consider the following uncertainties and questions of policy arising from the law as it currently operates:

- the uncertainty of the common law principles requiring court authorisation for certain medical decisions;
- possible gaps and inconsistencies in the legislative provisions relating to court or tribunal authorisation;
- questions and uncertainties surrounding which external body does and *should* have power to decide applications for authorisation, and the criteria that should be applied in reaching such a decision;
- at the most fundamental level, whether it is preferable to place the power and responsibility of making certain, very important decisions about a young person's medical care with an independent third party rather than with the young person's parents.

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rely on the discrepancy between these figures to argue that the current law is failing to ensure that there is adequate accountability for the sterilisation of young women, and that many young women are being sterilised without the required court or tribunal authority. However, the data collected from the HIC, reflecting a much higher figure for sterilisations than the figure for authorisations given by a court or tribunal, has been subsequently challenged by the Federal Minister for Health in a Senate Report on this issue. The Senate Report claims that, in fact, there was a total of only 22 sterilisations between 1993 and 1999, and that the number of sterilisations performed has declined since 1994. HREOC has responded by pointing out that the data on sterilisations is not very reliable, because the agencies involved in the collection of the data do not follow uniform, consistent, or comprehensive procedures: see generally, S Brady, J Briton and S Glover, *The sterilisation of girls and young women in Australia: issues and progress* (Human Rights and Equal Opportunity Commission, Sydney, 2001) Ch 2. For government measures taken since the release of the HREOC report to educate and make more accountable those performing sterilisation procedures on young people, see *The sterilisation of girls and young women in Australia: issues and progress* Ch 5.

[20] Several reports have recommended the implementation of a more comprehensive legislative framework, at least in respect of sterilisation procedures: see Family Law Council, *Sterilisation and other medical procedures on children: a report to the Attorney General* (AGPS, Canberra, 1994) Recommendations 1-4; Law Reform Commission of Western Australia, *Consent to sterilisation of minors* (Project 77 Part 2, 1994) Ch 11; R Martin, *Sterilisation of people with intellectual disability: a discussion paper* (Intellectual Disability Services Council, Adelaide, unpublished paper, 1998); S Brady, J Briton and S Glover, *The sterilisation of girls and young women in Australia: issues and progress* (Human Rights and Equal Opportunity Commission, Sydney, 2001) Ch 6.

4.10 In the following discussion, the Commission addresses these issues in the order in which they are listed. We pose questions that relate to these issues and invite responses.

Common law principles

4.11 At common law, parents have a responsibility to provide for the maintenance, protection, and education of their children and have the powers necessary to discharge that responsibility.[21] Those powers include the power to consent to or refuse medical treatment. This power is assumed to be exercised in the child's best interests, this being the overriding criterion to be applied in the exercise of parental authority. If there is any question about whether or not a parent's decision is in a child's best interests, any person who is concerned about the child's welfare may apply to a court for an order authorising appropriate treatment for the child.[22] Historically, the common law has conferred on the State Supreme Court the overriding power to ensure that parents, and others, act in a young person's best interests. This power derives from what is known as the "parens patriae" jurisdiction of the Supreme Court and originates from the ancient power of the English king to care for those subjects who could not care for themselves. The parens patriae jurisdiction of the Supreme Court allows it to act as the final decision-maker in relation to the medical treatment of a child, even if its orders go against the parents' decision.[23]

4.12 The Australian High Court has held, in *Marion's* case,[24] that there are certain medical procedures to which a parent cannot consent on a

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[21] See *Gillick v West Norfolk Area Health Authority* [1986] AC 112; *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218. See also *Family Law Act 1975* (Cth) s 61B, which reflects the common law principles.

[22] See *Marion's* case (1992) 175 CLR 218. For a general discussion of parental authority and the best interests of the child, see L Skene, *Law and medical practice: rights, duties, claims and defences* (2nd edition, LexisNexis Butterworths, Sydney, 2004) at para 4.28-4.35.

[23] See, for example, *Carseldine v Director, Department of Children's Services* (1974) 133 CLR 345; *Director-General of Social Welfare v J* [1976] VR 89; *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311; *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 at 258, where the majority cites with approval La Forest J in *Re Eve* (1986) 2 SCR 388 at 407-417; *B v Director-General, Department of Community Services* (NSW, Supreme Court, No 3308/86, McLelland J, 5 December 1986, unreported); *Department of Community Services v Y* [1999] NSWSC 644.

[24] See the joint judgment of Mason CJ, Dawson, Toohey and Gaudron JJ in *Marion's* case at 229-263. Note the various grounds of disagreement in the separate judgments of Deane J at 288-308 (court approval must be obtained for sterilisation

young person's behalf because, given their nature, they require an external, independent body, namely a court, to decide whether or not they are in the best interests of the child. The requirement for court authorisation in these cases provides a safeguard to ensure that the best interests of the child are met.

4.13 The particular procedure considered by the High Court in *Marion's* case was the sterilisation of a young woman with an intellectual disability. The majority of the High Court found that, in situations where a young person is not competent to give a personal consent, sterilisation was a special case that required authorisation from a court before it could be carried out on the young person. Medical practitioners could not perform such a procedure based solely on the consent of the parents. In coming to this conclusion, the majority of the High Court was careful to distinguish between sterilisation that was an end in itself and sterilisation that was an incidental by-product of surgery that was intended to cure some malfunction or disease. Sterilisation that was an incidental by-product could be authorised by the parents of a legally incompetent young person, whereas sterilisation that was not an incidental by-product, but an end in itself, must be authorised by a court.[25]

4.14 The majority of the High Court found that there were certain features of sterilisation that took it outside the ordinary scope of parental power to consent and required instead a court's assessment of whether it was in the young person's best interests. These features were, firstly, that the procedure involved invasive, irreversible and major surgery, secondly, that there was a significant risk of making the wrong decision about whether the procedure was in the young person's best interests, and lastly, that the consequences of such a wrong decision were particularly grave. It was the combined effect of these features that made sterilisation a special case and removed it from the scope of a parent's power to authorise.

4.15 The High Court's discussion in *Marion's* case was limited to the question of sterilisation. Are there other medical procedures that the High Court would consider to be special cases, requiring court authorisation before they can be carried out? There seems no reason in principle why the

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that is not obviously necessary for the welfare of the child, according to general community standards); McHugh J at 308-326 (parents can give lawful consent to sterilisation if the circumstances are so compelling that the protection of the child's welfare justifies the procedure, and the parents have no conflict of interest with the child's interests); Brennan J at 263-288 (neither parents nor Family Court can authorise non-therapeutic sterilisation). The majority judgment in *Marion's* case was applied by the High Court in *P v P* (1994) 181 CLR 583.

25. See *Marion's* case (1992) 175 CLR 218 at 239-254. But see the dissenting views of McHugh and Deane JJ, as noted above.

majority's ruling in *Marion's* case could not apply equally to other major medical procedures that have similar features to sterilisation in terms of being irreversible, invasive, with a high risk of making a wrong decision, and with the consequences of a wrong decision being particularly grave. There may be other major medical procedures which, applying the policy approach underlying the majority's decision, also require an objective assessment by an external body as a procedural safeguard against unjustified abuse of a young person's right to bodily integrity. For example, a lobotomy is one such medical procedure that could be argued to come within the category of a special case.[26] The Family Court has recently asserted that the principles arising from *Marion's* case should not necessarily be confined to cases involving surgery but could apply equally to treatment with a similarly irreversible effect involving, for example, the use of radiation or pharmaceuticals.[27]

Uncertainty of the common law

4.16 It might be argued that the common law is uncertain as to the types of medical treatment for which it requires court authorisation before they can be carried out. In *Marion's* case, the High Court stated categorically that (non-incidental) sterilisation required court authorisation, but it is not certain whether the majority's ruling can be confined to sterilisation alone, or whether the criteria that it set down for finding sterilisation to be a special case could be applied to other types of medical treatment.

Issue 4.4

(a) Should the common law have any role in limiting the types of medical treatment to which parents can consent or would it be preferable, or even possible, to spell out in legislation the medical procedures for which authorisation from an external body is required, or at least to list in legislation the criteria for deciding whether a particular procedure requires such authorisation?

(b) Should legislation specify certain medical procedures that should not be carried out on a young person until the young person is legally competent to consent to it personally, unless there are sound medical reasons for carrying out the procedure before that time? For example, should legislation prohibit gender-

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[26] Of course, there is legislation in New South Wales that already restricts the performance of a lobotomy, and other forms of psychosurgery: see *Mental Health Act 1990* (NSW) Ch 7 Part 1 Div 1. The text addresses the circumstances in which the common law imposes constraints on a parent's power to consent to medical procedures.

[27] See *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* [2004] Fam CA 297 at para 178 (Nicholson CJ).

assigning surgery on children with intersex conditions except when they are competent to consent to the surgery themselves?[28]

Legislative requirements

4.17 Three statutes operate in New South Wales to impose specific limits on parental power by requiring external authorisation for certain medical procedures in certain situations.[29] These are:

- the *Children and Young Persons (Care and Protection) Act 1998* (NSW);
- the *Guardianship Act 1987* (NSW); and
- the *Family Law Act 1975* (Cth).

4.18 The effect of these statutes in relation to medical treatment requiring external authorisation can be summarised as follows.

"Special medical treatment" for any child under 16

4.19 A medical practitioner cannot carry out "special medical treatment" on a child under 16 without first obtaining approval from the Guardianship Tribunal, except in cases of emergency, and irrespective of whether or not the child would otherwise be considered legally competent to consent.[30] "Special medical treatment" means:

- medical treatment that is intended or is reasonably likely to render the young person permanently infertile (except where it is intended to address a life-threatening condition or is an unwanted consequence);
- long-acting injectable hormonal substance for the purpose of contraception or menstrual regulation;
- medical treatment in the nature of a vasectomy or tubal occlusion;
- medical treatment involving the administration of an addictive drug;
- certain medical treatment involving an experimental procedure; and
- in the case of a child in residential care, the administration of a psychotropic drug used to control the child's behaviour.

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[28] See Androgen Insensitivity Syndrome Support Group, *Submission* (22 January 2003) at 14-16.

[29] As noted in para 4.7 above, the *Children and Young Persons (Care and Protection) Act 1998* (NSW) also makes general provision for the Department of Community Services to take action to protect a child or young person who is in need of care and protection. These provisions could be relied on to remove from a young person's parents the power to make medical decisions for their child.

[30] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175; *Children and Young Persons (Care and Protection) Regulation 2000* (NSW) cl 15.

4.20 Medical practitioners who carry out special medical treatment on a child under 16 without the Tribunal's consent in non-urgent cases face criminal liability. The Guardianship Tribunal can only consent to the treatment if it is satisfied that the treatment is necessary to save the child's life or to prevent serious damage to the child's psychological or physical health.

"Special treatment" for a young person, aged 16 or over, who is incapable of giving consent

4.21 For a young person aged 16 or over, who is incapable of giving consent (or an adult, who is incapable of giving consent), a medical practitioner cannot carry out "special treatment" without first obtaining the consent of the Guardianship Tribunal,[31] except in cases of emergency.[32] This provision forms part of a general framework set up by Part 5 of the *Guardianship Act 1987* (NSW) to provide medical and dental treatment to people aged 16 and over, who are incapable of giving personal consent. Under the Act, a person is considered incapable of giving consent if he or she is either incapable of understanding the general nature and effect of the proposed treatment or is incapable of indicating whether or not he or she consents to it.[33] "Special treatment" in this context means:[34]

- any treatment intended, or reasonably likely, to have the effect of rendering the person permanently infertile;
- any new treatment that has not yet gained the support of a substantial number of medical practitioners specialising in the area of practice concerned;
- administration of an addictive drug;
- termination of pregnancy;
- sterilisation by means of vasectomy or tubal occlusion; or
- aversion therapy.

4.22 For treatment intended, or reasonably likely, to render the person permanently infertile, the Tribunal must only give consent if satisfied that it is necessary to save the patient's life or to prevent serious damage to the patient's health.[35] For the other types of special treatment outlined above,

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[31] *Guardianship Act 1987*(NSW) s 36(1)(b), in conjunction with s 33.

[32] Section 37.

[33] Section 33(2).

[34] Section 33(1); *Guardianship Regulation 2000* (NSW) cl 6.

[35] *Guardianship Act 1987*(NSW) s 45(2).

the Tribunal may give its consent if it is satisfied that the treatment is the only or most appropriate way of treating the patient and is manifestly in the best interests of the patient and, if the National Health and Medical Research Council has prescribed guidelines that are relevant, those guidelines have been or will be complied with as regards the patient.[36]

Differences in rules for consent to special medical treatment

4.23 As is evident from the discussion above, different legislative provisions govern the rules relating to consent to special medical treatment for those people aged below 16 and those people who are legally incompetent to decide and are aged 16 and above: s 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) applies to young people below 16, and Part 5 of the *Guardianship Act 1987* (NSW) applies to young people, and adults, aged 16 and above. There are several differences between the two sets of legislative provisions that are worth noting:

- The types of treatment that are included within the definition of "special" medical treatment vary slightly for each age group. For those aged 16 and above, treatment that involves the administration of a long-acting injectable hormonal substance for the purpose of contraception or menstrual regulation is *not* special treatment and consequently, the young person's parents can consent to this type of treatment. In contrast, this type of treatment *is* considered special medical treatment for young people below the age of 16 and requires the authorisation of the Guardianship Tribunal before it can be carried out. The termination of a pregnancy and aversion therapy are both considered special treatment in respect of people aged 16 and over and consequently require the Tribunal's authorisation before they can be carried out. For people below 16, however, abortions and forms of aversion therapy are not special medical treatment and do not require the Tribunal's authorisation, but instead can be consented to by the parents (with the possibility of intervention by the Supreme Court or the Family Court, in exercise of their parens patriae or welfare jurisdiction). Finally, the administration of a psychotropic drug on a young person under 16, in out-of-home care, is considered to be special medical treatment, requiring the Tribunal's authorisation, but no such requirement applies in relation to a young person 16 or over who is in out-of-home care.
- The criteria by which the Guardianship Tribunal can consent to special treatment for a person aged 16 and over are more detailed and,

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[36] *Guardianship Act 1987* (NSW) s 45(3).

arguably, slightly broader than they are in respect of special medical treatment for a person aged below 16.

Issue 4.5

(a) Should different rules apply to the types of medical treatment that require the consent of the Guardianship Tribunal and to the criteria by which the Tribunal decides whether or not to give its consent, for young people aged below 16, from young people aged 16 and above?

(b) Are the statutory provisions relating to "special medical treatment" under the *Children and Young Persons (Care and Protection) Act 1998* (NSW), and "special treatment" under the *Guardianship Act 1987* (NSW), sufficiently clear to operate effectively in practice?

The Family Law Act 1975 (Cth)

4.24 The *Family Law Act 1975* (Cth) confers on the Family Court of Australia a general jurisdiction to make orders regarding the welfare of children. Section 67ZC of the Act gives the Family Court the power to make orders relating to the welfare of children, with the best interests of the child as the paramount consideration in making such orders.[37] This power is regarded as an independent head of power, separate from the Family Court's powers to make orders regarding children's residence and contact with parents, and has been likened to the parens patriae jurisdiction of the State Supreme Court.[38] It has been held to include the power to make orders regarding a child's medical treatment and to impose limits on a parent's power to make final decisions about a child's medical care.[39] For example, the Family Court can authorise or refuse sterilisation of a young girl who is incapable of giving personal consent, on the grounds that this is a decision that lies beyond the power of parents to make.[40] Other examples of treatment that the Family Court has jurisdiction to authorise (or refuse) include:

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[37] Section 68F of the *Family Law Act 1975* (Cth) provides the Family Court with some guidance on matters to consider when determining the best interests of the child.

[38] See majority in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 at 258-259; *P v P* (1994) 181 CLR 583 at 598; *B and B and Minister for Immigration and Multicultural and Indigenous Affairs* [2003] Fam CA 451. But see the recent decision of the High Court concerning the limits of the Family Court's welfare jurisdiction: *Minister for Immigration and Multicultural and Indigenous Affairs v B* [2004] HCA 20.

[39] See *Marion's* case; *P v P*.

[40] See *Marion's* case; *P v P*. See also Family Court of Australia, *A question of right treatment, the Family Court and special medical procedures for children – an introductory guide* (1998) (Victorian and Queensland versions) (as at 9 March 2004) «www.familycourt.gov.au/html/medical_procedures.html».

- gender reassignment performed on a hermaphroditic child;[41]
- life-saving heart surgery performed on a child with a congenital heart abnormality;[42]
- organ and bone marrow donation by a young person;[43]
- prescription of the contraceptive Pill for a teenage girl, in anticipation of subsequent hormone therapy once the girl reaches 16 years of age, as the first steps towards sex reassignment.[44]

4.25 The *Family Law Act 1975* is a piece of federal legislation and therefore is outside the scope of any recommendations for reform that the NSW Law Reform Commission makes. Similar to the common law principles, the welfare provision in the *Family Law Act 1975* is worded in broad terms and simply refers to the need for the child's best interests to be the paramount consideration in any order the Family Court makes. Unlike the common law, the concept of "best interests" is defined in greater detail in the *Family Law Act 1975*,[45] though it is defined in general terms rather than in its specific application to making decisions about a child's medical care. Like the common law, the jurisdiction of the Family Court to intervene in medical decisions relating to children has not been exhaustively defined. The Court appears to have a very broad power to intervene in such decisions whenever it determines that the medical treatment in question is of a sufficiently serious nature as to bring it outside the scope of parents' capacity to consent to or refuse. Whether this creates a significant degree of uncertainty in the day-to-day provision of medical care to young people is a matter that is open to question.

Human Tissue Act 1983 (NSW)

4.26 It is also worth making specific reference to s 10 of the *Human Tissue Act 1983* (NSW). This legislative provision, unlike those outlined above, does not require authorisation from a court or tribunal for certain medical procedures to be performed on a child. On the contrary, it expressly allows for parents to consent to the donation from their child's body of specified regenerative tissue, such as bone marrow, for the purpose of its transplantation to the body of a parent, brother or sister of the child. The child must understand the nature and effect of the procedure and must

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[41] See *Re A* [1993] FLC 92-402.

[42] See *Re Michael* [1994] FLC 92-471.

[43] See *GMW (Husband) and CMW (Wife)* (Family Court, No HB 1447/1996, Hannon J, 21 January 1997, unreported). For further discussion of consent to donation by a young person of body parts, see para 4.26 below.

[44] See *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* [2004] Fam CA 297.

[45] See *Family Law Act 1975* (Cth) s 68F.

agree with the proposed removal. A "child" is defined by the Act as a person who is not married and is under 18.

Issue 4.6

Does s 10 of the *Human Tissue Act 1983* (NSW) offer adequate safeguards to protect the health and well-being of the child?[46]

Jurisdiction to make medical decisions: choosing between the Family Court, the Supreme Court and the Guardianship Tribunal

4.27 As outlined in the discussion above, the Family Court, the Supreme Court and the Guardianship Tribunal all have power to authorise or veto medical treatment, as conferred on them either by legislation or by the common law. For parents (or any other interested party) seeking authorisation for a particular procedure, to which body should their application be made? The answer is not clear: there is a great deal of uncertainty about the jurisdictional limits of these three bodies, that is, which body has the power to make which medical decisions relating to young people. The practical consequence of this is that people seeking authorisation for a medical procedure may be unsure which body to apply to or may be able to apply to the Family Court if they receive an unfavourable outcome from the State bodies. As the Family Court applies different legislative criteria when making a decision from the criteria applied by the State bodies, the same case may, potentially, have a different outcome depending on the forum in which it is heard.

Constitutional complications

4.28 The uncertainty in jurisdictional limits arises largely from the constitutional constraints imposed on State and federal bodies. These constitutional constraints are discussed briefly below.

4.29 As summarised above, State legislation requires that certain medical procedures, such as sterilisation, be authorised by the Guardianship Tribunal for people under 16, and people 16 and over who are incapable of giving personal consent. As noted in paragraphs 4.24-4.25 above, the Family Court also has legislative power to make orders about the medical treatment of children including, for example, the power to authorise or refuse sterilisation of a young person, on the basis that such a procedure requires authorisation from a court rather than from the young person's parents. There is potential for conflict between the State tribunal and the

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[46] See Commissioner for Children and Young People, *Submission* (15 August 2001) at 3.

federal court because both are empowered to determine the same matters (although the federal court's jurisdiction is broader). Notwithstanding the potential conflict and duplication by a State body of a federal court's powers, the High Court has held that the State tribunal's power to hear and decide such applications remains valid, with the qualification that if the Family Court has already heard and determined a particular application, the Guardianship Tribunal cannot subsequently hear and decide the same application.[47] This position opens up a limited opportunity for "forum shopping". For example, parents (or any other interested party) could apply to the Guardianship Tribunal for authority to order the sterilisation of their child, and if the Tribunal dismisses that application, they could then have a second attempt at obtaining authorisation by applying to the Family Court.

4.30 It is open to question whether, and the extent to which, the New South Wales Supreme Court retains its parens patriae jurisdiction over children and their medical care. Traditionally, the Supreme Court exercised its parens patriae jurisdiction to make a child a ward of the court or, even without making a child a ward,[48] had wide powers to make orders concerning the child's life and welfare, superseding the rights and powers of parents to make such decisions.[49] As noted at paragraph 4.11, the Supreme Court's parens patriae jurisdiction derives from the common law and, as with most common law principles, legislation can exclude the Supreme Court's parens patriae jurisdiction either by express provision or by necessary implication, which means that the Court no longer has jurisdiction to make orders for the welfare of a child in the particular area dealt with by the legislation.

4.31 The *Guardianship Act 1987* (NSW) expressly preserves the Supreme Court's jurisdiction to make orders relating to the "special treatment" of people 16 and over, who are incapable of giving personal consent, except for certain types of special medical treatment such as sterilisation, which must be authorised by the Tribunal.[50] Both the Supreme Court and the Guardianship Tribunal could therefore authorise most treatment falling within the legislative definition of "special medical treatment" for people 16 and over who are incapable of consenting, except for certain types of treatment, such as sterilisation. There is no such express preservation of the Supreme Court's jurisdiction in s 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), requiring the Guardianship

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[47] This is by virtue of s 109 of the Commonwealth Constitution (inconsistency between State and federal laws): see *P v P* (1994) 181 CLR 583.

[48] See *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311.

[49] *Department of Community Services v Y* [1999] NSWSC 644.

[50] See *Guardianship Act 1987* (NSW) s 35(1)(c) and 35(1A).

Tribunal to authorise special medical treatment for people under 16. However, there is a general provision in the *Children and Young Persons (Care and Protection) Act 1998* to the effect that nothing in that Act limits the jurisdiction of the Supreme Court.[51] It has been held that, by virtue of that general provision, the parens patriae jurisdiction of the Supreme Court is not ousted by the *Children and Young Persons (Care and Protection) Act 1998* but, on the contrary, is expressly preserved.[52] It is open to question whether that general provision is enough to preserve the Supreme Court's parens patriae jurisdiction with respect to authorising the medical procedures listed as "special medical treatment" in s 175 of the Act, with the result that a parent could apply either to the Supreme Court or the Guardianship Tribunal for authorisation to carry out special medical treatment, as defined in s 175, on their child aged below 16.[53]

4.32 Whatever provision is made in State legislation to preserve the Supreme Court's parens patriae jurisdiction, it is not clear whether, and to what extent, the Supreme Court's jurisdiction is limited by the exercise of the Family Court of its welfare jurisdiction under s 67ZC of the *Family Law Act 1975* (Cth). The Supreme Court has held that its parens patriae jurisdiction is not affected by the Family Court's welfare jurisdiction, at least in respect of children who are already in custody under the State child protection legislation,[54] and it has also been suggested[55] that the whole of the Supreme Court's parens patriae jurisdiction with respect to the wardship, custody and care of children is unaffected by the *Family Law Act 1975*, whether or not the child is in custody by virtue of an order of the Children's Court.

4.33 It is possible that, like the Guardianship Tribunal, the Supreme Court retains jurisdiction to hear matters relating to the medical treatment

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[51] See s 247.

[52] See *Re Anna, Bruno, Courtney, and Deepak* [2001] NSWSC 79; *Spruill v Director General of the Department of Community Services* [2001] NSWCA 413.

[53] The Supreme Court has held that the predecessor to the *Children and Young Persons (Care and Protection) Act 1998* expressly preserved the parens patriae jurisdiction of the Supreme Court in respect of the general custody and guardianship of children: see *Department of Community Services v Y* [1999] NSWSC 644 at para 89.

[54] See *Director-General, Department of Community Services v Australian Broadcasting Corporation* (NSW, Supreme Court, No 2265/96, McLelland J, 4 June 1996, unreported); *Ensby v Director-General Department of Community Services* (NSW, Supreme Court, No 4319/93, Bryson J, 21 April 1994, unreported); *B v Director-General, Department of Community Services* (NSW, Supreme Court, No 3308/96, McLelland J, 5 December 1986, unreported); *Department of Community Services v Y* [1999] NSWSC 644.

[55] *Department of Community Services v Y.*

(among other things) of children, but cannot make an order in a case that has already been decided by the Family Court. One area in which, possibly, the Supreme Court may retain jurisdiction to the exclusion of the Family Court is in matters relating to the welfare of ex-nuptial children. It is not altogether certain whether the Family Court's welfare jurisdiction is limited to jurisdiction over children whose parents are or have been married, despite New South Wales referring its legislative power over ex-nuptial children to the Commonwealth.[56] If this is the case, parents in New South Wales may be faced with the situation that, if they have been married, they can apply to the Family Court for authority to carry out certain medical procedures on their child, but if they have not been married, they must apply to the Supreme Court (or the Guardianship Tribunal, if the medical procedure in question falls within the definition of "special medical treatment").

Who should decide?

4.34 Assuming support for the basic proposition that an independent body should have authority to intervene in certain decisions regarding a young person's medical care,[57] which body should decide? The Commission recognises the limitations on the extent to which it can recommend reform of this area, given the constitutional constraints outlined above. However, there is so much uncertainty and inconsistency surrounding the question of jurisdiction to authorise and refuse medical care, as well as a significant number of calls for reform,[58] that, despite its limitations, the Commission

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[56] The States referred their legislative powers over children to the Commonwealth in 1987. However, it has recently been argued that this reference of power did not include reference of their welfare power, but was limited to matters relating to the custody, guardianship, access and maintenance of ex-nuptial children. The Family Court's welfare jurisdiction is therefore based on the legislative powers conferred on the Commonwealth by s 51(xxi) and (xxii) of the Commonwealth Constitution relating to marriage, divorce, and incidental powers: see *B and B and Minister for Immigration and Multicultural and Indigenous Affairs* [2003] Fam CA 451; [2003] Fam CA 621, considered in *AI and AA and Minister for Immigration and Multicultural and Indigenous Affairs* [2003] Fam CA 943 (Chisholm J). The decision of the High Court in *Minister for Immigration and Multicultural and Indigenous Affairs v B* [2004] HCA 20 does not appear to touch this aspect of the welfare jurisdiction.

[57] This basic proposition is discussed below at para 4.40.

[58] See, for example, S Brady, J Briton and S Grover, *The sterilisation of girls and young women in Australia: issues and progress* (Human Rights and Equal Opportunity Commission, Sydney, 2001); S Brady and S Grover, *The sterilisation of girls and young women in Australia: a legal, medical and social context* (Human Rights and Equal Opportunity Commission, Sydney, 1997) at 59-60; Family Law Council, *Sterilisation and other medical procedures on children: a report to the Attorney General* (AGPS, Canberra, 1994); Law Reform Commission of Western

considers it important to discuss options for reform, if only to encourage further consultation and co-operation between the State and the Commonwealth and consideration of implementation of a recommended model.

4.35 Several agencies have previously considered the question of which body should, in an ideal scheme, have authority to hear and determine applications to carry out, or refuse, certain medical procedures on young people.[59] The focus of these earlier reports has been sterilisation of young people and opposing views were taken as to whether the Family Court or the Guardianship Tribunal was the more appropriate body.

4.36 The following arguments were made in favour of vesting exclusive jurisdiction in the Guardianship Tribunal:[60]

- The Tribunal has expertise and experience in hearing cases involving the medical treatment of young people and people with disabilities. Its composition includes a professional member, such as a medical practitioner, and community members with experience in the area of treating young people and people with disabilities, who bring their expertise to the process of scrutinising and assessing medical evidence.[61] In contrast, courts are more likely than tribunals to defer to the expert medical evidence presented to them.
- The Tribunal is sensitive to the special needs of the parties in particular cases and is flexible in the way it hears such cases to accommodate those needs.[62] For example, when hearing applications

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Australia, *Consent to sterilisation of minors* (Project 77 Part 2, 1994); R Martin, *Sterilisation of people with intellectual disability* (Intellectual Disability Services Council, Adelaide, unpublished paper, 1998).

[59] See S Brady, J Briton, S Grover, *The sterilisation of girls and young women in Australia: issues and progress*; Family Law Council, *Sterilisation and other medical procedures on children: a report to the Attorney General*; Law Reform Commission of Western Australia, *Consent to sterilisation of minors*; R Martin, *Sterilisation of people with intellectual disability*.

[60] Or equivalent tribunal of another State. See S Brady, J Briton and S Grover, *The sterilisation of girls and young women in Australia: issues and progress* Ch 6; Law Reform Commission of Western Australia, *Consent to sterilisation of minors*; R Martin, *Sterilisation of people with intellectual disability* at 6. See also D Tait, T Carney, and K Deane, "Legal resolution of sterilisation: the role of Guardianship Tribunals in NSW and Victoria" (1994) 8 *Australian Journal of Family Law* 141; T Carney and D Tait, *The Adult guardianship experiment: tribunals and popular justice* (Federation Press, Sydney, 1997).

[61] See *Guardianship Act 1987* (NSW) s 49 for the composition of the Tribunal.

[62] See Family Law Council, *Sterilisation and other medical procedures on children: a report to the Attorney General* at para 5.06-5.08; A Nicholson, M Harrison and D Sandor, "The role of the Family Court in medical procedure cases" (1996) 2

for sterilisation of young women, the Tribunal as a matter of convention has at least one female member sitting, who has a one-to-one discussion with the young woman for whom the application is made.

- Proceedings in the Tribunal are generally non-adversarial and more informal than court proceedings: it is not bound by the rules of evidence and legal representatives may only appear in the Tribunal with leave.[63] These factors should make the experience less intimidating than the experience of a court hearing for the parties involved, particularly for the young person. It also means that the Tribunal can take a more proactive role in assessing whether or not the medical treatment in question is really in the young person's best interests.
- Proceedings in the Guardianship Tribunal are much cheaper than in the Family Court (or Supreme Court), which in turn makes the Tribunal more accessible to a greater number of families.[64]
- State legislation conferring the Guardianship Tribunal with jurisdiction to decide matters relating to "special medical treatment" and "special treatment" also makes it a criminal offence to carry out such procedures without first obtaining the Tribunal's authorisation.[65] Procedures such as unlawful sterilisation are therefore criminalised under New South Wales law. There is no such obvious provision for criminal sanctions to be imposed under the *Family Law Act 1975.*

4.37 The following arguments were made in favour of vesting exclusive jurisdiction in the Family Court:[66]

- The decision whether or not to carry out a particular medical procedure, such as sterilisation, on a young person is a very important one, usually with grave and irreversible consequences. While court proceedings are generally more formal than those in a tribunal, this is

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Australian Journal of Human Rights 242 at 252; D Tait, T Carney, and K Deane, "Legal resolution of sterilisation: the role of Guardianship Tribunals in NSW and Victoria" 161.

[63] See *Guardianship Act 1987* (NSW) s 55, 58(1).

[64] The Family Law Council noted, in 1994, that the cost of bringing an application in the Family Court can be prohibitive to many families: see Family Law Council, *Sterilisation and other medical procedures on children: a report to the Attorney General* at para 5.45.

[65] See *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(1); *Guardianship Act 1987* s 35(1).

[66] See Family Law Council, *Sterilisation and other medical procedures on children: a report to the Attorney General* (AGPS, Canberra, 1994) at para 5.36-5.46**;** A Nicholson, M Harrison, and D Sandor, "The role of the Family Court in medical procedure cases" (1996) 2 *Australian Journal of Human Rights* 254-255.

not necessarily a disadvantage, but should instead ensure that the matter is heard in a fair, objective manner. A court hearing also makes a strong public statement about the seriousness of the issue and the importance of protecting the rights of the young person involved.

- The Family Court is able to establish a body of law over time in the area of the medical treatment of young people, which should allow for more consistent decision-making.
- It is only by vesting jurisdiction in a federal body such as the Family Court that there can be uniformity across Australia in this area. Uniformity is important to ensure that the rights of all Australian children are equally protected.
- Family Court proceedings involving children are not governed by the same adversarial procedures as other Family Court proceedings. There is scope for the Court to take on a more inquisitorial role in medical treatment cases, with a move towards more informal proceedings, and use of the Court's counselling facilities to ensure that formal proceedings are a matter of last resort.[67] Indeed, the Family Court recently dealt with a matter concerning authorisation for medical treatment for a young girl.[68] The proceedings were more inquisitorial than adversarial. The matter was heard around a conference room table with evidence in chief from certain witnesses being given viva voce instead of by affidavit. There was an opportunity for general discussion and dialogue between the judge, the witnesses, and the legal representatives, much more than usually occurs in cross-examination in conventional court proceedings. The Chief Justice of the Family Court recommended that the Court follow this more unconventional procedure in special medical treatment cases.

Issue 4.7

(a) Is the current system for the authorisation of medical treatment for a young person in the Guardianship Tribunal, the Family Court or the Supreme Court working in practice?

(b) Are any of the following options preferable to the current system for deciding cases involving the medical treatment of young people, and why or why not?

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[67] The Family Court has developed a protocol dealing with special medical procedures for children, which stipulates that parties must take part in a dispute resolution process before a judge will hear the case in court. The main form of dispute resolution in this context is family group conferencing. See Family Court of Australia, *A question of right treatment, the family court and special medical procedures for children – an introductory guide* (1998) (Victorian version) at 20-22 (as at 9 March 2004) «www.familycourt.gov.au/html/medical_procedures.html».

[68] See *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* [2004] Fam CA 297 (Nicholson CJ).

Option A: The Family Court has sole jurisdiction to authorise or refuse medical procedures requiring external authorisation.

Option B: The NSW Guardianship Tribunal has sole jurisdiction to authorise or refuse medical procedures requiring external authorisation.

Option C: A co-ordinated system is established in which both the Family Court and the Guardianship Tribunal have jurisdiction to hear such cases, but the current uncertainties and duplications are worked out in some way.

(c) If any of these options are preferred to the current system, what role, if any, should the Supreme Court of New South Wales play in hearing cases involving the medical treatment of young people?

Guiding the decision: what criteria should apply?

4.38 What criteria should the chosen body apply, whether it be the Family Court, the Guardianship Tribunal, or even the Supreme Court, in making a decision to authorise or refuse medical treatment for a young person? At present, the Guardianship Tribunal and the Family Court are guided by two different sets of criteria:

- The Family Court is guided by a broad discretion, with reference only to considerations of the welfare of the child or the best interests of the child. As noted in paragraph 4.24 above, the *Family Law Act 1975* does spell out in general terms matters that the Court should consider in determining the best interests of the child, but these are not given any specific application to decisions about a child's medical care.
- The Guardianship Tribunal is guided by a more structured decision-making process, with legislation spelling out specific matters to consider in deciding whether or not to authorise the medical procedure in question.[69] These criteria set a very high threshold that must be met before a procedure can be authorised, requiring that the treatment be necessary either to save the patient's life or to prevent serious damage to the person's health.

4.39 Previous reviews of the law in this area have all supported adoption of a more detailed set of criteria to guide the decision-making process, such as that guiding the Guardianship Tribunal.[70] These reviews have focused

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[69] See, for example, *Guardianship Act 1987* (NSW) s 45, which sets out the matters for the Tribunal to consider in deciding whether to authorise certain procedures, such as sterilisation.

[70] See Family Law Council, *Sterilisation and other medical procedures on children: a report to the Attorney General* (AGPS, Canberra, 1994) Recommendation 3, para 4.53; Law Reform Commission of Western Australia, *Consent to sterilisation of minors* (Report, Project 77 Part 2, 1994) Chapter 7; S Brady and S Grover, *The sterilisation of girls and young women in Australia: a legal, medical and social context* (Human Rights and Equal Opportunity Commission, Sydney, 1997) at 10-11.

specifically on sterilisation. One review expressly took the view that sterilisation was a special case demanding special legislative attention, whereas the law relating to other medical procedures requiring external authorisation could be left unaltered, at least for the time being.[71] One issue to consider is whether legislation should focus on particular medical procedures, such as sterilisation, and spell out specific rules to apply in making decisions about those procedures, or whether it is preferable for legislation to set out criteria to apply generally to all medical procedures requiring external authorisation.

Issue 4.8

(a) In guiding the court or tribunal's decision whether or not to authorise certain medical treatment for a young person, should legislation provide for a broad discretion, with a general reference to the young person's best interests or welfare, or should it spell out a specific set of criteria that must be taken into account?

(b) Should legislation focus on specific types of medical treatment and apply special rules to making decisions about those procedures or should it set down criteria to be applied generally to all types of medical treatment requiring external authorisation?

Responsibility for the decision: parents versus authorisation by an external body

4.40 At the most fundamental level of this discussion is the question whether ultimate responsibility for certain medical decisions should lie with a court or tribunal, rather than with the parents of the young person affected. Should the law impose limits on the right of parents to consent to and refuse medical treatment for their child in this way? The following paragraphs outline arguments for and against placing ultimate responsibility for these decisions with an external body, such as a court or tribunal.[72]

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[71] Family Law Council, *Sterilisation and other medical procedures on children: a report to the Attorney General*; Law Reform Commission of Western Australia, *Consent to sterilisation of minors*.

[72] Family Law Council, *Sterilisation and other medical procedures on children: a report to the Attorney General;* Law Reform Commission of Western Australia, *Consent to sterilisation of minors*; S Brady and S Grover, *The sterilisation of girls and young women in Australia: a legal, medical and social* at 10-11, which all supported some form of external authorisation.

Arguments in favour of requiring authorisation by an external body

- Certain medical procedures and types of treatment have such serious consequences that the decision whether or not to carry them out should be made by an objective party, external to those who are closely affected by the decision. This approach ensures heightened accountability in the decision-making process in an area where young people are at significant risk of serious abuse of their fundamental human right to bodily integrity.
- Serious medical procedures, such as sterilisation, should be considered and weighed up as public policy issues, rather than as private family matters. They have such serious consequences for the individual rights of the young person that they should be open to public scrutiny and not left as private matters for parents alone to debate.
- From a medical practitioner's perspective, the involvement of the courts eases the burden on the medical profession in participating in making difficult decisions that often raise moral and ethical questions.

Arguments in favour of leaving responsibility for the decision with the parents

- Parents know their children at the most intimate level. They alone know the particular needs of their child as an individual and they know what is best for their child. Loving parents do not make serious medical decisions for their children lightly and such decisions should not be taken out of their hands.
- Parents are expected to cope with the consequences of the medical decision that is made and should be able to claim some control over the decision-making process.
- The requirement to seek external authorisation can cause crucial time delays and significant expense for families.

Issue 4.9

In cases where a young person is not legally competent to consent to or refuse treatment, should the decision to carry out or refuse certain medical treatment ever rest with an external body, such as a court or tribunal, rather than with the young person's parents?

Limits on the ability of the mature young person to make medical decisions

4.41 The legislation outlined above, requiring external authorisation for certain medical procedures on young people, applies whether or not the young person is generally considered legally competent to give a personal consent to medical treatment. In this way, the law imposes restrictions not only on the ability of parents to make medical decisions for their children, but also on the ability of young people to make such decisions themselves, even if they are considered sufficiently mature to understand the treatment involved. There are no such limitations on the ability of legally competent adults to consent to or refuse medical treatment. For example, a person under 16 cannot give a legal consent to be sterilised, even if he or she is considered sufficiently mature to understand the procedure and consequences involved,[73] whereas a legally competent person over 18 can consent to his or her own sterilisation.

4.42 In theory, at least, it seems harder to justify restricting the capacity of a mature young person to make medical decisions than it is to restrict the capacity of parents to make decisions on their child's behalf. If a young person is to be granted the right to make his or her own medical decisions on the basis that he or she has reached the requisite level of maturity, why should that young person not be able to exercise that right in the same way as an adult? The Commission can think of two bases on which to justify such a restriction on a mature young person's capacity to consent or refuse:

- The medical decision made by the young person may not be in his or her best interests (assuming that the notion of "best interests" can be satisfactorily determined in some way).[74] For certain medical procedures, such as sterilisation, the consequences can be so serious, and the risk of making a wrong decision so grave, that there should be some kind of external check on the young person's right to decide, with an objective body empowered to consider whether the decision is in the young person's best interests. This approach supports a more paternalistic framework for determining a young person's right to decide than a model that simply grants a young person a right to decide on reaching a certain level of maturity.
- The requirement for external authorisation provides an (indirect) means of double-checking the medical practitioner's assessment of the young person as sufficiently mature to understand and consent to (or refuse) the treatment in question. In the absence of any other mechanism for scrutinising the medical practitioner's assessment, it is

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[73] Section 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), which requires authorisation from the Guardianship Tribunal before "special medical treatment" is carried out (such as sterilisation), applies only in respect of young people below the age of 16. The equivalent provisions in Chapter 5 of the *Guardianship Act 1987* (NSW) relating to authorisation for special treatment apply only in respect of people aged 16 and over, who are not competent to consent to the treatment themselves. Presumably, therefore, young people aged 16 and above, who are sufficiently mature to understand the treatment proposed, could consent to such treatment.

[74] See Chapter 2 at para 2.32-2.34 for a discussion of the concept of "best interests".

important to provide some form of safeguard against the medical practitioner making an incorrect assessment, at least for procedures, such as sterilisation, for which the consequences are serious and irreversible.

Issue 4.10

(a) In cases where a young person is legally competent to consent to, or refuse, certain medical treatment, should the law restrict that young person's ability to consent to or refuse the treatment and require authorisation for the treatment from an external body, such as a court or tribunal?

(b) If so, should the same criteria apply to determining the types of medical treatment for which external authorisation is required as apply to determining the types of medical treatment to which a parent cannot consent to or refuse?

(c) Should the same procedures apply for obtaining such external authorisation as apply in the case of parents seeking authorisation?

5.

Treating young people without consent

- Emergency treatment
- Special medical treatment
- Suspected child abuse
- Public health measures
- Minor treatment

5.1 In New South Wales a medical practitioner can treat a person under 18 years without his or her consent or without the consent of that person's parent/s in certain situations. These situations fall into the following categories:

- Emergency treatment;
- Special medical treatment (emergencies or institutional consent);
- Suspected child abuse;
- Public health measures (for infectious diseases); and
- Minor treatment.

EMERGENCY TREATMENT

Common law

5.2 At common law, the lack of a person's consent[1] to medical treatment (being one type of application of force to a person) renders a medical practitioner liable in damages for the torts of assault and battery.[2] However, an emergency situation is an exception to this general common law rule.[3] An emergency is a circumstance in which immediate medical

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[1] If a "competent" person, or consent of the parent if a "non-competent" person.

[2] See *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case)* (1992) 175 CLR 218 at 310 (McHugh J).

[3] See *Marion's* case at 310 per McHugh J on the position at common law: "Consent is not necessary…where…medical treatment must be performed in an emergency and the patient does not have the capacity to consent and no legally authorised representative is available to give consent on his or her behalf." Note the passing reference to the emergency medical treatment exception at common law in *Rogers v Whitaker* (1992) 175 CLR 479 at 489 (Mason CJ and Brennan, Dawson, Toohey and McHugh JJ); *Malette v Shulman* (1990) 67 DLR (4th) 321 at 328-329: "The emergency situation is an exception to the general rule requiring a patient's prior consent. When immediate medical treatment is necessary to save the life or preserve the health of a person who, by reason of unconsciousness or extreme illness, is incapable of either giving or withholding consent, the doctor may proceed without the patient's consent. The delivery of medical services is rendered lawful in such circumstances either on the rationale that the doctor has implied consent from the patient to give emergency aid or…on the rationale that the doctor is privileged by reason of necessity in giving the aid and is not to be held liable for so doing. On either basis, in an emergency the law sets aside the requirement of consent on the assumption that the patient, as a reasonable person, would want emergency aid to be rendered if she were capable of giving instructions." In *Wilson v Pringle* [1987] QB 237 at 252 the English Court of Appeal analysed emergency medical treatment in the following way: "Hitherto it has been customary to say in such cases that consent is to be implied for what would otherwise be a battery on the unconscious body. It is better simply to say

treatment is required to save someone's life or prevent serious injury to health.[4] It includes any person giving medical assistance to an injured person at an accident site.[5]

Refusal of emergency care

5.3 Although there is no Australian authority, at common law a competent patient could arguably still refuse emergency medical treatment, if the refusal is given close in time to the emergency.[6] An example cited by the Queensland Law Reform Commission is "a patient's written unequivocal instructions to refuse certain emergency health care (given prior to and in anticipation of the need for emergency health care) - for example, a blood transfusion – where that patient has the legal capacity to refuse such health care."[7]

5.4 In South Australia, s 13(5) of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) states that, if available, parental consent to emergency medical treatment of a child (being someone under 16 years) must be sought. However, if the parent refuses to give consent to the emergency treatment, the treatment can nevertheless go ahead if in the best interests of the child's health and well-being.

Statute

5.5 Several statutory provisions in New South Wales deal with medical practitioners' liability for any physical contact necessarily involved in emergency medical treatment, that treatment having been carried out without consent. These statutory provisions collectively reinforce the

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that the surgeon's action is acceptable in the ordinary conduct of everyday life, and not a battery."

[4] *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 at 76-77, Lord Goff stated: "Where…a surgeon performs an operation without…consent on a patient temporarily rendered unconscious in an accident, he should do no more than is reasonably required, in the best interests of the patient, before he recovers consciousness. I can see no practical difficulty arising from this requirement, which derives from the fact that the patient is expected before long to regain consciousness and can then be consulted about longer term measures."

[5] Providing that the rescuer acts reasonably in the circumstances.

[6] See Queensland Law Reform Commission, "Consent to health care of young people" (Report No 51, 1996) Volume 1 at 47.

[7] Queensland Law Reform Commission at 47. In this regard, the Canadian case of *Malette v Shulman* (1990) 67 DLR (4th) 321 was cited. Note that in South Australia, the *Consent to Medical Treatment and Palliative Care Act 1995* s 13(1)(c) allows patients 16 years and over to refuse consent to emergency medical treatment.

common law position that consent to medical treatment is not necessary in an emergency.

Section 174 of the Children and Young Persons (Care and Protection) Act 1998 (NSW)

5.6 In New South Wales, s 174 of the *Children and Young Persons (Care and Protection) Act 1998* broadly allows medical practitioners[8] and registered dentists[9] to treat children (under 16 years)[10] and young persons (16 and 17 years)[11] without the child's or young person's or his or her parents' consent when, in the medical practitioner's or dentist's opinion,[12] it is an urgent matter to:

- save the child's or young person's life; or
- prevent serious damage to the child's or young person's health.[13]

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[8] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 174(1).

[9] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 174(3). Note that "medical treatment" and "dental treatment" are not defined for the purposes of s 174 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). However, note that in s 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) "medical treatment" is defined broadly for the purposes of that section.

[10] "Child" means a person under the age of 16 years: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 3.

[11] "Young person" means a person of 16 or 17 years: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 3.

[12] "Opinion" in s 174(1) is a medical practitioner's or dentist's subjective opinion at the time of the emergency. This is inferred from a Court of Appeal decision in *Birkett v Central Sydney Area Health Service* (NSW, Court of Appeal, No 40083/94, Priestly, Clarke JJA and Abadee AJA, 18 November 1996, unreported) dismissing an appeal from a decision of Bryson J in which his Honour had discussed the nature of the medical practitioner's opinion referred to in the predecessor of s 174(1) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), being s 20A(1) of the *Children (Care and Protection) Act 1987* (NSW). At 6 of *Birkett* their Honours quoted with approval the following from Bryson J's judgment: "…this is a test which is met not according to objective facts determined retrospectively by the court now, but according to the opinion of the medical practitioner at the time…The question of necessity is not one for philosophical analysis and does not involve, as perhaps as an exercise in logic it would involve, the exclusion of all possibilities of other outcomes however small; the question is referred by the terms of the subsection to medical opinion and must be answered according to medical opinion of what is necessary; and further of what is necessary as a matter of urgency…There is no need to wait until the last minute before acting under the subsection."

[13] Note that s 174 requires a connection between the child or young person and New South Wales: see *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 4.

5.7 Section 174 would therefore cover emergency situations such as giving blood transfusions to children and young persons.

5.8 Section 174 treats such emergency action by a medical practitioner or dentist as having been carried out with the relevant person's consent.[14] However, the section explicitly does not exclude the medical practitioner or dentist from liability for negligence in giving the medical or dental treatment.[15] Section 174 of the *Children and Young Persons (Care and Protection) Act 1998* appears to render irrelevant in New South Wales questions as to the content of the common law emergency medical treatment exception to the requirement for consent to the application of force to a person, at least where that person is under 18 years.[16] Certainly, the provision does not explicitly save the common law.

Issue 5.1

(a) Does s 174 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) operate effectively in its present form? In particular, is s 174 sufficiently comprehensive and clear about the situations in which young people can be provided with emergency medical treatment without a preliminary requirement for consent, or should general statutory guidelines be made for the guidance of those involved in the emergency medical treatment of young people?

(b) Should parents or young people be able to refuse emergency medical treatment (of their child)? If so, in what circumstances?

(c) Generally, should the law regarding medical emergencies be different for young people than for adults in the same situation?

Other statutory provisions covering the emergency exception to consent to medical treatment

5.9 Section 175(2) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) exonerates a medical practitioner from obtaining the prior consent of the Guardianship Tribunal for "special

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[14] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 174(3). This sub-section uses the devise of "deemed" consent to emergency medical or dental treatment. That is, although no prior consent has actually been given to the emergency medical or dental treatment which has been carried out by the medical practitioner or dentist on a child or young person pursuant to s 174(1) or (2); sub-section (3) deems a parent of the child to have given prior consent where the emergency treatment has been carried out on that "child" within the meaning of the Act, and deems a young person to have given prior consent where the emergency treatment has been carried out on that "young person" within the meaning of the Act.

[15] See *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 174(4).

[16] See also T Carney, "Regulation of treatment of severe anorexia nervosa: assessing the options" (2002) 11 *Australian Health Law Bulletin* 25 at 27, n 17 and accompanying text.

medical treatment"[17] in emergency situations, where in the opinion of the medical practitioner, it is necessary in order to save the life of a person under 16 years of age[18] or to prevent serious damage to that person's health. This includes where the treatment is likely to render the young person, among other serious consequences, permanently infertile. Section 175 is discussed further below under "Special Medical Treatment".

5.10 Section 37 of the *Guardianship Act 1987* (NSW)[19] also allows urgent medical or dental treatment[20] (without the requisite guardian or tribunal consent) on a patient of 16 years or over who is incapable of giving consent in order to: [21]

- save the patient's life;
- prevent serious damage to the patient's health; or
- prevent the patient suffering from significant pain or distress (except in the case of special treatment). [22]

5.11 Section 201 of the *Mental Health Act 1990* (NSW) allows certain medical personnel[23] in hospitals to consent[24] to surgical operations[25] on a patient (as variously defined under the Act)[26] or any other person under detention in a hospital, who is[27] incapable of giving consent (or if capable, refuses to give consent),[28] where in the opinion of the medical personnel, it

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17. As defined in s 175(5) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).
18. See *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 3 ("child").
19. Section 37 of the *Guardianship Act 1987* (NSW) is discussed further below under "Special Medical Treatment".
20. "Medical or dental treatment" or "treatment" as defined in s 33(1) of the *Guardianship Act 1987* (NSW).
21. *Guardianship Act 1987* (NSW) s 34.
22. "Special treatment" is defined in s 33(1) of the *Guardianship Act 1987* (NSW) and cl 6 of *Guardianship Regulation 2000* (NSW).
23. A "prescribed person" being a medical superintendent, deputy medical superintendent, responsible medical officer or authorised officer: *Mental Health Act 1990* (NSW) s 201(4).
24. In writing and signed: *Mental Health Act 1990* (NSW) s 201(3). As soon as practicable after the surgical operation, notice must be given by the medical superintendent to those specified: *Mental Health Act 1990* (NSW) s 203.
25. As defined in Schedule 1 (s 3 Definitions refers) of the *Mental Health Act 1990* (NSW), but note that s 200 excludes certain treatments.
26. Examples include: "informal patient", "temporary patient", "continued treatment patient", "forensic patient", "patient": see further for definitions of each in Schedule 1 (s 3 Definitions refers) of the *Mental Health Act 1990* (NSW).
27. In the opinion of the prescribed person: *Mental Health Act 1990* (NSW) s 201(1) and (3).
28. *Mental Health Act 1990* (NSW) s 201(1)(a).

is an urgent situation to save the patient's life or prevent serious damage to the patient's health.[29] Such consent by medical personnel is treated as if it were given by the patient or other person (14 years or over) or the parent or guardian of the patient or other person (under 14 years).[30]

First responders in emergencies

5.12 ***Emergency services.*** Section 26 of the *Ambulance Services Act 1990* (NSW) states that an ambulance service employee is not liable for injury or damage in carrying out his or her duties in good faith in providing ambulance services or in protecting others from injury or death.

5.13 Other statutes similarly protect first responders when carrying out their occupational duties (including attending emergencies) from personal liability, if acting in good faith. These include: s 78 of the *Fire Brigades Act 1989* (NSW); s 213 of the *Police Act 1990* (NSW); s 25 of the *State Emergency Service Act 1989* (NSW); and s 41, 59 and 62 of the *State Emergency and Rescue Management Act 1989* (NSW).

5.14 ***Section 36(1)(l) of the Medical Practice Act 1992 (NSW).*** This provision includes in its description of "unsatisfactory professional conduct" the refusal or failure of a registered medical practitioner (without reasonable cause) to attend professionally to a person in need of urgent medical attention, unless all reasonable steps have been taken by that practitioner to ensure another practitioner attends the person within a reasonable time.[31] Potentially, such a failure or refusal under s 36(1)(l) could amount to "professional misconduct" of the registered medical practitioner justifying suspension from practice or removal from the Register under s 37 of the Act.

Issue 5.2

Should clearer guidelines be given to medical practitioners as to when they have to respond to emergency situations involving people who are not their patients?

5.15 ***Part 8 of the Civil Liability Act 2002 (NSW).*** Protection from personal civil liability[32] for first responders generally, is found in Part 8

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[29] *Mental Health Act 1990* (NSW) s 201.

[30] *Mental Health Act 1990* (NSW) s 202.

[31] See also *Woods v Lowns & Anor* (1995) 36 NSWLR 344 (regarding a general practitioner's common law duty of care in circumstances where he failed to attend a person in proximity to him, who was not his patient but was in need of emergency care, and liability under a statutory predecessor of s 36(1)(l)); and *Lowns & Anor v Woods & Ors* (1996) Aust Torts Reports 81-376 (on appeal).

[32] *Civil Liability Act 2002* (NSW) s 57.

(s 55 to 58) of the *Civil Liability Act 2002* (NSW).[33] The protection applies to any kind of personal civil liability (unless specifically excluded)[34] of "good samaritans" for any acts or omissions in an emergency when the good samaritan is assisting an apparently injured person or a person at risk of being injured.[35] A "good samaritan" is defined in s 56 as "a person who, in good faith and without expectation of payment or other reward, comes to the assistance of a person who is apparently injured or at risk of being injured". This wide definition could therefore include medical practitioners. An injured person could obviously include a person under 18 years. However, the Act gives no definition of the term "injury" for the purposes of Part 8. Protection from personal liability does not apply if an intentional or negligent act or omission by the good samaritan caused the injury.[36]

5.16 Part 8 creates a wide protection against personal liability. For example, no reference is made in s 57(1) of the Act to any requirement for consent by or on behalf of the person who is apparently injured (or at risk of being injured) to the acts or omissions done or made by the good samaritan, before the protection from liability conferred by the provision operates. It is most unlikely that the provision would be construed as impliedly requiring such consent.

5.17 Also, s 57(1) confers protection from civil liability generally, not only, for instance, from civil liability for assault or battery. Civil liability in negligence is therefore protected against under this section (subject, of course, to s 58). In this respect, s 57(1), when the conditions of its operation are satisfied, is more generous to a medical practitioner than are s 174 and s 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), s 204 of the *Mental Health Act 1990* (NSW) and s 37 of the *Guardianship Act 1987* (NSW) when the conditions of their operation are satisfied.[37]

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[33] Note that other jurisdictions have also introduced "good samaritan" legislation providing protection for those voluntarily providing assistance to others in an emergency, for example *Wrongs Act 1936* (SA) s 38.

[34] *Civil Liability Act 2002* (NSW) s 55, and see s 3B for exclusions.

[35] *Civil Liability Act 2002* (NSW) s 57.

[36] *Civil Liability Act 2002* (NSW) s 58(1).

[37] However, note that protection from civil liability under s 57 of the *Civil Liability Act 2002* (NSW) does not affect the vicarious liability of any other person for the acts or omissions of the good samaritan (see s 57(2)). This exclusion could create difficulties for a medical practitioner who conducts his or her medical practice by means of a company controlled or conducted by him or her. If the particular act or omission done or made by the "good samaritan" medical practitioner in an emergency when assisting a person who is apparently injured or at risk of being injured could be said to have been done or made in the course of the medical practitioner's employment by the company, then the immunity conferred on the

Issue 5.3

Does Part 8 of the *Civil Liability Act 2002* (NSW) sufficiently protect first responders in emergencies from civil liability? For example, does Part 8 make sufficiently clear that medical practitioners and the public are not liable for assault and battery for emergency health care treatment? Should first responders be protected from liability for assisting an injured person below 18 years, who refuses, or whose parent refuses, emergency assistance?

SPECIAL MEDICAL TREATMENT

5.18 Some medical procedures are regarded as intervening in the health and well-being of a person under 18 years to such a degree as to be outside even the consent of that person or his or her parent/s, requiring court or tribunal consent before the procedures can be carried out. These "special medical treatments" are described in s 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), s 204 of the *Mental Health Act 1990* (NSW), and generally in Part 5 of the *Guardianship Act 1987* (NSW).[38] These provisions are discussed in some detail elsewhere in this paper.[39]

5.19 Each set of provisions creates a serious criminal offence of carrying out certain types of medical treatment on either a class of young people or on a class of persons (which includes at least some young people) without court or tribunal consent. However, each set of provisions expressly excludes from liability for the offence created the carrying out by a medical practitioner of medical treatment in an emergency.

Section 175 of the Children and Young Persons (Care and Protection) Act 1998 (NSW)

5.20 Section 175(1) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) creates a serious criminal offence[40] of the carrying out of "special medical treatment" on a "child". Note that s 175 only deals with children, that is people under the age of 16 years.[41]

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medical practitioner by s 57(1) could be rendered nugatory, practically speaking, by s 57(2), depending on the extent to which beneficial ownership of the company resides in the medical practitioner.

[38] Specifically, *Guardianship Act 1987* (NSW) s 34, 35, 37, 46 and 47.

[39] See Chapters 4 and 6.

[40] Penalty on indictment - imprisonment for 7 years: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(1).

[41] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 3.

5.21 "Special medical treatment" is defined in s 175(5) as being any medical treatment (which includes "any medical procedure, operation or examination") that in the long term or permanently interferes with a person's reproductive ability or personality and behaviour.[42]

5.22 However, an emergency exception to the offence created under s 175 exists.[43] Under s 175(2) an offence has not been committed by a medical practitioner who has carried out the special medical treatment on a child, if the medical practitioner held at the relevant time the opinion that an emergency existed (regarding the child's life or serious health issues).[44]

Section 204 of the Mental Health Act 1990 (NSW)

5.23 Similar to s 175(1) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), s 204(1) of the *Mental Health Act 1990* (NSW) creates a serious criminal offence of the carrying out of "special medical treatment" (the respective definitions of this term are similar but not the same under each Act)[45] on a "patient" within the meaning of the *Mental Health Act 1990*[46] (and who may be a patient under the age of 18 years),[47] without an emergency existing or tribunal consent.[48]

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[42] Specifically, s 175(5) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) defines "special medical treatment" under sub-paragraphs (a),(b),(c),(d) and also defines "medical treatment". Note that the definition of "special medical treatment" in sub-paragraph (d) refers to cl 15 of the *Children and Young Persons (Care and Protection) Regulation 2000* (NSW).

[43] The other exception to the offence under s 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) is where the Guardianship Tribunal has consented to the treatment interfering with the child's reproductive ability: s 175(2)(b).

[44] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(2)(a).

[45] "Special medical treatment" under s 204 of the *Mental Health Act 1990* (NSW) is narrower than "special medical treatment" under s 175(5) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). Under the former Act it means "a treatment, procedure, operation or examination that is intended, or is reasonable likely, to have the effect of rendering permanently infertile the person on whom it is carried out": as defined in Sch 1 (s 3 Definitions refers) of the *Mental Health Act 1990* (NSW).

[46] See definition of "patient" in the *Mental Health Act 1990* (NSW) Sch 1 (s 3 Definitions refers) meaning a person who is admitted to hospital in accordance with this Act.

[47] It is apparent from various provisions of the *Mental Health Act 1990* (NSW) that a person of any age less than eighteen years can be such a patient: see, for example, s 202. Therefore, in so far as patients who are under the age of sixteen are concerned, both s 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and s 204 of the *Mental Health Act 1990* (NSW) (so far as the latter concerns emergency medical treatment) are potentially applicable. So far as

5.24 Also similar to s 175(2)(a) of the *Children and Young Persons (Care and Protection) Act 1998*, s 204(2)(a) of the *Mental Health Act 1990* then provides in effect that the offence created by s 204(1) has not been committed by a medical practitioner who has carried out special medical treatment on a patient provided the medical practitioner held at the relevant time the opinion that an emergency existed.

Part 5 of the Guardianship Act 1987 (NSW)

5.25 Sections 35 and 37 of the *Guardianship Act 1987* (NSW) create a regime broadly similar to that created by s 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and s 204 of the *Mental Health Act 1990* (NSW).[49]

5.26 Section 35(1) of the *Guardianship Act 1987* creates an offence with different penalty regimes depending on the type of treatment involved (that is, special treatment, treatment in the course of a clinical trial, minor or major treatment)[50] for performing medical or dental treatment[51] on a patient[52] to whom Part 5 applies, unless consent has been given in

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patients who are sixteen or seventeen years old, only the latter provision is potentially applicable (so far as it concerns emergency medical treatment).

[48] Being the Mental Health Review Tribunal: *Mental Health Act 1990* (NSW) Sch 1 (s 3 Definitions refers).

[49] See further Chapters 4 and 6.

[50] Definitions of "medical or dental treatment", "treatment", "major treatment", "minor treatment", "special treatment" and "clinical trial" are found in s 33(1) of the *Guardianship Act 1987* (NSW).

[51] "Medical or dental treatment or treatment" are broadly defined in s 33(1) of the *Guardianship Act 1987* (NSW).

[52] Section 34(1) of the *Guardianship Act 1987* (NSW) applies to a "patient" who is 16 years or older and who is incapable of giving consent to the carrying out of medical or dental treatment. This includes a person who is incapable of understanding the general nature and effect of the proposed treatment or incapable of indicating consent to the treatment: s 33(2). Section 34(1)(a) makes it clear that a "patient" in s 35 and 37 can include a child who is 16 or 17 years of age, but no younger. In this respect, s 35 and 37 of the *Guardianship Act 1987* (NSW) differ from s 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), which deals only with children under the age of sixteen years, and from s 204 of the *Mental Health Act 1990* (NSW), which deals with, among others, children of any age (so far as emergency treatment is concerned). It follows that, in so far as "patient(s)" within the meaning of the *Guardianship Act* are children who are sixteen or seventeen years of age and are also "patient(s)" within the meaning of the *Mental Health Act*, both s 204 of the *Mental Health Act 1990* (NSW) (so far as it concerns emergency medical treatment) and s 35 and 37 of the *Guardianship Act 1987* (NSW) are potentially applicable. Note that s 34(2) of the *Guardianship Act* states that if there is any inconsistency between Part 5 of the *Guardianship Act* and the provisions of the *Mental Health Act*, the latter Act prevails.

accordance with Part 5[53] or treatment authorised by Part 5 without consent.[54]

5.27 Section 37 then sets out the medical or dental treatment which may be carried out *without* any such consent. These are emergencies[55] and minor treatments.[56]

Emergencies under the Guardianship Act

5.28 Similar to s 175 of the *Children and Young Persons (Care and Protection) Act 1998* and s 204 of the *Mental Health Act 1990*, s 37(1) of the *Guardianship Act 1987* states no consent is needed for medical or dental treatment[57] carried out by a medical practitioner or dentist in an emergency, that is:

- saving the patient's life;[58]
- preventing serious damage to the patient's health;[59] or
- preventing the patient from suffering significant pain or distress (except in the case of "special treatment").[60]

5.29 "Special treatment" as in the other two Acts mentioned above, covers similar medical procedures, being broadly treatment which: permanently interferes with an individual's reproductive ability, terminates a pregnancy, uses medically unsupported new treatments, administers long-term addictive drugs (except if terminally ill), or uses aversive stimuli.[61]

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[53] See s 35(1), (1A) and 36 of the *Guardianship Act 1987* (NSW) which collectively set out who may give consent to medical or dental treatment under Part 5.

[54] Note that s 35(2) of the *Guardianship Act 1987* (NSW) states that s 35 does not limit the operation of any other Act or law under which minor treatment may be carried out on a person without that person's consent.

[55] *Guardianship Act 1987* (NSW) s 37(1).

[56] Section 37(2) and (3) of the *Guardianship Act 1987* (NSW) if there is no "person responsible" (as defined in s 33A) for the patient or such a person is unable or unwilling to make decisions for the patient, and the doctor or dentist certifies that the treatment is necessary and will promote the patient's health, and the patient does not object. "Minor treatment" is defined in s 33(1) as treatment that is not special treatment, major treatment or treatment in the course of a clinical trial.

[57] "Medical or dental treatment" or "treatment" are broadly defined in s 33(1) of the *Guardianship Act 1987* (NSW), but do *not* include treatments, such as: first aid, non-prescription drugs, non-intrusive examinations for diagnostic purposes.

[58] *Guardianship Act 1987* (NSW) s 37(1)(a).

[59] *Guardianship Act 1987* (NSW) s 37(1)(b).

[60] *Guardianship Act 1987* (NSW) s 37(1)(c).

[61] See definitions of "special treatment" in s 33(1) of the *Guardianship Act 1987* (NSW) and "special medical treatment" in cl 6 of the *Guardianship Regulation 2000* (NSW).

"Special treatment" does not include treatment in the course of a clinical trial.[62] Any such "special treatment" requires consent.[63]

5.30 Section 47 of the *Guardianship Act 1987* preserves liability for negligence under Part 5 of the Act. This means that s 37 of the *Guardianship Act 1987* (allowing medical or dental treatment without consent in cases of emergency or minor treatment) protects against allegations such as assault or trespass to the person, but does not protect against allegations of negligence in such treatment.

SUSPECTED CHILD ABUSE

5.31 Wide statutory powers are given to government authorities to intervene in cases of suspected child abuse, including forced medical examinations of children without parental consent.[64]

Medical examination of children in need of care and protection

5.32 Section 173 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) allows either the Director-General of the Department of Community Services or a police officer, who believes on reasonable grounds[65] that a child[66] is in need of care and protection[67] to force[68] that child to be medically examined by a medical practitioner.[69] Section 173 only

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[62] "Clinical trial" is defined in s 33(1) of the *Guardianship Act 1987* (NSW).

[63] See *Guardainship Act 1987* (NSW) s 35 and 37.

[64] Note that the provision for "special medical examinations" under s 176 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) of children or young people *already* in the care of the Department of Community Services under a Children's Court order has not commenced. Furthermore, s 176 is being considered for repeal. As such, it will not be discussed in this chapter.

[65] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 173(1). Note that the "reasonable grounds" language in relation to the Director-General and police officers is also used in other sections of the Act, for example: s 43 with regard to the removal of children or young persons from places of risk, and s 34 regarding the taking of action by Director-General.

[66] "Child" means a person who is under the age of 16 years: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 3 (Definitions).

[67] Although "in need of care and protection" is not specifically defined in the *Children and Young Persons (Care and Protection) Act 1998* (NSW), guidance as to its meaning is found in s 8(a) (objects of the Act), s 34 (when the Director-General can take action), s 36 (principles of intervention), and s 71 (grounds for a Children's Court care order).

[68] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 173(3).

[69] Medical examination is as the medical practitioner "thinks fit" (s 173(4)(a)) and includes the taking and analysis of samples and the use of any machine or device that assists in the examination: s 173(5).

relates to children under the age of 16 years.[70] The person who has or appears to have care of the child is guilty of an offence if he or she does not comply with the official request.[71] While the child is undergoing the medical examination, or for up to three days (whichever is the shorter time period), the Director-General is considered to be the parent of the child for the purpose only of enabling the examination to be carried out .[72]

5.33 The medical practitioner can examine the child as he or she thinks fit.[73] This wide discretion includes the location of the medical examination and the type of medical procedure undertaken.[74] The medical practitioner must prepare a written report of the examination for the Director-General.[75] The transmission of the medical report to the Director-General cannot be held to constitute a departure from accepted standards of professional conduct and the making of the report does not give rise to liability for defamation.[76] Furthermore, a general exclusion from liability is given to all those involved in the instigation of and the actual medical examination of the child, if those persons have acted in good faith and with reasonable care.[77]

Children's Court assessment orders

5.34 Under s 53 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), the Children's Court can make orders for the physical, psychological, psychiatric or other medical examination of a child[78] or young person.[79] These are called "assessment orders."[80] A medical examination can be carried out in the terms of the order.[81] However, if the child or young person is of sufficient understanding to make an informed

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[70] See "child" in s 3 (Definitions).

[71] Section 173(1) and (2), and *Children and Young Persons (Care and Protection) Regulation 2000* (NSW) cl 14 and Sch 1 – Form 1 [Notice of medical examination].

[72] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 173(4)(b).

[73] Section 173(4)(a). This includes taking and analysing samples and using any machine that assists the examination: s 173(5).

[74] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 173(4)(a) and (5).

[75] Section 173(4)(c).

[76] Section 173(7).

[77] Section 173(6).

[78] "Child" is a person under the 16 years of age: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 3 (Definitions).

[79] "Young person" is someone who is 16 or 17 years of age: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 3 (Definitions).

[80] Section 52.

[81] This includes taking and analysing samples and using any machine that assists the examination: s 53(3).

choice, then he or she can refuse to submit to the medical examination or assessment.[82] The child or young person must be informed of the reasons for the assessment in an appropriate manner for his or her development and circumstances.[83]

5.35 The Court must take into consideration various matters when deciding whether to make an assessment order,[84] including not subjecting the child or young person to undue distress[85] or to unnecessary assessment.[86] The assessment report is usually prepared by the Children's Court Clinic[87] and once submitted to the Children's Court, is considered to be a report to the Court and not evidence tendered by one party.[88] If someone other than the Children's Court Clinic is to prepare the assessment report, then agreement as to this person should (as far as possible) be obtained from the child or young person, parents and Director General.[89] It is noted that this inclusive agreement as to the person undertaking the assessment report (as required in s 58(2)) is not similarly required in respect of a s 173 medical examination.

5.36 Any medical examination under a Children's Court assessment order can be as wide-ranging as a medical examination conducted under s 173 of the *Children and Young Persons (Care and Protection) Act 1998*.[90] However, unlike the medical examination of a child under s 173, s 53(4) states that a child or young person of sufficient understanding to make an informed decision can refuse to submit to the Children's Court ordered medical examination or assessment.[91] Also, the child or young person must be informed of the reasons for any proposed assessment in a manner that he or she can understand having regard to his or her development and circumstances.[92]

Issue 5.4

(a) Should a child or young person ever be forced to undergo a medical examination against their will, and without their parent's consent?

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[82] Section 53(4).
[83] Section 57(1).
[84] Section 56.
[85] Section 56(1)(b).
[86] Section 56(2).
[87] Section 58.
[88] Section 59.
[89] Section 58(2).
[90] Section 53(3) and 173(5).
[91] Section 53(4).
[92] Section 57(1). See also generally regarding s 173 and 53: *Children and Young Persons* (*Care and Protection) Act 1998* (NSW) s 10 – The principle of participation.

(b) If so, in what circumstances should a child or young person be forced to undergo a medical examination? What type of medical examination should they be forced to undergo against their will?
(c) Is the present law covering medical examinations in cases of suspected child abuse sufficient?
(d) Should medical examinations under s 173 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) be more aligned with the consensual approach taken to medical examinations of children and young people under Children's Court "assessment orders" (s 53 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW))? Is there a reason why a s 173 medical examination should be different?

PUBLIC HEALTH MEASURES

5.37 Public health measures are designed to protect the general community from severely debilitating and life-threatening contagious diseases. As such, they cover all people in the community, both adult and child.

5.38 Section 22 of the *Public Health Act 1991* (NSW) allows the Director-General of the Department of Health to require any person to undergo a medical examination carried out by a medical practitioner of that person's choice if the Director-General believes on reasonable grounds that the person is suffering from a Category 4 or 5 medical condition. Category 4 medical conditions are SARS (severe acute respiratory syndrome), tuberculosis and typhoid. Category 5 medical conditions are AIDS (acquired immune deficiency syndrome) and HIV (human immunodeficiency virus infection).[93] A written notice is served on the person and if the person fails without reasonable excuse to comply with the medical examination, he or she is guilty of an offence.[94]

5.39 Other coercive government powers with specific regard to young people and their medical conditions are found in the *Public Health Act 1991* (NSW). Part 3A of the *Public Health Act 1991* refers to the duties of school principals and directors of child care facilities in relation to keeping records of young people's immunisation status and how to control an outbreak of vaccine preventable diseases in their institutions.[95] If a young person

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[93] *Public Health Act 1991* (NSW) s 3 (Definitions) and Sch 1.

[94] *Public Health Act 1991* (NSW) s 22(2). Note that if such a person (with a category 4 or 5 medical condition) is behaving in a way reasonably likely to endanger the public health, then a public health order can be placed on that person, including a requirement to undergo specified treatment, by an authorised medical practitioner: see s 23, 24 and 25.

[95] Part 3A – Control of vaccine preventable diseases (s 42A, 42B, 42C and 42D). See also, cl 14, 15, 16 and 17 of the *Public Health (General) Regulation 2002* (NSW).

attending school or a child care facility has a vaccine preventable disease, then after informing the local medical officer of health, the principal or director must comply with the medical officer's direction.[96] This direction to the principal or director includes notifying the parent of the young person that the young person is excluded from the school or child care facility for the duration of the outbreak of the disease, and for the principal or director to take such other action with respect to the young person as is specified in the direction.[97]

5.40 The chief executive officer of a hospital also has a duty to notify the Director-General of any patient with a notifiable disease.[98] Schedule 3 lists these notifiable diseases, which include childhood diseases such as measles, meningococcal disease, poliomyelitis and whooping cough.

Issue 5.5

Should s 22 of the *Public Health Act 1991* (NSW) have specific provisions governing young people with a category 4 or 5 contagious disease?

MINOR TREATMENT

5.41 People such as teachers or day care centre workers, who have temporary care of a young person, with the parents' authority, can probably consent to treatment for the young person if the treatment is minor, such as first aid, or the administration of non-prescription medication. Their authority to do so is likely based on the implied consent of the parents upon leaving their child in the carer's temporary care.[99]

5.42 However, educational institutions caring for young people, such as day care centres and primary schools, often request parental consent to the giving of non-prescription medications such as Panadol or cough medicines for young people attending these institutions. The practice of obtaining prior parental consent for administering non-prescription or "over the counter" common medications to young people in schools, pre-schools, and day care centres, vary with the type of institution involved.[100]

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[96] *Public Health Act 1991* (NSW) s 42D(4).

[97] Section 42D(2).

[98] Section 68 definition of "notifiable disease" and 69(2).

[99] There has not been any judicial consideration of the basis of this authority: see L Skene, *Law and medical practice: rights, duties, claims and defences* (2nd edition, LexisNexis Butterworths, Sydney, 2004) at para 4.6.

[100] Parental consent requirements derive from various authorisations and accreditations required by different State and federal government departments depending on the type of educational institution concerned.

Issue 5.6

(a) Should there be greater clarity and consistency across educational and other institutions caring for young persons, as to any requirement/s for parental consent/s to minor medical treatments for their children, such as the administering of first aid or non-prescription medications?

(b) Should educational and other institutions be required first to obtain a young person's consent, in the case of an 'older' young person, before providing minor medical treatment? If so, how should such a young person be defined?

(c) Should legislation define exactly what is meant by "minor" medical treatment?[101]

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[101] Queensland Law Reform Commission, *Consent to health care of young people* (Report No 51, December 1996) Volume 2 at 300 recommended that a competent young person of 12 years of age or older (or their parent) should consent to minor health care. At 301, the Commission also recommended a definition of what constitutes "minor health care."

6.

Young people with mental illness or intellectual disability

- Introduction
- Definitions
- Application of the general rules
- Special rules
- The Mental Health Act 1990 (NSW)
- Out-of-home care

INTRODUCTION

6.1 The incidence of mental illness and intellectual disability among young people is quite significant. In a 2001 study by NSW Health, more than 20% of 12-17 year olds in New South Wales were found to have a level of symptoms and disruption of functioning that warranted a formal diagnosis of mental disorder.[1] This finding reflected those of an Australia-wide study published in 2000, which found that 19% of adolescents reported having mental health problems and 15% had symptoms of one of the three most common mental disorders namely, attention-deficit/hyperactivity disorder, depressive disorder and conduct disorder.[2] On the other hand, almost 1% of the population of New South Wales has been estimated to have *profound or severe* intellectual disability and about half of this group is below the age of 18 years.[3]

6.2 This chapter examines the legal framework of consent to, and refusal of, medical treatment by young people with mental illness or intellectual disability. The next chapter discusses other groups of young people with special needs.

DEFINITIONS

Mental illness

6.3 The distinguishing feature of mental illness is the presence of symptoms indicating disturbance in mental functioning such as thought, perception, memory and judgment. Medical diagnosis involves identifying clusters of symptoms according to one or another of the standard psychiatric protocols. A widely accepted psychiatric classification system is the *Diagnostic and Statistical Manual of Mental Disorders*, which arranges over 300 mental disorders in diagnostic hierarchies with descriptions of the

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[1] NSW Health, *Mental health clinical care and prevention model: a population mental health model* (2001) at 14.

[2] MG Sawyer, FM Arney, PA Baghurst, JJ Clark, BW Graetz, RJ Kosky, B Nurcombe, GC Patton, MR Prior, B Raphael, J Rey, LC Whaites and SR Zubrick, *Mental health of young people in Australia* (Commonwealth Department of Health and Aged Care, Canberra, 2000).

[3] Information supplied by Mr David Kay, NSW Department of Aging, Disability and Home Care (12 December 2003). According to the NSW Council for Intellectual Disability, the total number of people with intellectual disabilities has been estimated at between 2.3% to 3% of the general population. This means that in New South Wales, with a population of around 6 million people, there are between 138,000 and 180,000 people with intellectual disabilities.

essential and the associated features of each one.[4] The manual defines mental disorder as

> a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (eg, a painful symptom) or disability (ie, impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expected and culturally sanctioned response to a particular event, for example, the death of a loved one.[5]

6.4 In New South Wales, mental illness is defined more narrowly in the *Mental Health Act 1990* (NSW) as a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

(a) delusions;

(b) hallucinations;

(c) serious disorder of thought form;

(d) a severe disturbance of mood; or

(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a) - (d).[6]

6.5 This definition is mainly relevant in the context of the involuntary admission to hospitals of those who have a mental illness and are at risk of causing harm to themselves or others.[7]

Intellectual disability

6.6 People with an intellectual disability have significantly lower than average intellectual ability and deficits in social and adaptive functioning. Their capacity to learn and communicate may be impaired. They may have

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[4] Another diagnostic protocol is the World Health Organisation's *International classification of disorders (ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines).*

[5] *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (American Psychiatric Association, Washington DC, 2000) at xxxi.

[6] *Mental Health Act 1990* (NSW) Sch 1.

[7] See para 6.21-6.22.

difficulty in grasping abstract concepts, handling complex tasks, and absorbing and assessing information at a "normal" rate.[8]

6.7 The cause of a person's intellectual disability is often unknown. Some known causes include: genetic defects, such as Down's Syndrome; trauma, infection or exposure to harmful drugs before or at birth; or an "acquired" disability due to brain damage, malnutrition or deprivation in early childhood.[9]

6.8 A person's intellectual disability is usually classified as mild, moderate, severe or profound, based upon certain IQ (intelligence quotient) ranges. A person with a severe or profound disability may be unable to learn basic social skills or have a capacity for speech or personal care. The majority of people with an intellectual disability, however, have a mild level of intellectual disability and can learn skills of reading, writing, numeracy, and daily living sufficient to enable them to live independently in the community.[10]

6.9 There is no general statutory definition of intellectual disability in New South Wales.[11] An illustrative definition is found in Victoria's *Intellectually Disabled Persons' Services Act 1986* (Vic), which defines intellectual disability, in relation to a person over the age of 5 years, as the concurrent existence of:

(a) significant sub-average general intellectual functioning; and

(b) significant deficits in adaptive behaviour.[12]

The permanence/transience of a condition and capacity to consent

6.10 In the majority of cases, the intellectual disability of a person is not capable of being overcome by any medical, psychological or psychiatric treatment. It is usually a permanent condition. This is in contrast to some forms of mental illness. Many people with mental illnesses recover fully.

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[8] NSW Law Reform Commission, *People with an intellectual disability and the criminal justice system: courts and sentencing issues* (Discussion Paper 35, 1994) at para 2.6.

[9] L Gething, T Poynter and F Reynolds, *Disability awareness package - manual* (Community Disability and Ageing Program, University of Sydney, 1991) at 48.

[10] NSW Law Reform Commission, *People with an intellectual disability and the criminal justice system: courts and sentencing issues* (Discussion Paper 35, 1994) at para 2.4.

[11] The Commission proposed a statutory definition of intellectual disability in *People with an intellectual disability and the criminal justice system: courts and sentencing issues* (Report 80, 1996) Recommendation 1.

[12] *Intellectually Disabled Persons' Services Act 1986* (Vic) s 3.

Some may only have one episode of mental illness and then recover. In other cases, mental illness can come and go in people's lives. A person with a mental illness may therefore, at some stages of his or her life, pass the test of capacity to give consent to a medical treatment, but at other points, fail it. On the other hand, a person with a severe intellectual disability who, as a result of such disability, is incapable of understanding and weighing information about medical treatments may never attain capacity to give consent to any medical treatment.

Case study

R, a 15 year old girl, suffered increasing episodes of mental illness. Following one such episode, she was admitted to the adolescent psychiatric unit of a hospital where the proposed program of treatment included the administration of antipsychotic drugs. In a lucid interval, she indicated her refusal to such treatment. Wardship proceedings were commenced and the permission of the court was sought to allow the hospital to administer the drugs without R's consent. The consultant child psychiatrist was of the opinion that between episodes of psychosis, R sufficiently understood the nature of her illness and the proposed treatment, and was therefore competent to withhold her consent. The court was of the view that it had the authority to override the young person's refusal to the treatment, whether or not she was *Gillick*-competent.[13]

APPLICATION OF THE GENERAL RULES

Consent

6.11 The competence of young people to consent to medical treatment may be affected not only by their immaturity, but also by mental illness or intellectual disability. However, the courts do not presume that young people with such conditions are incompetent to make their own medical decisions.[14] As with all young people, their competence is assessed according to each individual's capacity to understand a proposed treatment. For instance, a person with schizophrenia may still be capable of understanding, weighing and retaining information about a medical procedure to come to a conclusion about whether or not to undergo treatment.[15]

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[13] *In Re R (A Minor) (Wardship: Consent to Treatment)* [1991] Fam11.

[14] *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218 at 238 (Mason CJ, Dawson, Toohey, and Gaudron JJ).

[15] See *Re C (Adult: Refusal of Medical Treatment)* 1994] 1 All ER 819.

6.12 The same criteria therefore apply to assess the competence of a young person with mental illness or intellectual disability as apply to the general population of young people. As discussed in Chapter 2, these criteria are derived mainly from the common law, the "*Gillick*-competent" test in particular, as modified by s 49 of the *Minors (Property and Contracts) Act 1970* (NSW).

6.13 For 16 and 17 year olds who have a mental illness or an intellectual disability, Part 5 of the *Guardianship Act 1987* (NSW) sets out rules for consenting to medical treatment.[16] These are discussed in detail in Chapter 2.[17]

Refusal

6.14 Young people do not have an absolute right to refuse medical treatments. A court may override a child's wish not to undergo medical treatment if: (1) he or she lacks sufficient understanding, intelligence and maturity to appreciate the consequences of the refusal; or (2) the refusal is not in the young person's best interests.[18]

6.15 Mental illness or intellectual disability may affect a young person's capacity to refuse medical treatment. Hence, in a case involving two 15 year old girls one with unsocialised adolescent conduct disorder and another with bipolar affective disorder, the court found neither of them to be *Gillick*-competent.[19] In a case involving a 16 year old girl with anorexia nervosa, Lord Donaldson made the following observations:

> it is a feature of anorexia nervosa that it is capable of destroying the ability to make an informed choice. It creates a compulsion to refuse treatment or only to accept treatment which is likely to be ineffective. This attitude is part and parcel of the disease and the more advanced the illness, the more compelling it may become.[20]

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[16] In general, the *Guardianship Act 1987* (NSW) is designed to uphold the welfare of people with disabilities who are not competent to make decisions about aspects of their lives: see s 4. For purposes of the Act, a person with a disability includes a person who has an intellectual disability, as well as one who is a mentally ill person under the *Mental Health Act 1990* (NSW): s 3(2). However, Part 5 of the *Guardianship Act 1987*, dealing with consent to medical (and dental) treatment, is not restricted to people suffering from a disability. It applies to any person, 16 and over, who is incapable of understanding the general nature and effect of the proposed treatment, or is incapable of indicating whether or not he or she consents or does not consent to the treatment being carried out: s 33(2).

[17] See para 2.35-2.46.

[18] See para 2.47-2.53.

[19] *Re K, W and H (Minors) (Medical Treatment)* [1993] 1 FLR 854.

[20] *In re W (A Minor)* [1993] Fam 64 at 81 (Lord Donaldson MR).

6.16 Regardless of a young person's competence, a court exercising its inherent powers can override his or her refusal of medical treatment, if the refusal is against the young person's welfare. The point at which a court can veto a child's wishes "will have come if the child is seeking to refuse treatment in circumstances which will probably lead to the death of the child or to severe permanent injury."[21]

Case study

X, a 16 year old girl, was admitted for hospital treatment of her anorexia nervosa. Her weight varied from 35-38 kg (well within the wasting range) and at some point dropped to 23 kg. She was put on naso-gastric re-feeding to enable her to gain weight. However, she sabotaged her program of re-feeding by siphoning food out of her stomach. One night, she surreptitiously left the hospital. The Department of Community Services (DoCS) sought to return her to the hospital but she refused. Her parents supported her refusal of hospital treatment but proposed alternative treatments. On application by DoCS, the Supreme Court ordered X to return to the hospital to resume a strict treatment program involving re-feeding, psychotherapy, physiotherapy and ongoing monitoring. In overriding X's refusal of hospital-based treatment, the Court underscored the fact that her health and survival were at serious risk without the treatment.[22]

SPECIAL RULES

6.17 There are two groups of young people with mental illness or intellectual disability whose consent to and refusal of medical treatment is governed by different rules:

- those admitted to public hospitals or are otherwise getting treatment pursuant to the *Mental Health Act 1990* (NSW); and
- those who are in out-of-home care.

THE MENTAL HEALTH ACT 1990 (NSW)

6.18 The main law in New South Wales that provides for the treatment of people with mental illnesses in hospitals and in the community is the *Mental Health Act 1990* (NSW). It aims to protect the rights of people with mental illness while ensuring that they have access to appropriate care. It

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[21] *In re W (A Minor)* [1993] Fam 64 at 88 (Balcombe LJ). See also *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180.

[22] *Department of Community Services v Y* [1999] NSWSC 644.

contains rules on consent to medical treatments, which operate once a person with a mental illness is admitted in a public hospital or is otherwise covered by the provisions of that Act.[23] The rules vary according to whether the patient was voluntarily or involuntarily admitted.

Voluntary admission to hospitals

6.19 The *Mental Health Act 1990* (NSW) provides for admission to a hospital as a voluntary patient on application by the person concerned, or in the case of a person under guardianship, by the person's guardian with the approval of the Guardianship Board.[24] Like adults, young people with mental illness may voluntarily seek psychiatric treatment and may be admitted to a hospital,[25] if they are likely to benefit from inpatient care and treatment.[26] However, there are special rules for young people:

- If a person below the age of 16 is admitted to hospital as a voluntary patient, the hospital must do everything reasonably practicable to notify the person's parents or guardians of the admission.[27]
- If a parent of a 14 or 15 year old person objects to the person's admission as a voluntary patient, the young person must be discharged from hospital, unless he or she elects to remain as a voluntary patient.[28]
- A person under 14 cannot be admitted or remain in hospital as a voluntary patient if the person's parent objects to his or her admission.[29]

Issue 6.1

For young people below 14 years old who have mental illnesses, should the objection of one parent be sufficient to bar their voluntary admission in a psychiatric hospital? Alternatively, should there be other factors to consider: for example, the child's level of understanding concerning his or her proposed hospitalisation, the opinion of medical practitioner(s) who have been treating the young person, the wishes of the other parent and the child's best interests?

6.20 The provisions on voluntary admission are different from the general rules regarding consent by young people to medical treatment, as set out in

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[23] The Act contains provisions that allow patients to receive treatment in the community: *Mental Health Act 1990* (NSW) Chapter 6.

[24] Section 12.

[25] Section 12.

[26] Section 17.

[27] Section 13.

[28] Section 14.

[29] Section 15.

Chapter 2. They give young people aged 14 and 15 a right to override the wishes of their parents with respect to their right to receive voluntary psychiatric inpatient care. They also give parents an explicit right to override the wishes of young people below the age of 14 – something that the general law does not do.

Issue 6.2

Should the provisions regarding the right of young people to consent to voluntary admission for psychiatric treatments in hospitals be the same as the general rules on young people's competence to consent to medical treatment?

Involuntary admission to hospitals

6.21 A person, including one who is below the age of 18, can be involuntarily detained in a hospital if he or she is considered to be either:[30]

- a "mentally ill person", defined as a person who is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary for the person's own protection or the protection of others from serious harm;[31] or
- a "mentally disordered person", who is someone whose behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary for the person's own protection or the protection of others from serious physical harm.[32] A mentally disordered person need not have a mental illness.

6.22 One means of involuntary admission is through certification by a medical practitioner that the person is a mentally ill person or a mentally disordered person. The certifying medical practitioner must have personally examined the person immediately before completing the certificate. Moreover, the medical practitioner must be of the opinion that no other appropriate means for dealing with the person are reasonably available, and that involuntary admission and detention are necessary.[33] Involuntary detention may also be initiated by the police, a welfare officer, a magistrate or, in special circumstances, on the request of a relative or friend.[34]

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[30] Section 8-11.
[31] Section 9(1).
[32] Section 10.
[33] Section 21.
[34] Section 22 - 27.

Consent and refusal to treatments for those admitted to hospitals

General rule

6.23 The *Mental Health Act 1990* (NSW) abrogates the common law right of a person to refuse to consent to general psychiatric treatment so far as persons involuntarily detained in mental health facilities are concerned.[35] There is a broad discretion conferred on the medical superintendent of a hospital to give or authorise a treatment on a person involuntarily detained.[36] In other words, a treatment may be performed on an involuntary patient without his or her consent, and indeed over his or her refusal to the treatment. The authority of the medical superintendent to give or authorise treatment to involuntary patients does not extend to surgical operations, electroconvulsive therapy, psychosurgery and special medical treatments. The consent rules for these particular treatments are discussed below.

6.24 The *Mental Health Act 1990* does not give the same powers to the medical superintendent in respect to voluntary hospital patients. Hence, medical practitioners must seek the consent of voluntary hospital patients before administering psychiatric treatment, relying on the general tests of consent and refusal that apply to the treatment of young people, as discussed in Chapter 2.

Surgical operations

6.25 If a person is involuntarily detained in a psychiatric hospital and needs a surgical operation (other than psychosurgery, electroconvulsive therapy or special medical treatments) certain medical officers[37] may consent to the surgical operation:

- if the patient is incapable of giving consent to the performance of the operation or is capable of giving that consent but refuses to give that consent or neither gives nor refuses to give that consent, and
- if the medical officer concerned is of the opinion that it is necessary, as a matter of urgency, to perform a surgical operation to save the life of the patient or to prevent serious damage to the health of the patient.[38]

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[35] See Human Rights and Equal Opportunity Commission, *Background paper for the national inquiry concerning the human rights of people with mental illness* (AGPS, Canberra, 1992) at 35.

[36] *Mental Health Act 1990* (NSW) s 31.

[37] This could be a medical superintendent, deputy medical superintendent, responsible medical officer or authorised officer: *Mental Health Act 1990*(NSW) s 201(4).

[38] *Mental Health Act 1990* (NSW) s 201.

6.26 If a surgical operation is not an emergency, but a medical superintendent is of the opinion that it is desirable, having regard to the interests of the patient, the medical superintendent may apply to the Mental Health Review Tribunal or an authorised officer[39] for consent to the performance of the surgical operation.[40]

6.27 These rules do not apply to voluntary psychiatric patients. Hence, doctors cannot perform surgical operations on them without their consent.

Psychosurgery

6.28 In broad terms, psychosurgery is the creation of lesions in the brain by any surgical procedure for the purpose of altering the thoughts, emotions or behaviour of the person.[41] This treatment is sometimes offered to patients who have a severe, distressing and debilitating mental illness that has not responded to other treatments.

6.29 The law prohibits the performance of psychosurgery without the patient's informed consent.[42] The requirements of the *Mental Health Act 1990* (NSW) on informed consent are more comprehensive than those found at common law.[43] The Act provides that before the consent of a patient is obtained to the performance of psychosurgery:

> (a) a fair explanation must be made to the patient of the techniques or procedures to be followed;
>
> (b) a full description must be given to the patient of the possible discomforts and risks;
>
> (c) a full description must be given to the patient of the benefits to be expected;
>
> (d) a full disclosure must be made to the patient of appropriate alternative treatments;
>
> (e) an offer must be made to the patient to answer any inquiries;

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[39] The Director-General may, by instrument in writing, appoint as authorised officers employed within the Department of Health employees of a public health organisation within the meaning of the *Health Services Act 1997*: *Mental Health Act 1990* (NSW) s 235.

[40] *Mental Health Act 1990* (NSW) s 205.

[41] For a more detailed definition of psychosurgery, see *Mental Health Act 1990* (NSW) Schedule 1.

[42] *Mental Health Act 1990* (NSW) s 154.

[43] For a discussion of the common law on the obligation of doctors to disclose the material risks, more popularly known as the doctrine of informed consent, see para 8.9.

(f) notice must be given that the patient is free to refuse or to withdraw his or her consent and to discontinue the procedures or any of them at any time;

(g) a full disclosure must be made of any financial relationship between the person by whom consent for psychosurgery is sought or the medical practitioner who proposes to perform the psychosurgery, or both, and the hospital or institution in which it is proposed to perform the psychosurgery;

(h) notice must be given to the patient that the patient has the right to legal advice and representation; and

(i) any question relating to the procedures asked by the patient must have been answered and the answers must appear to have been understood by the patient.[44]

6.30 In addition to obtaining the patient's informed consent, the law requires the consent of the Psychosurgery Review Board,[45] which may only consent if satisfied that the patient is capable of giving consent; the psychosurgery has clinical merit; the doctors are qualified and the hospital is a proper place to perform psychosurgery; all other reasonable treatments for the patient have been adequately administered without sufficient resulting benefits.[46]

6.31 Pursuant to s 156 of the *Mental Health Act 1990*, a person below the age of 18 is conclusively presumed incapable of giving informed consent to psychosurgery.

6.32 However, the Psychosurgery Review Board may, if it is not satisfied that the patient is capable of giving informed consent, apply to the Supreme Court for a determination.[47] The Supreme Court is empowered to determine: (a) whether the patient is capable of giving informed consent to the psychosurgery, and (b) whether the patient has given that consent, and (c) if the Court determines that the patient is not capable of giving that consent, whether the Court should give that consent on behalf of the patient.[48] In making its decision on the matter, the Court is not bound by

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[44] *Mental Health Act 1990* (NSW) s 155.
[45] Section 157.
[46] Section 169.
[47] Section 174.
[48] Section 175.

the conclusive presumption that persons below the age of 18 are incapable of consenting to psychosurgery.[49]

Electroconvulsive therapy

6.33 ECT is a treatment that involves passing a small electric current through the brain.[50] It induces a convulsion in the patient. It is thought that the brain's response to the convulsion may be what makes the treatment effective.[51] While it is used in a range of psychiatric disorders, it is most commonly used in the treatment of severe depression where suicide is a risk.[52]

6.34 ECT has been a controversial treatment, mainly because of past misuse and its possible side effects. In the United States, the National Institutes of Health and the National Institute of Mental Health have issued a statement that ECT produces deficits in memory function, which persist after termination of a normal course of ECT.[53] In addition to memory loss, brain damage is another possible side effect of ECT.[54] There are, however, a number of studies that show that ECT does not produce brain damage or long-term memory loss.[55] The Royal Australian and New Zealand College of Psychiatrists has issued a memorandum stating that ECT is an important and effective treatment for a variety of psychiatric conditions.[56]

6.35 ECT is used less commonly in young people.[57] There is a view that the administration of ECT on children who have not yet reached puberty has

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[49] Section 156(2).

[50] The *Mental Health Act 1990* (NSW) does not define this treatment.

[51] I Freckleton and B Wilson, "Electroconvulsive therapy: law, history and practice" (2001) 8 *Journal of Law and Medicine* 389 at 391.

[52] Freckleton and Wilson; see also Centre for Mental Health, *Mental Health Act guide book* (NSW Institute of Psychiatry, Parramatta, 2003) at 63.

[53] National Institutes of Health and National Institute of Mental Health, *Electroconvulsive therapy: consensus development conference and statement, no 11* (1985). For a more recent work detailing the side effects of ECT, see R Abrams, *Electroconvulsive therapy* (Oxford University Press, New York, 1997).

[54] G Boyle, "Electroconvulsive shock treatment: does it induce brain damage and memory loss?" (1988) 23 *Australian Psychologist* 62.

[55] These studies are surveyed in I Freckleton and B Wilson, "Electroconvulsive therapy: law, history and practice" (2001) 8 *Journal of Law and Medicine* 389 at 396.

[56] Royal Australian and New Zealand College of Psychiatrists, *Electroconvulsive therapy* (Clinical Memorandum No. 12, 1999) at para 1.

[57] There is no readily available data on the use of ECT on young people in Australia. However, a study in the United Kingdom found that ECT is rarely administered to young people in that country: R Duffett, P Hill and P Lelliott, "Use of

no established usefulness.[58] It may be a useful treatment for older adolescents suffering from severe psychosis and some types of bipolar disorder.[59] The Royal Australian and New Zealand College of Psychiatry has said that no recommendations can be made on the use of ECT on children prior to puberty. However, it sanctions its use on adolescents, pointing to research suggesting that the indications, effectiveness and side effects of ECT in adolescents are similar to those in adults.[60]

6.36 The *Mental Health Act 1990* (NSW) contains stringent requirements on the use of ECT. It may be used only in certain gazetted psychiatric hospitals, authorised private hospitals or other places authorised by the Director General of Health. It may be administered only in the presence of two doctors.

6.37 ***Voluntary patients.*** ECT may be performed on a voluntary patient only if he or she has given his or her written consent. In addition, two medical practitioners (at least one of whom is a psychiatrist) must certify that, after considering the person's clinical condition, history of treatment and any appropriate alternative treatments, they are of the opinion that the treatment is a reasonable and proper treatment to be administered to the person and is necessary or desirable for the safety or welfare of the person.[61]

6.38 The requirements for informed consent to the administration of ECT[62] are similar to that of psychosurgery.[63] A person is presumed to be incapable of giving informed consent to ECT if before or at the time at which the consent is sought, the person has received medication that impairs the person's ability to consent.[64] A medical superintendent who is unsure whether a person is capable of giving informed consent may apply to the Mental Health Review Tribunal to determine whether the person is capable of giving informed consent and has given that consent.[65] Unlike the provisions for psychosurgery, those for ECT do not contain a presumption that young people are incapable of giving consent to this treatment.

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electroconvulsive therapy in young people" (1999) 175 *British Journal of Psychiatry* 228.

[58] F Frankel, "Electroconvulsive therapy in Massachusetts: a task force report" (1973) 3 *Massachusetts Journal of Mental Health* 3.

[59] G Martin, "Depression in teenagers" (1996) 37 *Current Therapeutics* 57.

[60] Royal Australian and New Zealand College of Psychiatrists, *Electroconvulsive therapy* (Clinical Memorandum No. 12, 1999) at para 11.

[61] *Mental Health Act 1990* (NSW) s 185.

[62] Section 183.

[63] See para 6.29.

[64] Section 184.

[65] Section 185(2).

6.39 ***Involuntary patients.*** ECT may be administered on an involuntary patient who is incapable of giving informed consent, or who is capable of giving informed consent but has refused, or has neither consented to nor refused the treatment. This may only be done with the approval of the Mental Health Review Tribunal.[66]

Issue 6.3

(a) Should young people be considered potentially competent to consent to Electroconvulsive Therapy (ECT)?
(b) Should the provisions of the *Mental Health Act 1990* (NSW) concerning young people's competence to consent to ECT, and treatment in the absence of such consent, be the same as those for psychosurgery?

Special Medical Treatment

6.40 Section 204(1) of the *Mental Health Act 1990* (NSW) prohibits and criminalises the carrying out of a special medical treatment on an involuntary patient. The Act defines special medical treatment as "a treatment, procedure, operation or examination that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out".[67]

6.41 The *Children and Young Persons (Care and Protection) Act 1998* (NSW) and the *Guardianship Act 1987* (NSW) also have provisions relating to special medical treatment.[68] The definitions of special medical treatment in these two other statutes are broader than that found in s 204(1) of the *Mental Health Act 1990*. The treatments that are covered in those statutes include:[69]

long-acting injectable hormonal substance for the purpose of contraception or menstrual regulation;
medical treatment in the nature of a vasectomy or tubal occlusion;
medical treatment involving the administration of an addictive drug;
certain medical treatment involving an experimental procedure;
in the case of a child in residential care, the administration of a psychotropic drug used to control the child's behaviour;
any new treatment that has not yet gained the support of a substantial number of medical practitioners specialising in the area of practice concerned;
termination of pregnancy;
aversion therapy.

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[66] Section 188-194.
[67] Schedule 1.
[68] See Chapter 4.
[69] See *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175; *Children and Young Persons (Care and Protection) Regulation 2000* (NSW) cl 15; *Guardianship Act 1987* (NSW) s 33(1); *Guardianship Regulation 2000* (NSW) cl 6.

Issue 6.4

Should special medical treatment in the *Mental Health Act 1990* (NSW) include those treatments listed in the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and the *Guardianship Act 1987* (NSW)?

6.42 A medical practitioner may carry out special medical treatment without incurring liability for the offence created in s 204(1) of the *Mental Health Act 1990* (NSW):[70]

- if the medical practitioner carries out the special medical treatment on a patient based on his or her opinion that it is necessary, as a matter of urgency, to carry out the treatment on the patient in order to save the patient's life or to prevent serious damage to the patient's health, or
- if the Mental Health Review Tribunal consents to the carrying out of the special medical treatment.

6.43 The Mental Health Review Tribunal must not consent to the carrying out of special medical treatment on a patient unless the treatment is necessary to save the patient's life or to prevent serious damage to the patient's health.[71] Moreover, consent to the carrying out of special medical treatment on a patient must not be granted if the patient is under the age of 16 years.[72] Hence, the *Mental Health Act 1990* does not authorise the performance of a special medical treatment on patients below 16 unless there is an emergency. However, there is no general policy against the performance of special medical treatments on those who are under the age of 16. Pursuant to s 175 of the *Children and Young Persons (Care and Protection) Act 1998*, the Guardianship Tribunal may give consent to the performance of a special medical treatment on a child under 16.

Issue 6.5

Should the Mental Health Review Tribunal have the authority to consent to the performance of special medical treatment on patients below 16 years old?

Prohibited Treatments

6.44 The *Mental Health Act 1990* (NSW) prohibits the performance of deep sleep therapy and insulin coma therapy on any person.[73] Moreover, doctors

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[70] *Mental Health Act 1990* (NSW) s 204(2).

[71] Section 204(2A).

[72] Section 204(3).

[73] Section 197.

are prohibited from administering drugs or a dosage of drugs, which, having regard to proper professional standards are excessive or inappropriate.[74]

OUT-OF-HOME CARE

6.45 In the past, many children with disabilities were placed in large institutions. The current policy is to have such children live with a family, preferably their birth family. However, the presence of a child with an intellectual disability, especially if severe, invariably leads to great personal and financial stress in the home. Financial and other support for the family, while helpful, is not always a complete solution.[75] A 1996 survey conducted in New South Wales of families with children under seven years with disabilities and high support needs found that 25% had either sought alternative residential care for their child or considered it might become necessary, particularly if the mother was unable to continue as carer, or the child became larger and harder to manage.[76]

6.46 The New South Wales government, principally through the Department of Community Services, provides and regulates out-of-home care for children, including those with intellectual disabilities. Out-of-home care may take the form of foster care, kinship care and small residential services in the community.[77] Services are provided for crisis, short, medium or extended periods, and sometimes permanently.

6.47 The *Children and Young Persons (Care and Protection) Act 1998* (NSW) provides a framework for out-of-home care. It defines out-of-home care as residential care and control (whether paid or not) at a place other than the child's usual home by a person, other than a parent or relative, for a period of more than 28 days (consecutive or aggregate in a 12 month period), or for a period of more than 14 days (if the child or young person is in the person's care and control because of an order from the Children's Court).[78]

6.48 The Act contains provisions on consent to medical treatment of young people who are in out-of-home care. These are discussed in detail in

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[74] Section 198.

[75] See K Bain, "Children with severe disabilities: options for residential care" (1998) 169 *Medical Journal of Australia* 598.

[76] G Llewellyn, P Dunn, M Fante, et al, *Families with young children with disabilities and high support needs* (University Of Sydney Family Support and Services Project, Sydney, 1996).

[77] Of 5,007 children entering out-of-home care in 2000/2001, over 57% were placed in kinship/family care, while 32% were placed in foster care: NSW Department of Community Services, *Out of home care: fact sheet* (2002).

[78] Section 135.

Chapter 7. In a nutshell, they give those authorised to provide out-of-home care the power to consent to certain medical and dental treatments of those under their care. The treatments they are allowed to consent to are: (1) those that do not involve surgery, and (2) surgery certified as urgent by a medical practitioner or dentist.[79] The Act also imposes special requirements for a valid consent to be given to a "special medical examination" (certain vaginal, anal or penile examinations) carried out on children and young people who are in out-of-home care in accordance with an order of the Children's Court.[80]

6.49 The provisions in the *Children and Young Persons (Care and Protection) Act 1998* on out-of-home care apply generally to children who cannot live in their own homes. They were not designed specifically for children with intellectual disabilities.

Issue 6.6

(a) Are there issues particular to young people with intellectual disabilities that should be taken into account as regards consent to, and refusal of, medical treatment while they are in out-of-home care?

(b) Are there types of medical treatment/therapy particularly relevant to this group of young people that require special rules on consent?

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[79] Section 157(1).

[80] Section 176.

7.

Treating young people with special needs

- Young people in out-of-home care
- Young people from a non-English speaking background
- Young Aboriginal and Torres Strait Islander people
- Young people who are homeless
- Young people in juvenile detention centres
- Young people whose parents are not competent to make medical decisions

7.1 Chapter 6 gave special consideration to the needs of young people with intellectual disabilities and/or mental illnesses in respect of their medical treatment. This chapter considers the legal framework governing consent to, and refusal of, medical treatment as it relates to several other groups of young people with special needs. These groups are:

- young people in out-of-home care;
- young people from a non-English speaking background;
- young people who are Aboriginal or Torres Strait Islander;
- young people who are homeless;
- young people in juvenile detention centres; and
- young people whose parents are not competent to make medical decisions.

7.2 For all of these groups, either the law already applies special rules for determining who can consent to, and refuse, medical treatment, or their particular needs require consideration of whether special rules for making medical decisions *should* apply in respect of them.

Issue 7.1

Are there any other groups of young people, besides those discussed in Chapters 6 and 7, that require special consideration in formulating a legal framework for making decisions about their medical treatment?

YOUNG PEOPLE IN OUT-OF-HOME CARE

7.3 There are specific legislative provisions regulating, to a limited extent, the power to consent to medical treatment for young people in "out-of-home" care. These provisions are found in the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

Meaning of "out-of-home care"

7.4 A young person, or child, is in "out-of-home" care if he or she is:

- in the residential care and control of a person who is not a parent or a relative (whether or not for money);
- at a place other than the child's or young person's usual home;
- for a period of more than 14 days (if the child or young person is in the person's care and control because of an order from the Children's

Court), or for a period of more than 28 days in total over a 12 month period.[1]

7.5 A typical situation where a child is in out-of-home care is where the Children's Court considers that child to be in need of care and protection, and orders him or her to be placed in the care of foster carers. Certain arrangements are prescribed not to be out-of-home care, such as boarding schools, holiday camps or private hospitals.[2] A young person or child can be placed in out-of-home care by the Director-General of the Department of Community Services in cases of emergency removal from parents,[3] or by an order of the Children's Court,[4] or through a voluntary care arrangement, generally with a parent's consent.[5]

Power to consent to medical treatment

The authorised carer

7.6 Out-of-home care can only be provided by an "authorised carer".[6] The legislation, together with the subordinate legislation, set up procedures for a person to be authorised as an authorised carer.[7]

7.7 An authorised carer has the authority to consent to:

- medical treatment, not involving surgery, for a child or young person in his or her care, on the advice of a medical practitioner;[8]
- medical treatment involving surgery, if a medical practitioner certifies in writing that the treatment needs to be carried out as a matter of urgency in the best interests of the child or young person;[9]
- non-urgent medical treatment involving surgery, if the authorised carer is delegated that authority in accordance with the legislation.[10]

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[1] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 135.

[2] See *Children and Young Persons (Care and Protection) Regulation 2000* cl 17. Section 135(2) of the Act also excludes from the meaning of out-of-home care the care and control provided by a person in his or her capacity as a licensed provider of children's services. This includes, for example, day care centres: *Children and Young Person (Care and Protection) Act 1998* (NSW) s 200.

[3] Section 43, 44.

[4] Section 46, 69, 71, 76.

[5] Chapter 8 Part 3.

[6] Section 136.

[7] See *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 137; *Children and Young Persons (Care and Protection) Regulation 2000* cl 20-22.

[8] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 157(1)(a).

[9] Section 157(1)(b).

7.8 There is no definition of "medical treatment" in the legislative provisions relating to out-of-home care. The authority of the authorised carer to consent to medical treatment applies in respect of a person below the age of 18 in his or her care.[11]

7.9 If an authorised carer has the authority to consent to medical treatment for a child or young person in his or her care, a medical practitioner can rely on that consent as if it were a consent given by the parent, for the purpose of defending a civil claim for battery or assault as provided for in s 49 of the *Minors (Property and Contracts) Act 1970* (NSW).[12] The legislative provision that grants this immunity in respect of children and young people in out-of-home care is not clear. Under s 49 of the *Minors (Property and Contracts) Act 1970*, the power of parents to consent to medical treatment for their child is limited to young people below the age of 16, that is, a parent can consent to medical treatment for their child until that child is 16. However, an authorised carer is authorised by legislation to consent to medical treatment for any person in his or her care who is below the age of 18. By virtue of that authority, does the immunity granted to medical practitioners to treat young people in out-of-home care, based on the consent of their authorised carer, extend until such young people have reached the age of 18, rather than 16, whether or not the young person objects to the treatment proposed?[13] If this is the case, it seems inconsistent, and discriminatory, if young people in out-of-home care could have their objections to medical treatment overridden by the consent of an authorised carer, where other young people aged 16 and above could not.

The young person

7.10 Presumably, the power of a mature young person to give a personal consent to medical treatment, as provided for at common law, and reflected

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10. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 157(2) and s 157(2) *Note*.
11. Section 157 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) refers to child or "young person". "Young person" is defined in s 3 of the Act as a person aged 16 or 17.
12. See *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 177. Section 177 is headed "Ordinary medical and dental treatment", although the term "medical treatment" is not qualified by the word "ordinary" in the actual text of the provision. "Ordinary medical treatment" is not defined, but presumably the word "ordinary" was used to contrast this provision with the provision setting down the requirements for consent to "special medical treatment" in the preceding s 175 of the Act. See Chapter 2 at para 2.15-2.17 for a discussion of s 49.
13. This is the way in which the Children's Commissioner has interpreted the effect of the legislation: see Commissioner for Children and Young People, *Submission* (February 2001) at para 8.02.

in s 49 of the *Minors (Property and Contracts) Act 1970*, is not altered by the legislation above in respect of young people in out-of-home care.

The parents

7.11 Whether the parents of a child in out-of-home care retain any power to consent to the medical treatment of their child depends on the way in which parental responsibility is allocated upon the child entering into out-of-home care. In situations where a child or young person is placed in out-of-home care upon an order of the Children's Court, the Director-General must usually prepare a care plan which details the allocation of parental responsibility between the Minister of Community Services and the parents. The Children's Court can make its own orders regarding the allocation of parental responsibility.[14] Similarly, a care plan must be prepared for children and young people entering into voluntary out-of-home care (other than under a temporary care arrangement), which plan would detail the allocation of parental responsibility.[15] For children or young people placed in out-of-home care under a temporary care arrangement, the legislation specifies that the Director-General has the "care responsibility" of the child or young person, which includes the authority to consent to his or her medical treatment.[16] It does not seem clear whether the exercise of this care responsibility operates to remove the power to consent from parents of children in a temporary care arrangement.

7.12 There is one final legislative provision dealing with the "special medical examination" of children and young people in out-of-home care.[17] This provision imposes special requirements for a valid consent to be given to certain types of medical examination on children and young people who are in out-of-home care in accordance with an order of the Children's Court, and applies to certain vaginal, penile, and anal examinations. This section has not yet commenced operation, and is being considered for repeal. As such, it will not be discussed here.

Issue 7.2

Is the legislative framework governing consent to medical treatment for children and young people in out-of-home care sufficiently clear?

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[14] See *Children and Young Persons (Care and Protection) Act 1998*(NSW) s 78, 79, 81.

[15] Section 155(2).

[16] Section 154, 157.

[17] Section 176.

YOUNG PEOPLE FROM A NON-ENGLISH SPEAKING BACKGROUND[18]

7.13 In 2001, approximately 20% of the population in New South Wales spoke a language other than English at home.[19] Young people who come from a non-English speaking background often face special health concerns and barriers to receiving appropriate medical treatment. Young people who have migrated to Australia may suffer significant mental health problems, as a result of trauma suffered in their country of origin, as well as the stress of migrating and resettling. Young people from a non-English speaking background sometimes suffer stress as a result of racism, English language difficulties, and intergenerational and intercultural conflicts. Adolescents from a non-English speaking background face the usual changes and challenges characteristic of puberty, while also often having to cope with different and conflicting behavioural expectations from their family and Australian-born peers.

7.14 Young people from a non-English speaking background may face particular barriers to receiving medical services. Poor English language skills can affect either their, or their parents', capacity to seek out and consent to medical treatment. Cultural beliefs and perceptions of certain illnesses, especially mental illness, may create a stigma in seeking help. Some non-Western cultures do not readily conceive of the notion of adolescence as a time of attaining a degree of independence from the family and an individual identity, and may not accept that a person below 18 could be judged competent to make his or her own medical decisions, without the assistance of parents and other family members.

7.15 It is open to question whether these issues should affect the formulation of a legal framework governing consent to, and refusal of, medical treatment of young people, or whether, instead, they should form the basis of strategies for education in the community and in the medical profession, and for the delivery of culturally sensitive health services.[20]

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[18] Note that NSW Health prefers the term, "culturally and linguistically diverse community", rather than people from a non-English speaking background.

[19] See Australian Bureau of Statistics, *2001 Census of population and housing: selected social and housing characteristics for statistical Local Areas, NSW and Jervis Bay Territory* (as at 9 March 2004) «www.abs.gov.au/Ausstats/abs%40.nsf/e8ae5488b598839cca25682000131612/6f61db97cfa2e96fca256c3100814657!OpenDocument».

[20] Consideration of issues involving health services to people of non-English speaking backgrounds has already been widely discussed and included in many government policies regarding the delivery of health services: see, for example, NSW Health, *NSW strategy: making mental health better for children and adolescents* (1999) strategy 3.4.3; NSW Health, *Caring for mental health in a multicultural society: a strategy for the mental health care of people from culturally and linguistically*

Issue 7.3

Are there issues particular to young people from a non-English speaking background that should be taken into account in formulating a legal model to govern consent to, and refusal of, medical treatment for young people?

YOUNG ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

7.16 Aboriginal and Torres Strait Islander young people have the poorest health of all young Australians. Indeed, across all age groups, they face a higher risk of disease or injury and have higher mortality rates than other young people.[21] A number of specific health problems occur among Indigenous children and teenagers at a particularly high rate and contribute to the overall levels of poor health. For example, 11% of Indigenous young people, aged 15 years and under, suffer from ear and hearing problems. By contrast, only 2% of non-Indigenous girls and 3% of non-Indigenous boys suffer the same problems.[22]

7.17 The high incidence of poor health among Indigenous young people is accompanied by the disproportionate rate at which these children and teenagers have additional special needs, which may affect their interactions with medical practitioners. In New South Wales, Indigenous young people, aged 10–17 years, are 17 times more likely to be in juvenile corrective institutions than non-Indigenous young people.[23] The figures are similarly skewed in relation to homelessness[24] and to young Indigenous women who are parents themselves.[25]

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diverse backgrounds (1998); Western Melbourne Division of General Practice, *Enhancing Refugee Young People's Access to Health Services* (2000); J Luntz, *Report on the usage of child and adolescent mental health services by NESB adolescents and their families* (Child and Adolescent Mental Health Services, 1998) (as at 9 March 2004) «www.mmha.org.au/library/services/specialist_reports/camhs_main.html».

[21] F Al-Yaman, M Bryant and H Sargeant, *Australia's children: their health and wellbeing 2002* (AIHW, Canberra, 2002) at 253.

[22] Council on the Cost of Government, *NSW government programs for Aboriginal people: service efforts and accomplishments 1998* (CCG, Sydney, 1998) at 63.

[23] Australian Institute of Criminology, *Australian crime: facts and figures 2002* (AIC, Canberra, 2002) at 71.

[24] Australian Institute of Health and Welfare, *Young homeless people in Australia 2001–2002* (AIHW, Canberra, 2003) at 12-13.

[25] In Australia in 2002, the fertility rate of Indigenous women aged 15–19 was more than four times that of all teenage women in the same age group: Australian Bureau of Statistics, *Births, Australia 2002* (ABS, Canberra, 2003) at 20.

7.18 Indigenous young people also suffer from disproportionately high levels of mental illness.[26] Within this area, elevated rates of youth suicide are a major concern. This is particularly so with respect to Indigenous young men, aged 15–19 years, who commit suicide at a rate four times higher than their non-Indigenous counterparts.[27]

7.19 A number of factors contribute to the elevated rates of poor health among Indigenous young people. Among these, disadvantaged socio-economic status and barriers to accessing health care play a significant role.[28] Commonly encountered barriers include a lack of culturally appropriate health care,[29] affordability and communication difficulties.[30]

Issue 7.4

Are there issues particular to Indigenous young people that should be taken into account in formulating a legal model to govern consent to, and refusal of, medical treatment for young people?

YOUNG PEOPLE WHO ARE HOMELESS

7.20 Perhaps more than any other group of young people, the health concerns of our homeless youth are the most acute, and their access to adequate health services most limited. As one medical practitioner has observed, "[h]omelessness is not conducive to good health".[31] Back in 1989, the number of young people in Australia who were homeless or at serious risk was estimated to be at least 20,000 to 25,000, with the actual figure

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[26] For example, in 1999–2000, Indigenous girls aged 5–9 years were hospitalised for mental and behavioural disorders at a rate 3.6 times that for non-Indigenous girls: *Australia's children: their health and wellbeing 2002* at 200.

[27] NSW Department of Health, *Prevention initiatives for child and adolescent mental health: NSW resource document* (NSW Department of Health, Sydney, 2002) at 52.

[28] Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2003* (ABS, Canberra, 2003) at 33 and 54.

[29] For example, medical practitioners may not be familiar with extended family networks, in which family members, other than a parent, have primary responsibility for a child's welfare: Human Rights and Equal Opportunity Commission, *Our homeless children: report of the National Inquiry into Homeless Children* (AGPS, Canberra, 1989) at 129.

[30] Australian Bureau of Statistics and Australian Institute of Health and Welfare, *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2003* (ABS, Canberra, 2003) at 54-63.

[31] See D Bennett and L Rowe, *What to do when your children turn into teenagers* (Doubleday, Sydney, 2003) at 289.

more likely to be closer to 50,000 to 70,000.[32] The number of young people who are homeless appears to be increasing.[33]

7.21 Young people leave, or are thrown out of, their family home for a number of reasons. Often they leave to escape physical or sexual abuse. There may be an intolerable level of conflict and tension at home, and family relationships may have broken down. Other factors, such as substance abuse within the family, poverty, the need to find work, and parents remarrying, are said sometimes to contribute to a young person leaving home.[34] A proportion of the young homeless population are refugees, who have arrived in Australia without parents or other family networks, and are expected somehow to survive on their own.[35]

7.22 Homeless young people suffer a wide range of health problems.[36] Their itinerant lifestyle tends to lead to malnutrition, poor hygiene and infections. They often suffer from poor dental health, a high incidence of

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[32] See Human Rights and Equal Opportunity Commission, *Our homeless children: report of the National Inquiry Into Homeless Children* (AGPS, Canberra, 1989) Chapter 6.

[33] The Australian Bureau of Statistics found that, on census night 2001, there were 99,900 homeless people in Australia, where "homelessness" included anyone in need of safe and secure accommodation, rather than just those actually sleeping on the streets. Of that total number, 10% were below the age of 10, and 36% were young people aged between 12 and 24 years: see C Chamberlain and D MacKenzie, *Counting the homeless, 2001* (ABS, Canberra, 2001). See also the report of the Australian Institute of Health and Welfare, which found that, in 2001-2002, 36% of all clients of the Supported Accommodation Assistance Program (designed to provide temporary supported accommodation to homeless people) were aged between 12 and 25: see Australian Institute of Health and Welfare, *Young homeless people in Australia 2001-2002: a report from the SAAP national data collection* (Canberra, 2003) at 1, 3. In *Youth homelessness 2001*, it was estimated that, on any given day in 2001, there were 26,060 homeless youth in Australia (aged 12-18), of which 12,230 remained in the school system. This figure represented an overall increase of 8.4% of the homeless youth population since 1994: see C Chamberlain and D MacKenzie, *Youth homelessness 2001* (RMIT, Melbourne, 2002).

[34] See Human Rights and Equal Opportunity Commission, *Our homeless children: report of the National Inquiry Into Homeless Children* (AGPS, Canberra, 1989) Chapter 8.

[35] See P Rice, A Rice and P Dhamarak, "'Some day, when my health is good …': The experiences of young Southeast Asian refugees in Australian schools" (1993) *Youth Studies Australia* 39 at 43; A Chambon, "Refugee families' experiences: three family themes – family disruption, violent trauma and acculturation" (1989) 8 *Bonus Issue* 3 at 6.

[36] See Human Rights and Equal Opportunity Commission, *Our homeless children: report of the National Inquiry Into Homeless Children* (AGPS, Canberra, 1989) at para 19.419.17; D Bennett and L Rowe, *What to do when your children turn into teenagers* (Doubleday, Sydney, 2003) at 289-290.

skin complaints, such as scabies and eczema and ear infections. In an effort to survive, many homeless young people become involved in prostitution, exposing them in turn to other high-risk activities, such as drug taking and violence. They risk contraction of sexually transmitted diseases, such as genital herpes, Chlamydia and HIV, as well as drug overdose and infections contracted through needle use. Homeless young people also tend to suffer significant mental health problems. They may already have incurred emotional and psychological injuries in the time leading up to leaving their family home, and the stress of their current lives can give rise to insomnia, depression, the risk of suicide, and behavioural disturbances. Homeless young people are said to be generally reluctant to use health services, for a number of reasons, such as distrust of medical practitioners, social workers, and other "establishment" figures; concerns about confidentiality; and, at a most basic level, lack of money or a Medicare card.

7.23 The terms of the Law Reform Commission's reference do not extend to a detailed consideration of the health, and other, needs of homeless young people. Other reviews and commentators have already noted the plight of our homeless youth, and have urged greater government action to establish and fund more support services.[37] What the Commission can do, however, is to consider ways of ensuring that the law allows for available health services to be as accessible as possible to homeless young people who decide to make use of them. The current law governing consent to medical treatment may create obstacles, or at least uncertainties, in the provision of treatment to this group of young people, who are usually separated from their parents and families. There are no specific provisions, either in legislation or at common law, dealing with consent to medical treatment of young people who are homeless and estranged from their parents.[38] Moreover, medical practitioners, and other health professionals, need to know their legal obligations and potential liability in treating young people who are homeless and have no contact with their parents.

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[37] See, for example, Human Rights and Equal Opportunity Commission, *Our homeless children: report of the National Inquiry Into Homeless Children* (AGPS, Canberra, 1989), especially Chapter 24; C Chamberlain and D MacKenzie, *Youth Homelessness 2001* (RMIT, Melbourne, 2002) Chapter 5; Salvation Army, *Response to Chamberlain and MacKenzie's youth homelessness census 2001* [2002] (as at 9 March 2004) («www.salvationarmy.org.au/media/2002/020715_homeless.asp»).

[38] The *Children and Young Persons (Care and Protection) Act 1998* (NSW) includes provisions relating specifically to homeless children and young people. However, these deal with voluntary reporting to the Director-General of a child or young person who is homeless: s 120-121. The Act also provides for the making of compulsory assistance orders for children and young people to protect them from life-threatening or seriously self-destructive behaviour, which could be applied to assist homeless young people: see Chapter 7 Part 3. These provisions do not deal with issues of consent.

Issue 7.5

(a) In practice, do medical practitioners generally treat homeless young people based on their consent alone?
(b) What steps (if any) do medical practitioners take to treat a homeless young person who refuses medical treatment?
(c) Should there be special provisions in the law to deal with consent to medical treatment for homeless young people? If so, what should these provisions be?

YOUNG PEOPLE IN JUVENILE DETENTION CENTRES

7.24 Young people who have been charged with, or convicted of, committing a criminal offence may be remanded into custody, or sentenced to a period of custody, in a detention centre.[39] There are nine detention centres in New South Wales. The average daily number of young people in detention centres on any given day in 2002-2003 was 290, with over 90% of the detainee population being male and about 39% being Aboriginal or Torres Strait Islander.[40]

7.25 Young people in detention commonly face significant mental and physical health problems. Many come from a background of broken family relationships, have experienced physical, emotional, and sexual abuse, have dropped out of school and are described as frequently confused, damaged, angry and alienated. Many have survived periods of homelessness. Many abuse drugs or alcohol.

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[39] A “child” (below the age of 18), or a person charged before the Children’s Court, who is an accused person within the meaning of the *Bail Act 1978* (NSW) and who has not been released on bail, must generally be detained in a detention centre: see *Children (Detention Centres) Act 1987* (NSW) s 3, 9. Likewise, a person found guilty of an offence before the Children’s Court may be placed in a detention centre for a period of less than two years: *Children (Detention Centres) Act 1987* (NSW) s 3, 9; *Children (Criminal Proceedings) Act 1987* (NSW) s 33(1)(g). A person who is convicted of an indictable offence by a court other than the Children’s Court, who was below the age of 18 when he or she committed the offence, and was under the age of 21 when charged, and has been sentenced to a term of imprisonment, may be ordered to serve some or all of that term of imprisonment in a detention centre: *Children (Criminal Proceedings) Act 1987* (NSW) s 16, 19; *Children (Detention Centres) Act 1987* (NSW) s 3, 9. A person under the age of 21 who is on remand or in custody in an adult prison may be directed to be transferred from prison to a detention centre: *Children (Detention Centres) Act 1987* (NSW) s 3, 9, 10.

[40] The average daily number is based on the number of young people in custody on the last day of each month for that year. See NSW Department of Juvenile Justice, *Annual Report 2002-2003* at 8-9, 16-17. See also the Director-General’s message on the Department of Juvenile Justice website (as at 9 March 2004) «www.djj.nsw.gov/Director_General_Message.html»; and the Corrections Health website (as at 9 March 2004) «www.chs.health.nsw.gov.au/areas/corrections/profile/comm_profile.html».

7.26 The administration and delivery of health services to young people in detention centres was recently transferred from the Department of Juvenile Justice to Corrections Health Services, NSW Health. Registered nurses in detention centres provide health care services to detainees, and local medical practitioners visit each centre regularly to provide young people with medical treatment and assessment. Consultant psychiatrists are also engaged through Corrections Health when necessary. The decision to transfer health services for young detainees to Corrections Health was aimed, among other things, at facilitating the integration of health services in detention centres into mainstream public health services across New South Wales, and at formalising links between detention centres and external health care providers.

7.27 There is no clear legislative framework, which specifically regulates the medical treatment of young people in detention.[41] The *Children (Detention Centres) Act 1987* (NSW), in conjunction with the *Children (Detention Centres) Regulation 2000*, governs the operation and administration of juvenile detention centres. They make some provision for the medical treatment of young people in detention. For example, the Director-General of the Department of Juvenile Justice is responsible for ensuring, among other things, that adequate arrangements exist to maintain the physical, psychological, and emotional well-being of detainees.[42] Detainees are deemed to be in the custody of the centre manager of the detention centre.[43] Young people must be medically assessed on first arriving at a detention centre,[44] and must be supplied with such medical and dental treatment as is necessary, in the opinion of the medical officer, dental officer, or registered nurse, to promote and maintain the detainee's health and well-being.[45] A detainee may be removed to a hospital, or some other specified place, for medical treatment, upon either the order of the Director-General, or, in an emergency, by order of the centre manager of the detention centre.[46] The detainee may only be discharged from the hospital, or other specified place, if a medical superintendent, or other person in charge of the hospital, or medical practitioner, certifies that the detainee may be discharged.[47] Provisions

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[41] Note that juvenile detention centres are *not* considered "out-of-home" care so as to come within legislative regime governing the treatment (including medical treatment) of young people and children in out-of-home care: see *Children and Young Persons (Care and Protection) Regulation 2000* cl 17.

[42] See *Children (Detention Centres) Act 1987* (NSW) s 14(a).

[43] See *Children (Detention Centres) Act 1987* (NSW) s 15.

[44] See *Children (Detention Centres) Regulation 2000* cl 7(2).

[45] See *Children (Detention Centres) Regulation 2000* cl 7(1).

[46] See *Children (Detention Centres) Act 1987* (NSW) s 25(1).

[47] See *Children (Detention Centres) Act 1987* (NSW) s 25(4).

such as these do not seem to consider the possibility of requiring the consent of the young person in question, or even his or her parents, before providing the particular medical treatment, and certainly would not appear to allow much opportunity for the young person to refuse such treatment. In contrast, legislation governing the administration of detention centres for adult prisoners does appear to envisage some right of the adult prisoner generally to consent, or refuse, medical treatment.[48]

Issue 7.6

Is the existing law sufficiently clear as to the rights of young people, and others, in respect of the medical treatment of young people in juvenile detention centres?

YOUNG PEOPLE WHOSE PARENTS ARE NOT COMPETENT TO MAKE MEDICAL DECISIONS

7.28 Is there a need for special rules governing the power to consent to, and refuse, medical treatment for young people whose parents are not themselves competent to make medical decisions? Parents may not be legally competent to make medical decisions if, for example, they are themselves below the age of 18, and not considered sufficiently mature to pass the *Gillick* test, or if they suffer from a mental illness or intellectual disability, which impairs their capacity to understand.

7.29 Short of resorting to an application for a care order under the child protection legislation, there are no special provisions in the current law to facilitate the provision of medical treatment for young people who are not legally competent to consent to or refuse it, and whose parents are similarly not competent. For young parents who are below the age of 18, their status as parents does not make them automatically competent to make decisions about their own medical care. As with young people generally, each young parent must be assessed as to the level of his or her maturity, understanding and intelligence to determine whether or not he or she can give a personal consent to his or her own medical treatment.[49]

7.30 Similarly, there are no specific provisions that deem a young person automatically competent to consent to or refuse medical treatment on

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[48] Such right may be recognised by implication only. Section 73 of the *Crimes (Administration of Sentences) Act 1999* (NSW) makes provision for the compulsory medical treatment of (adult) inmates where the Chief Executive Officer of Corrections Health Service consider that it is necessary to do so in order to save the inmate's life or prevent serious damage to the inmate's health, and such medical treatment is taken to have been carried out with the inmate's consent.

[49] See Chapter 2.

behalf of his or her child. Legislation does vest parents generally with the obligations and powers inherent to exercising parental responsibility over their children, with no distinction made between parents who are adults and parents who are below 18.[50] Section 49(1) of the *Minors (Property and Contracts) Act 1970* (NSW) provides for a medical practitioner to rely on the consent of a parent to treat a person below 16 without incurring civil liability for assault or battery, and "parent" is not defined (and certainly not expressly confined to parents aged 18 and above).[51] However, the Commission does not consider that the effect of s 49(1) is to make young parents automatically competent to consent. Instead, the validity of a parent's consent under s 49(1) should be read as qualified by the common law requirement that the parent's consent be "true", and not affected by the parent's own mental incapacity by reason of, for example, immaturity.

7.31 Similarly, there are no specific legal mechanisms for providing medical treatment to children who are not legally competent to make their own medical decisions, and whose parents are also legally incompetent to consent, or refuse, by reason of, for example, a mental illness or intellectual disability. The *Children and Young Persons (Care and Protection) Act 1998* (NSW) makes general provision for children or their parents to request assistance to enable the child to remain in his or her family's care,[52] and also allows for intervention by the Department of Community Services, and the Children's Court, in ensuring that a child's welfare is protected.[53] These provisions could be relied on to vest the parental responsibility to make medical decisions on behalf of a child in someone other than the child's parents, if the parents were not competent to make those decisions themselves. In some situations, however, these may be considered fairly draconian measures to have to take.

7.32 Previous reviews of this area have recommended that legislation make specific provision in relation to the power of young parents to consent to medical treatment for their child. One review recommended that a young woman (below 18) who has a child should be competent to consent to health care both for herself and for her child.[54] Another review recommended that a parent under 18 should be able to consent to, or refuse, health care of his

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[50] See *Family Law Act 1975* (Cth) s 61C (see also s 61B for a definition of "parental responsibility"). Section 3 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) also refers to "parental responsibility" as the duties, powers, responsibilities and authority which parents have in relation to their children, with no distinction made for parents who are below the age of 18.

[51] See Chapter 2 at para 2.15-2.17 for a discussion of s 49.

[52] Section 21.

[53] See Chapters 4 and 5.

[54] Institute of Law Research and Reform, University of Alberta, *Consent of minors to health care* (Report 19, 1975) Recommendation 3.

or her child if the parent understands the nature and consequences of the health care, and communicates his or her decision about the health care in some way.[55] It is difficult to see, however, how this recommendation differs from the existing common law position.

Issue 7.7

(a) Should there be special provision in legislation to allow parents who are below the age of 18 to consent to and refuse medical treatment for their child?

(b) Should there be special provision in legislation, additional to existing provisions, to allow someone other than a child's parent to consent to or refuse medical treatment if the parent is not competent to consent or refuse?

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[55] Queensland Law Reform Commission, *Consent to health care of young people* (Report 51, 1996) Volume 2 at 328.

8.

Liability and protection of medical practitioners

- Civil liability
- Criminal liability
- Disciplinary action
- Honest and reasonable mistakes by medical practitioners
- Non-touching medical treatment
- Professional indemnity insurance

8.1 This chapter examines the legal liability of medical practitioners who treat young people without first obtaining a legally valid consent, where such consent is required by law.[1] It also looks at the forms of protection afforded to medical practitioners, both from liability and from personal payment of damages, when they treat young people.

CIVIL LIABILITY

Intentional wrongs

8.2 A medical practitioner who treats a patient without first obtaining a legally valid consent, where such is required, may attract liability from three separate torts or wrongs: battery, assault and false imprisonment.

8.3 Battery is an act of one person which directly causes some physical contact with another person. Any unauthorised physical contact with another may constitute battery.[2] The touching need not be accompanied or motivated by hostile intent.[3] Consequently, a medical practitioner who touches a patient when treating him or her, and mistakenly believes that a legally valid consent has been obtained, may be civilly liable for battery.[4]

8.4 Assault is conduct that causes a person to apprehend[5] the infliction of bodily harm.[6] An assault may be committed on its own, where no actual physical contact is made. However, assault and battery may be committed in quick succession, which is the type of situation that could arise in the context of medical treatment without consent.

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1. For situations in which the law does not require a consent for medical treatment of a young person, see Chapter 5.
2. The least amount of touching may constitute battery: *Campbell v Samuels* (1980) 23 SASR 389 at 393 (Zelling J).
3. *Boughey v The Queen* (1986) 161 CLR 10.
4. See *Re F* [1990] 2 AC 1 at 73B (Lord Goff). See also *T v T* [1988] 2 WLR 189 at 203 where Wood J said: "The incision made by a surgeon's scalpel need not be and probably is most unlikely to be hostile, but unless a defence or justification is established it must in my judgment fall within the definition of a trespass to the person."
5. It is sufficient that the belief was reasonable under the circumstances: see *Brady v Schatzel; Ex parte Brady* [1911] St R Qd 206; *McClelland v Symons* [1951] VLR 157 at 163-164 (Sholl J).
6. The threat must be that, while it continues to operate on the plaintiff's mind, there is a reasonable belief that violence will be done immediately or imminently: *Zanker v Vatzokas* (1988) 34 A Crim R 11; *Knight* (1988) 35 A Crim R 314 at 317-318 (Lee J). See also *R v Ireland* [1998] AC 147 at 162 (Steyn LJ), at 166 (Hope LJ).

8.5 False imprisonment occurs when a voluntary act of one person directly subjects another person to total deprivation of freedom of movement. Any restraint upon the personal liberty of an individual, which is not warranted by law, is false imprisonment, provided it is total, that is, there is no alternative means of exit.[7] The tort may be committed even if the person restrained was not aware of the restraint at the time.[8] Furthermore, the act occasioning the false imprisonment need not have been motivated by malice.[9] Hence, a medical practitioner who acted with a patient's best interests in mind could still be liable for the false imprisonment.

8.6 The New South Wales case of *Hart v Herron*[10] provides an example of where the provision of medical treatment led to a claim for false imprisonment. The plaintiff alleged that, after going into a private hospital, he had been asked to sign a form consenting to such treatment, but had refused. He said that a short time later a nurse asked him to take a tablet, which he did, after which everything went black. His next recollection was waking up and eventually discovering that he had been treated by the psychiatrist with Deep Sleep Therapy, which involved electroconvulsive therapy and narcosis therapy. The court held that the medical practitioner and hospital had wrongfully imprisoned the plaintiff.

8.7 Consent of the plaintiff may be a defence to a civil action for an intentional wrong. In *Hart v Herron*, for example, the defendant would not have been found liable for false imprisonment if he had evidence that the plaintiff had given his consent. Likewise, it has been said no action lies in battery or assault if the defendant can prove that the plaintiff consented to the bodily contact, or its apprehension, of which the latter complains.[11] In the context of a medical treatment, the consent necessary to negative battery is satisfied by the patient being advised in broad terms of the nature of the proposed procedure.[12] This is in contrast to an action for

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[7] *Bridgett v Coyney* (1827) 1 Man & Ry KB 211 at 215-216 (Tenterden CJ).

[8] *Meering v Grahame-White Aviation Co Ltd* (1919) 122 LT 44; *Murray v Ministry of Defence* [1988] 2 All ER 521. However, this factor is relevant to the measure of damages: *Myer Store v Soo* [1991] 2 VR 597.

[9] The only relevant intention is the intention to detain the plaintiff: *Cowell v Corrective Services Commission of New South Wales* (1988) 13 NSWLR 714.

[10] [1984] Australian Torts Report ¶80-201; [1996] Australian Torts Report ¶81-395 (appeal on the amount of damages dismissed). On the background to this case, see B Bromberger and J Fife-Yeomans, *Deep sleep: Harry Bailey and the scandal of Chelmsford* (Simon & Schuster Australia, East Roseville NSW, 1991).

[11] *Christopherson v Bare* (1848) 11 QB 473; *Latter v Braddell* (1848) 44 LT 369.

[12] *Rogers and Whitaker* (1992) 175 CLR 479 at 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ); *Chatterton v Gerson* [1981] 1 All ER 257 at 265 (Bristow J).

negligence based on failure to obtain a patient's "informed consent",[13] which requires medical practitioners to disclose more information to the patient, in particular, any material risk of the proposed treatment.[14]

Negligence

8.8 Negligence consists of the breach of a legal duty of care owed by one person (in this case, the medical practitioner) to another person (the patient) that results in damage.[15] Failure to obtain a person's consent to medical treatment, while giving rise to a claim for an unintentional wrong, is not itself a basis for a negligence claim.[16] However, where that consent is obtained without the medical practitioner first disclosing all of the material risks of the medical treatment that is proposed, then the medical practitioner may be liable to the patient in negligence.

8.9 In this context, the term "informed consent" is used in the United States to refer to a medical practitioner's duty to disclose information to his or her patient about the medical treatment for which consent is sought. However, the High Court of Australia has said that the phrase, "informed consent", is not very useful for the purposes of Australian law because it creates the impression of being a test for the validity of a patient's consent. The law in this jurisdiction refers to the duty of medical practitioners to warn patients of any material risk inherent in a proposed treatment. A risk is material if, in the circumstances of a particular case, a reasonable person, in the patient's position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should

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[13] See para 8.9.

[14] *Rogers and Whitaker* (1992) 175 CLR 479 at 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

[15] To establish this duty, the plaintiff will need to prove foreseeability of the harm and proximity between the plaintiff and the defendant. In addition, the plaintiff needs to prove that the defendant breached the duty by failing to exercise the necessary level of care, and that the plaintiff suffered damage which is not too remote. The existence of a duty of care has long been presumed to exist in the doctor-patient relationship. For a discussion of the elements of medical negligence, see L Skene, *Law and medical practice: rights, duties, claims and defences* (2nd edition, LexisNexis Butterworths, Sydney, 2004), Chapter 7; *Halsbury's laws of Australia* (Butterworths, Sydney, 1993) Volume 18 at [280-2000], [280-2005], [280-2025].

[16] For a distinction between an action for trespass to person and negligence in the context of consent to medical treatment, see *Reibl v Hughes* (1980) 114 DLR (3d) 1; *Chatterton v Gerson* [1981] 1 All ER 257.

reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.[17]

8.10 This Commission, in conjunction with the Australian Law Reform Commission and the Law Reform Commission of Victoria, has previously examined the principles governing the provision of information by medical practitioners to patients. In the report entitled, *Informed Decisions About Medical Procedures*,[18] these recommendations were made:

- the common law standard of care that applies to the provision of information to patients should not be replaced by a statutory standard;
- guidelines for the provision of information to patients concerning proposed treatment or medical procedure be formulated by the National Health and Medical Research Council (NH&MRC); and
- in an action for professional negligence, the guidelines should be admissible in evidence and the courts should consider them in deciding whether a medical practitioner has acted reasonably in relation to the provision of information.

8.11 Pursuant to the Commission's recommendation, the NH&MRC adopted in 1993 the *General Guidelines for Medical Practitioners on Providing Information to Patients.* Their stated purpose is to enhance medical practitioner-patient communication and cover the following topics:

- the type of information that should be given to patients;
- the particular need to give information about potential risks, as well as benefits, of a proposed medical intervention;
- the manner in which information should be given; and
- the circumstances where withholding information may be justified.

8.12 The guidelines state that they reflect the common law right of legally competent patients to make their own decisions about medical treatment, and their right to grant, withhold, or withdraw consent before or during examination or treatment. While they are of general application, they do not contain provisions to deal specifically with situations where the patient is below the age of 18.

8.13 The New South Wales Medical Board's guidelines on medical practitioners' duties recognise, to a limited extent, such situations by

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[17] *Rogers and Whitaker* (1992) 175 CLR 479 at 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

[18] NSW Law Reform Commission, *Informed Decisions About Medical Procedures* (Report 62, 1989); Australian Reform Commission, *Informed Decisions About Medical Procedures* (Report 50, 1989); Law Reform Commission of Victoria, *Informed Decisions About Medical Procedures* (Report 24, 1989).

requiring that full information about the condition, treatment and prognosis of a patient be provided to those with parental responsibility where patients lack the maturity to understand what their condition or its treatment may involve, if this is in the young person's best interests.[19]

Issue 8.1

Should specific guidelines be developed to assist medical practitioners in discharging their duty to inform under-age patients about the material risks involved in a proposed medical treatment?

8.14 It is clear that the doctrine of "informed consent" or, more accurately, the duty to disclose, is separate from the legal principles that ordinarily require a medical practitioner to obtain a legally valid consent from a competent person. Breach of a duty to disclose may give rise to liability in negligence, whereas the provision of medical treatment without consent opens the way to liability for trespass to the person, that is, for battery, assault, or false imprisonment. However, when treating young people, the distinction between the two legal doctrines may not always be so easily drawn in practice. Where it is open to question whether or not a young person has understood the medical treatment that is proposed, does this possible lack of understanding derive from the young person's own immaturity (involving a determination of the young person's legal competence), or from the medical practitioner's failure to inform the young person of the material risks of the treatment (focusing on the medical practitioner's duty to disclose)? How is a medical practitioner to differentiate between the two doctrines when faced with a young patient whose level of maturity is not obviously apparent? If the law requires a relatively low level of understanding for a young person to be legally competent to consent, does it expose medical practitioners to a greater risk of liability in negligence, for failing to disclose all material risks to their young patients, whose maturity may be sufficient for competency to consent, but insufficient when it comes to understanding the material risks involved in the medical treatment that is proposed?

Issue 8.2

Do the duties to obtain a patient's consent and to warn the patient of material risks of a proposed treatment create confusion in practice about what is required of medical practitioners when dealing with under-age patients?

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[19] The New South Wales Medical Board, *The duties of a doctor registered with the New South Wales Medical Board* at para 2.3.

Current protection from civil liability

8.15 In Chapter 2, the Commission outlined the aim and effect of s 49 of the *Minors (Contract and Property) Act 1970* (NSW).[20] As we noted in that chapter, s 49 provides some protection for medical practitioners from liability for battery or assault when treating young people if they first obtain the consent of the young person's parent or guardian, where the young person is aged below 16, or from the young person himself or herself, where the young person is aged 14 or above. As we also noted, it does not protect medical practitioners from liability for false imprisonment.[21] An issue that needs to be addressed is whether or not medical practitioners should be protected more generally from civil liability if they obtained a legally effective consent to a treatment they performed.[22]

8.16 The law gives protection to medical practitioners from liability for treatments without consent in various emergency situations. For example, s 55 to 58 of the *Civil Liability Act 2002* (NSW) protects "good samaritans" (which may include medical practitioners) from any kind of personal civil liability for any act or omission in an emergency when assisting an apparently injured person or a person at risk of being injured.[23] The various laws on emergency treatment and the issues arising from them are discussed in Chapter 5.

CRIMINAL LIABILITY

8.17 The provision of medical treatment without consent may also attract criminal liability. In particular, a medical practitioner may be prosecuted for assault where the medical practitioner touches or physically examines the patient without the latter's consent. The medical practitioner may be liable for aggravated assault, such as assault occasioning bodily harm under s 59 of the *Crimes Act 1900* (NSW), where the medical treatment results in any physical or psychiatric hurt or injury.[24] In addition, a medical practitioner could be liable for the common law offence of false imprisonment, if it can be proved that in treating the patient without

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[20] See para 2.15 – 2.31.

[21] See para 2.17.

[22] See Issue 2.1.

[23] *Civil Liability Act 2002 (NSW)* s 57.

[24] The phrase "bodily harm" is capable of including psychiatric injury but does not include emotions such as fear or panic nor states of mind that were not themselves evidence of some identifiable clinical condition: *R v Chan-Fook* [1994] 1 WLR 691 at 696; *R v Lardner* (NSW, Court of Appeal, No 9804715, 10 September 1998, unreported).

consent, the medical practitioner unlawfully restrained the patient's liberty or freedom of movement.

8.18 Section 49 of the *Minors (Contract and Property) Act 1970* (NSW) gives protection from "a claim for …assault and battery". These words imply that the protection is limited to civil liability and only for those two types of torts.[25] This is in contrast to the parallel legislation operating in the United Kingdom, which gives medical practitioners protection from civil, as well as criminal, liability for acts that would otherwise constitute a trespass to the person.[26] It may be argued that in New South Wales the threat of criminal liability may deter medical practitioners from treating young people, given the ambiguities and uncertainties that surround the current law governing a young person's competence to consent to medical treatment. In Chapter 2, the Commission raised the issue of whether or not a medical practitioner should be given protection from criminal liability for acts that would otherwise constitute assault, battery or false imprisonment but for the presence of legally effective consent to the treatment.[27]

DISCIPLINARY ACTION

8.19 The *Medical Practice Act 1992* (NSW) and the *Health Care Complaints Act 1994* (NSW) establish a system that enables people to make complaints about medical practitioners and other health care practitioners. Complaints can be based on:

- a criminal conviction;
- unsatisfactory professional conduct;
- professional misconduct;
- lack of competence;
- impairment; and
- lack of good character.[28]

8.20 Unsatisfactory professional conduct includes each of the following:

- any conduct that demonstrates a lack of adequate knowledge, skill, judgement or care, by the practitioner in the practice of medicine;
- contravention of the *Medical Practice Act 1992* (NSW) or its Regulations;

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[25] See para 2.17.

[26] See *Family Law Reform Act* 1969 (UK) s 8. See *In re W (A Minor)* [1993] Fam 64 at 76 (Lord Donaldson MR).

[27] See Issue 2.1.

[28] *Medical Practice Act 1992* (NSW) s 39.

- contravention of registration conditions;
- criminal conviction relating to restrictions on the performance of "special medical treatment" under the *Children and Young Persons (Care and Protection) Act 1998* (NSW), the *Mental Health Act 1990* (NSW) and the *Guardianship Act 1987* (NSW);
- conviction for Medicare fraud under the *Health Insurance Act 1973* (Cth);
- conviction for offences relating to disclosure of pecuniary interests to patients under the *Private Hospitals and Day Procedure Centres Act 1988* (NSW) or the *Nursing Homes Act 1988* (NSW);
- accepting a benefit for a referral or recommendation to a health service provider, offering a benefit for a referral or recommendation, failure to disclose a pecuniary interest in giving a referral or recommendation;
- engaging in over-servicing, that is, the provision of service which is unnecessary, not reasonably required or excessive;
- permitting unqualified assistants to attend on patients where professional discretion or skill is required;
- knowingly allowing unregistered persons to perform surgery or to issue certificates or otherwise engage in professional practice, except in connection with proper training of students, the lawful employment of nurses etc, or the conduct of research work;
- failure to attend in an emergency when requested to do so unless reasonable steps have been taken to ensure that another practitioner will attend; and
- any other improper or unethical conduct relating to the practice of medicine.[29]

8.21 A medical practitioner who has been found to engage in unsatisfactory professional conduct may face (among other things)[30] a reprimand or caution, conditions imposed on his or her registration as a medical practitioner, or a fine.

8.22 Section 37 of the *Medical Practice Act 1992* (NSW) defines professional misconduct as unsatisfactory professional conduct of a sufficiently serious nature to justify suspension of the practitioner from practising medicine or the removal of the practitioner's name from the Register.[31] Prior to this legislative definition, case law construed

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[29] *Medical Practice Act 1992* (NSW) s 36.

[30] See Part 4 Division 4 of the *Medical Practice Act 1992* (NSW) for the disciplinary powers of the Medical Tribunal and Professional Standards Committees.

[31] *Medical Practice Act 1992* (NSW) s 37.

professional misconduct as conduct in such breach of standards accepted by the medical profession in this State as would reasonably incur the strong reprobation of fellow practitioners of good repute and competence.[32] Some NSW Medical Tribunal decisions continue to find this common law test useful when applying the provisions of s 37.[33]

8.23 The law makes it clear that a medical practitioner convicted of an offence involving the performance of "special medical treatment" on a young person[34] without the consent required by the relevant legislation[35] may be the subject of a disciplinary complaint for at least unsatisfactory professional conduct.

8.24 On the other hand, the law does not expressly make the provision of medical treatment that is not "special medical treatment" without consent a ground for disciplinary complaint against the medical practitioner. However, it is possible that a medical practitioner, who provides medical treatment without a valid consent, where this is required, may face a claim of unsatisfactory professional conduct on one of two grounds. First, it may be argued that a medical practitioner in such situation demonstrated a lack of adequate judgment or care in the practice of medicine. In addition or alternatively, it may be argued that the medical practitioner committed improper or unethical conduct relating to the practice of medicine. For example, the Australian Medical Association Code of Ethics sets out, as one of its principles, that a medical practitioner must respect a patient's right to accept or reject advice, and to make his or her own decisions about treatment or procedures.[36] It could be argued that a medical practitioner who has not obtained a patient's consent has not observed this principle, and has engaged in unethical conduct, giving rise to a claim of

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[32] *Qidwai v Brown* (1984) 1 NSWLR 100. See also *Pillai v Messiter* [No. 2] (1989) 16 NSWLR 197 at 200 where Kirby P construed professional misconduct as the "[d]eparture from elementary and generally accepted standards of which a medical practitioner could scarcely be heard to say that he or she was ignorant…But the statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of privileges which accompany registration as a medical practitioner."

[33] See *Re Dr Gad* (NSW Medical Tribunal, No 40035/99, 21 September 2001, unreported).

[34] For a discussion on the meaning of special medical treatment and the restrictions on such treatments, see para 4.19-4.23, 5.20-5.30.

[35] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175, *Mental Health Act 1990* (NSW) s 35, *Guardianship Act 1987* (NSW) s 35-39.

[36] Australian Medical Association, *Code of ethics 2003* at para 1.1(k).

unsatisfactory professional conduct or, if sufficiently serious, of professional misconduct.

Issue 8.3

Should legislation expressly provide that, where consent is a legal prerequisite for the provision of medical treatment, failure by a medical practitioner to obtain a valid consent is a ground for disciplinary action?

HONEST AND REASONABLE MISTAKES BY MEDICAL PRACTITIONERS

8.25 Should the law make some provision to exonerate medical practitioners from liability where they make honest and reasonable mistakes about the legal validity of the consent that they have obtained before treating a young person? In Chapter 3, the Commission canvassed various models for a legal framework to decide when young people should be able to consent to or refuse medical treatment. Several of these models, or variations of these models, included one or both of the following two features:

- an assessment of the young person's maturity, that is, whether or not the young person has the ability to understand the nature and possible consequences of the proposed treatment;
- an assessment of whether or not the medical treatment is in the young person's best interest.

8.26 Maturity can be used as the sole test for determining whether or not a young person is legally competent to consent[37] or it can be combined with a fixed age test.[38] The maturity test may also be coupled with a further requirement that the medical practitioner be satisfied that the treatment is in the young person's best interests.[39]

8.27 A test for competence that requires a medical practitioner to assess a young person's capacity to understand the nature of the treatment proposed carries the risk that the medical practitioner may make a mistake in his or her assessment. If the medical practitioner makes such a mistake, the consent may subsequently be found to be legally ineffective, and the medical practitioner may, at least in theory, face liability in tort, whether or not he or she acted in good faith in the circumstances, including for example, taking reasonable steps to inquire into the young person's maturity. Unless medical practitioners are given protection from civil,

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[37] See para 3.10-3.21.

[38] See para 3.24-3.26.

[39] See para 3.18.

criminal or disciplinary action in this context, medical practitioners might avoid the problem by refusing to treat young people.

8.28 The same problem may arise where medical practitioners are required to assess whether or not medical treatment is in a young person's best interests. If the law were to require that young people be competent to consent to medical treatment that is only in their best interests, a medical practitioner may face liability for acting on a young person's consent that is later found not to be legally effective, because the medical treatment is found, in hindsight, not to serve the young person's best interests.

8.29 As in other contexts where mistake is a defence,[40] reasonable belief will need to be determined by reference to what the defendant (the medical practitioner) might reasonably have thought in all the circumstances he or she faced, not to what a reasonable person would have believed.[41] However, it is an essential requirement that it be shown that there existed reasonable grounds for the mistaken belief in facts which if true would have made the act lawful.[42]

Issue 8.4

(a) Should the law exonerate a medical practitioner from liability and/or disciplinary action for making an honest and reasonable mistake about a young patient's competence to consent to medical treatment?

(b) Should the law exonerate a medical practitioner from liability and/or disciplinary action for making an honest and reasonable mistake about whether or not medical treatment is in the best interests of a young person?

NON-TOUCHING MEDICAL TREATMENT

8.30 Special mention should be made about the possible grounds of liability that arise from situations in which a medical practitioner treats a patient without the requisite consent where the medical treatment does not involve any physical contact, or the prospect of any physical contact. Examples of this type of situation include a psychiatrist who provides counselling to a patient, without any physical contact, or a medical practitioner who provides medical advice or information without any actual or threatened physical contact with the patient.

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40. In criminal law, an honest and reasonable belief in a state of facts, which had they existed would make the accused's act innocent, is a common law defence: *Proudman v Dayman* (1941) 67 CLR 536.
41. *Viro v The Queen* (1978) 141 CLR 88 at 146-147 (Mason J).
42. *Handmer v Taylor* [1971] VR 308.

8.31 The usual grounds of liability that arise from the provision of medical treatment without consent, namely battery and assault, do not apply to these situations, because there is no actual or threatened physical contact with the patient. Does the provision of medical treatment without the requisite consent, where the medical treatment does not involve physical contact, attract any form of legal liability? Should it attract liability? To answer the first question, there does not seem to be any clear and certain basis on which to impose liability on a medical practitioner who treats a patient without the required consent in this type of situation. It is possible that, in more extreme cases, a patient could make a claim of false imprisonment against the medical practitioner, although in most situations it would be difficult to establish such a claim, given that an action for false imprisonment requires proof of total restraint of the patient, with no alternative means of exit available. A patient may be able to claim false imprisonment where, for example, he or she was subjected to some therapy,[43] without the medical practitioner first obtaining a legally valid consent, but it would be more difficult to establish false imprisonment where the patient was merely receiving psychiatric counselling or medical advice.

8.32 In the *Gillick* case, a mother of five teenage girls brought an action for a declaration that a Department of Health memorandum allowing medical practitioners to provide contraceptive advice and treatment to underage patients was unlawful. It was not a criminal case: it was not contended that the issue of the guidance was itself a crime or that a medical practitioner had in fact committed an offence. Instead, the case against the Department was simply that the guidance, if followed by medical practitioners, would result in the offence of causing or encouraging unlawful sexual intercourse with a girl below the age of consent, or as an accessory to the crime of unlawful sexual intercourse with an underage girl.[44] The court rejected this argument, noting that a medical practitioner who provides contraceptive advice is not encouraging or aiding or abetting the commission of unlawful sexual intercourse, but instead providing protection for the girl against disease and unwanted pregnancy, in recognition that sexual intercourse was likely to take place.[45] It was further observed that if it were criminal or contrary to public policy to prescribe contraception to a girl under the age of 16 on the ground that sexual intercourse with her is a crime on the part

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[43] See para 8.6.

[44] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

[45] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 at 174-175 (Lord Fraser of Tullybelton), 190-191 (Lord Scarman) 194 (Lord Bridge of Harwich).

of her male partner, the fact that her parent knew and consented would not make it less so.[46]

8.33 It is possible that a medical practitioner who treats a patient without the requisite consent, where the treatment does not involve any physical contact, could be found liable for breach of his or her fiduciary duty to the patient. A person owes a fiduciary duty to another person if he or she stands in a position of trust with respect to that person, and has an obligation to act in that person's interests.[47] The Canadian Supreme Court has recognised the doctor-patient relationship as giving rise to a fiduciary duty,[48] although the Australian High Court has found that the doctor-patient relationship is not necessarily a fiduciary one.[49]

8.34 Of course, medical practitioners who provide medical treatment to patients where the treatment does not involve physical contact may still face liability for negligence, or disciplinary action, if, for example, they have acted in an unprofessional or unethical manner. These do not depend on proof of a failure to obtain a valid consent.

8.35 As to the second question raised in paragraph 8.31, should a medical practitioner be liable for treating a patient below the age of 18 without consent where the treatment did not involve any actual or threatened physical contact with the patient? On the one hand, it might be argued that this kind of treatment does not involve the same level of intrusion and compromise of a person's bodily integrity as arises from treatment involving physical contact. On the other hand, some treatments that do not involve physical contact, for example medical advice on reproduction and sexual health, and psychiatric counselling, can have significant and long-term effects on a patient's health and well-being.

Issue 8.5

(a) Is the current law adequate in imposing liability on medical practitioners for treating young people without a valid consent (where consent is legally required), where the medical treatment in question does not involve any physical contact?

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[46] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 at 190 (Lord Scarman).

[47] See for example *Hospital Products Ltd v United States Surgical Corp* (1984) 156 CLR 41 at 96-97; See also B Bennet, *Law and medicine* (Law Book Company, North Ryde, 1997) at para 4.28-4.33.

[48] See *McInerney v MacDonald* (1992) 93 DLR (4th) 415; *Norberg v Wynrib* (1993) 92 DLR (4th) 449.

[49] *Breen v Williams* (1996) 186 CLR 71. This case involved the question of a patient's access to medical records, and the Court found that there was no fiduciary relationship that gave rise to a duty to provide access to such records.

(b) Should the law impose liability on medical practitioners for treating young people without the requisite consent, where the medical treatment in question does not involve any physical contact?

PROFESSIONAL INDEMNITY INSURANCE

8.36 The main outcome of a successful case in tort against a medical practitioner is payment of damages. Pursuant to a standard medical indemnity insurance policy, indemnity is provided to the insured medical practitioner for civil liability in respect of claims that arise directly from the insured's provision of medical services. In other words, indemnity would be available to a medical practitioner who loses an action in assault, battery or negligence, provided the circumstances surrounding the wrong arose directly in connection with the insured's provision of medical services.[50] The insurance policy may, however, limit the type of damages that it will indemnify: for example, claims arising out of exemplary or aggravated damages are usually excluded.[51]

Will indemnity be barred if the medical practitioner's conduct constitutes a crime?

8.37 A possible bar to protection from insurance may arise if the medical practitioner's conduct that forms the basis of the claim for indemnity is alleged to be criminal. United Medical Protection (UMP), the largest mutual medical indemnity provider in Australia, does not cover indemnity for any civil liability arising from allegations concerning criminal acts.[52] Even if the insurance policy does not expressly exclude such claims, the insurer might seek to deny liability on the basis of public policy considerations.

8.38 There are cases that have held that public policy bars the insured from obtaining or enforcing any rights resulting from his or her crime.[53] However, this doctrine is not absolute. A claim in tort will not necessarily be defeated merely because the loss was caused by conduct amounting to a

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[50] Information provided by A Took, In-House Counsel, United Medical Protection (6 November 2003).

[51] See for example Australasian Medical Insurance Limited, *Professional indemnity insurance policy* at para 3.23

[52] Information provided by A Took, In-House Counsel, United Medical Protection (6 November 2003). However, UMP has a policy that provides for the meeting of legal costs of criminal proceedings, which arise from the insured's practice of medicine.

[53] *Haseldine v Hosken* [1933] 1 KB 822; *Beresford v Royal Insurance Co Ltd* [1938] AC 586; *Geismar v Sun Alliance and London Insurance Ltd* [1978] 2 QB 383.

crime.[54] If the act of the party seeking indemnity was unlawful but was done in honest ignorance of the circumstances that constituted its unlawfulness, the action for indemnity may be maintained.[55] Moreover, the nature of the alleged offence is an important consideration. A criminal act can vary in its seriousness, and the test to be applied is whether the act is of such an anti-social character that the interests of the public require that the courts should for their protection decline to enforce arrangements connected with the act.[56] Similarly, it has been stated that public policy implies some form of moral blameworthiness such that it would shock the conscience to allow a person to benefit from his or her own misdeed.[57] Consequently, a mere allegation that a medical practitioner's conduct was criminal in nature should not defeat a claim for indemnity arising from such conduct. The claim may be denied only if the medical practitioner's conduct is intentional and is a crime that shocks the conscience of reasonable members of the community.

The medical indemnity crisis

8.39 One of the most pressing problems facing medical practitioners these days is the high cost of insurance. There have been reports of medical practitioners who have stopped practising because they could no longer afford indemnity cover. The increase in the number of medical malpractice cases and the escalation in the amount of damages being awarded are among the alleged causes of the problem. Others include the failure of medical defence organisations (MDOs), which provide professional insurance for medical practitioners, to provide adequately for future claims and financial pressures in the wider insurance industry.[58]

8.40 The Commonwealth and New South Wales governments have taken steps to deal with the problem. For example, the federal government

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[54] *Jackson v Harrison* (1978) 138 CLR 438.

[55] *Burrows v Rhodes* [1899] 1 QB 816; *Geismar v Sun Alliance and London Insurance Ltd* [1978] 2 QB 383.

[56] See *Fire and All Risks Insurance Co Ltd v Powell* (1966) VR 513 at 523 (O'Bryan and Pape JJ).

[57] *S & Y Investments (No 2) Pty Ltd (in liquidation) v Commercial Union Assurance Co of Australia Ltd* (1986) 44 NTR 14.

[58] For an account and analysis of the medical insurance problem, see L Skene, *Law and medical practice: rights, duties, claims and defences* (2nd edition, LexisNexis Butterworths, Sydney, 2004), Chapter 1; Medical Indemnity Review Panel, *Affordable, secure and fair* (Report to the Prime Minister of the Medical Indemnity Review Panel, 2003); H Luntz, "Medical indemnity and tort law reform: the medical indemnity crisis" (2003) 10 *Journal of Law and Medicine* 385; P Cashman, "Tort reform and the medical indemnity 'crisis'" (2002) 8 *University of New South Wales Law Journal Forum* 51.

enacted legislation giving financial support to UMP and other MDOs.[59] New South Wales has undertaken tort law reform.[60] Further reforms are expected.[61]

8.41 This reference is not a review of medical indemnity and will therefore not directly deal with issues on that matter. Nevertheless, to the extent that one of its aims is to achieve clarity and consistency in the discrete area of young people's consent to medical treatment, this review may contribute to the prevention of unnecessary claims against medical practitioners and consequently avert further pressures relating to medical indemnity.

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[59] *Medical Indemnity Agreement (Financial Assistance-Binding Commonwealth Obligations) Act 2002* (Cth); *Medical Indemnity (IBNR) Contribution Act 2002* (Cth); *Medical Indemnity (Consequential Amendments) Act 2002* (Cth); *Medical Indemnity (Enhanced UMP Indemnity) Contribution Act 2002* (Cth).

[60] See, for example, the *Civil Liability Act 2002* (NSW).

[61] The Commonwealth Government has recently announced that it is adopting the Report of the Medical Indemnity Review Panel.

9.

Disclosure of and access to young people's health information

- Overview
- Disclosure of health information
- Patient access to medical records
- Retention of young people's health information

OVERVIEW

9.1 Information about an individual's health is one of the most sensitive types of data, irrespective of the age of the individual. In regulating the disclosure of and access to this type of information, the law must achieve a balance between various competing interests. One of the most fundamental contests is between the patient's interests in confidentiality and third party interests in disclosure of health information. A further area of tension involves patient access to medical records and the interests that may justify denying access to those records. This chapter considers the ways in which the law currently manages these issues in relation to young people and highlights the areas that may require clarification or change.

DISCLOSURE OF HEALTH INFORMATION

The duty of confidentiality

9.2 The basic legal and ethical position is that medical practitioners must not disclose any health information without the consent of the patient concerned. This position is reflected in the duty of confidentiality, which is owed by all medical practitioners.[1] The duty ensures that patients are able to discuss their health freely with their medical practitioner, safe in the knowledge that the information will remain confidential. In so doing, it promotes both private and public interests in addressing individuals' health problems and encouraging good health more generally.[2] Case law confirms that these interests apply equally to young people as to adults.[3]

Sources of the duty of confidentiality

9.3 The duty of confidentiality is an ethical and legal obligation owed by medical practitioners to their patients. In its legal dimension, the duty may stem from contract, tort, equity or statute.

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[1] See generally L Skene, *Law and medical practice: rights, duties, claims and defences* (2nd edition, LexisNexis Butterworths, Sydney, 2004), Chapter 9.

[2] See, for example, the comments in *X v Y* [1988] 2 All ER 648 at 653 (Rose J) concerning the importance of confidentiality in respect of patients who are HIV positive.

[3] "Children, like adults, are entitled to confidentiality in respect of certain information. Medical records is the obvious example": *Venables v News Group Newspaper Ltd* [2001] 1 All ER 908 at 939. See also *Re C (a minor) (wardship: medical treatment) (No 2)* [1989] 2 All ER 791.

Ethics

9.4 A duty of confidentiality is imposed by various codes of ethics, which apply to the medical profession. For example, under the Hippocratic Code, which is probably the most widely-known statement of medical ethics, medical practitioners are obliged to keep in confidence patient information that was seen or heard "professionally or privately, which ought not to be divulged."[4] A similar obligation is enshrined in the Australian Medical Association's Code of Ethics:

> Maintain your patient's confidentiality. Exceptions to this must be taken very seriously. They may include where there is a serious risk to the patient or another person, where required by law, where part of approved research, or where there are overwhelming societal interests.[5]

9.5 Codes of ethics are not, however, legally enforceable. Instead, they provide principles of appropriate conduct, a breach of which may lead to disciplinary proceedings against a medical practitioner for unsatisfactory professional conduct or professional misconduct.[6]

Contract

9.6 The relationship between a medical practitioner and a patient is traditionally regarded as contractual in nature. The medical practitioner performs services in consideration for fees payable by the patient. Case law suggests that in the absence of a special contract between the medical practitioner and patient, the medical practitioner impliedly undertakes to advise and treat the patient with reasonable care and skill, and to maintain or improve the health of the patient generally.[7] Confidentiality may be regarded as a necessary element of compliance with these duties.

9.7 The traditional contractual view of the medical practitioner/patient relationship may be difficult to sustain where a third party pays the cost of the medical practitioner's fees. Where a young person receives medical treatment, the consideration for the service is likely to be provided by his or her parents or by a health care system such as Medicare. One view is that in this type of situation, there is no contractual relationship between the medical practitioner and the under-aged patient and consequently no implied duty of confidentiality. The alternative view can be based on one or other argument that submission to treatment by the under-aged patient is

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[4] See G Lloyd (ed), *Hippocratic writings* (Penguin, Harmondsworth, 1978) at 67.

[5] Australian Medical Association, *Code of ethics* (2003) at para 1.1(l).

[6] See *Hoile v Medical Board of South Australia* (1960) 104 CLR 157 at 163; *Medical Practice Act 1992* (NSW) s 36(1)(m). See also para 8.20, 8.24.

[7] *Breen v Williams* (1996) 186 CLR 71.

a form of consideration[8] or payment by a third party is properly regarded as payment on behalf of the under-age contracting party.[9]

Tort

9.8 Medical practitioners owe their patients a duty of reasonable care and skill in tort.[10] No case in Australia has considered whether this duty embodies an obligation of confidentiality. However, applying the traditional principles of negligence, it is arguable that disregard of patient confidentiality may breach the duty of care in certain circumstances. These circumstances are as follows:

- the medical practitioner failed to exercise reasonable care in not keeping the information confidential;
- it was reasonably foreseeable that disclosure could harm the patient; and
- the patient has suffered some actual measurable harm or loss as a result of the disclosure.[11]

Equity

9.9 The clearest statements of obligations relating to confidential information are found in equity. Medical practitioners owe their patients an equitable duty of confidence.[12] Disclosure of information about a patient will breach this duty if the information:

- is confidential in nature;
- was imparted in circumstances giving rise to an obligation of confidence; and
- was used without authorisation to the detriment of the patient.[13]

9.10 The first two elements are easily satisfied. It is broadly accepted that information relating to an individual's health or medical condition is prima facie confidential in nature. Similarly, case law acknowledges that the "circumstances" of the medical practitioner/patient relationship and the

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[8] *Breen v Williams* (1996) 186 CLR 71 at 78 (Brennan CJ).

[9] *Furniss v Fitchett* [1958] NZLR 396 at 399 (Barrowclough CJ).

[10] *Rogers v Whitaker* (1992) 175 CLR 479.

[11] See *Furniss v Fitchett* [1958] NZLR 396.

[12] *W v Egdell* [1990] Ch 359 at 389 (Scott J).

[13] *Coco v AN Clark (Engineers) Ltd* [1969] RPC 41 at 47 (Megarry J). This test has been approved in Australia in *Commonwealth of Australia v John Fairfax & Son Ltd* (1980) 147 CLR 39 at 51 (Mason J).

character of the information exchange it involves give rise to an obligation of confidence.[14]

9.11 However, difficulties may arise in establishing the third element of a breach. It will be necessary for the affected individual to demonstrate that some form of detriment flowed from the unauthorised disclosure. As case law accepts that detriment need not be economic, consequences such as distress, humiliation or embarrassment may suffice.[15]

Statute

9.12 While various statutes touch on the issue of medical confidentiality,[16] the most comprehensive statutory statements are found in privacy legislation. Commonwealth and State privacy legislation regulates the collection, storage, use and disclosure of health information by public and private sector health service providers. At the federal level, the relevant legislation is the *Privacy Act 1988* (Cth).[17] This Act contains ten National Privacy Principles, which set the minimum standards for patient privacy.[18] Principle 2 imposes an indirect statutory duty of confidentiality on health professionals by providing that information must not be disclosed unless certain, specified circumstances exist.[19]

9.13 In New South Wales, the privacy of individuals' health information is addressed by the *Health Records and Information Privacy Act 2002* (NSW), which commences on 1 July 2004. It covers every public or private sector organisation that is a health service provider or that collects, holds or uses health information. The primary way in which it regulates the handling of health information is by requiring that these organisations comply with the Health Privacy Principles.[20] Principles 10 and 11 regulate the use and disclosure of health information by establishing a basic prohibition on non-consensual use or disclosure, which is accompanied by

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[14] See *W v Egdell* [1990] Ch 359 at 389 (Scott J) and *Stephens v Avery* [1988] 2 All ER 477 at 482 (Browne-Wilkinson V-C).

[15] See *Attorney-General (UK) v Heinemann Publishers Australia Pty Ltd* (1987) 8 NSWLR 86 at 90 (McHugh J). In addition, it should be noted that the need to demonstrate any form of detriment has been questioned: *NRMA v Geeson* (2001) 40 ACSR 1 at [58] (Bryson J).

[16] See, for example, the *Health Administration Act 1982* (NSW).

[17] The applicability of this Act was extended to the private sector by the *Privacy Amendment (Private Sector) Act 2000* (Cth).

[18] The Principles are set out in Schedule 3 of the *Privacy Act 1988* (Cth).

[19] *Privacy Act 1988* (Cth) Sch 3.

[20] These Principles are contained in *Health Records and Information Privacy Act 2002* (NSW) Sch 1.

an exhaustive list of circumstances in which non-consensual use or disclosure is permissible.[21] Accordingly, like the *Privacy Act 1988*, the *Health Records and Information Privacy Act 2002* imposes an indirect statutory duty of confidentiality on medical practitioners.

Permissible disclosure of health information

9.14 While the duty of confidentiality is an essential element of the relationship between medical practitioners and their patients, the duty is not absolute. This reflects the realities of medical practice and the existence of competing interests, such as the public interest in detecting child abuse. In an effort to achieve a balance between confidentiality and practicality or other interests, the law permits, and sometimes compels, disclosure of confidential health information. There are four particular circumstances in which the law concerning permissible disclosure of young people's health information may require change or clarification:

- when parents request disclosure of their child's health information;
- when the consent of the patient renders disclosure permissible;
- when disclosure is authorised by the *Health Records and Information Privacy Act 2002* (NSW); and
- when the public interest in preventing harm to a young person requires disclosure.

Parental access to young people's medical information

9.15 It is unclear to what extent young people have a right to have medical information kept confidential from their parents. The prevailing view in the literature is that a young person who has sufficient understanding and intelligence to consent to a particular medical treatment should have the right of confidentiality with respect to that treatment.[22] Hence, if a medical practitioner adjudges a young person to be competent to consent to receive advice on contraception, the medical practitioner is obliged not only to give such advice but also to keep the consultation confidential from the young

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[21] These circumstances are discussed below at para 9.24.

[22] I O'Connor and A McMillan, "Youth, the law and health: emerging issue in service delivery "(April 1987) *Queensland Law Society Journal* 95; S P De Cruz, "Parents, doctors and children: the *Gillick* case and beyond" [1987] *Journal of Social Welfare Law* 93; I Kennedy, "The doctor, the pill and the fifteen year old girl" in I Kennedy (ed) *Treat me right* (Oxford, Clarendon Press, 1988). In the UK, the General Medical Council's guidance on confidentiality, *Confidentiality: protecting and providing information* (2000), contains special rules on children who cannot consent to medical treatment. The guidance's general rules, that is, those that must be observed in relation to adult patients, apply to children who are competent to consent to a medical treatment.

person's parents. The rationale for this view is that if parents do not have the power to consent to a medical treatment that their child seeks, they do not require the power to obtain medical information about that treatment.

9.16 There are two competing views regarding the position of young people who are incapable of giving valid consent to a medical treatment. One view states that if a young person proves to be incompetent to consent to a treatment, the medical practitioner may disclose the young person's medical information to the parents.[23] The basis of this view is twofold. First, it is argued that the obligation of confidence is based on a person's autonomy. No obligation of confidence can be owed to a young person who is incompetent to give consent to a medical treatment, since he or she is, by that token, not capable of exercising autonomy as regards the treatment he or she wanted. Secondly, it is argued that parents have a right to know information necessary to carry out effectively their parental duties of care.[24] A parent may not be able to ensure the welfare and health of a young person without information about the young person's health or medical requirements.

9.17 The alternative view is that even where a young person is found to lack the capacity to consent to a medical treatment, the fact that he or she consulted the medical practitioner, and what the medical practitioner has learned in the process of assessing competence for that particular treatment, must be kept confidential, if the young person expressly objects to the disclosure or gave the information with an expectation that it would not be disclosed to others. Such a test requires an inquiry into whether or not the young person can comprehend an obligation of secrecy with respect to the medical information obtained by the medical practitioner.[25] In support of this view, it is argued that the preservation of confidentiality is not based solely on the recognition of the autonomy of certain young people. It is also founded on young people's right to and need for privacy, which should not be less than those of adults. Moreover, there is a public interest argument relating to effective health services: without the guarantee of confidentiality, many young people will not seek medical advice or treatment.[26] For example, almost half of adolescent girls in a US study said

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[23] See I Kennedy, "The doctor, the pill and the fifteen year old girl" in I Kennedy (ed) *Treat me right* (Oxford, Clarendon Press, 1988) at 111-114.

[24] See *Family Law Act 1975* (Cth) s 61C(1) regarding the concept of "parental responsibility".

[25] J Loughrey, "Medical Information, confidentiality and a child's right to privacy" (2003) 23 *Legal Studies* 510.

[26] T Bartholomew and S Paxton, "General practitioners' perspectives re competence and confidentiality in an adolescent with suspected anorexia nervosa: legal and ethical considerations" (2003) 10 *Journal of Law and Medicine* 308 at 314.

they would stop using Planned Parenthood clinics (which provide family planning and reproductive health services) if parental notification of contraceptive services were required, and many would engage in behaviours that increase their risk of pregnancy and sexually infectious diseases.[27]

Case study

Sarah is a 13 year old who is sexually active and has been seeing a 15 year old boy. She went to see a medical practitioner because she had some abnormal discharge from her vagina. She tested positive for Chlamydia, for which she was given some medication. The medical practitioner also gave Sarah advice on sexually transmitted diseases and contraception. However, she was not always certain that Sarah fully understood all the information. She was concerned about Sarah's seeming sexual recklessness and vulnerability to pressure from her peers, especially her boyfriend. She feared Sarah might in the future contract a more serious STD or have an unwanted pregnancy. The medical practitioner assured Sarah that she was welcome to talk to her anytime and in fact planned a few more sessions. However, she also encouraged her talk to her parents about her boyfriend, perhaps even about the fact that she had contracted an STD. Sarah was adamant that her parents should not know about her health situation or any other information she had given.

Queries:

Should Sarah's parents have a right to be informed that (1) she had an STD; and (2) she is getting contraceptive advice and treatment?[28]

Is parental involvement, which allows parents to discuss their values with their children, the most effective way of preventing children's sexual health problems?

Does confidentiality of young people's health information undermine parental authority and family autonomy?

If sexually active young people will refuse to seek care if they have to inform a parent or need to get their parent's consent, do the benefits of

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[27] D Reddy, R Fleming and C Swain, "Effect of mandatory parental notification on adolescent girls use of sexual health care services" (2002) 288 *Journal of American Medical Association* 710.

[28] In the United States, parental notification is required in cases of minors seeking contraception services from federally funded family-planning clinics, except for treatment for STD's and when such notification would lead to physical harm of the minor: *Parental notification requirements applicable to projects for family planning services*, 48 *Federal Regulations* 3600, 3614 (1983).

confidentiality outweigh other interests, in particular the rights of the parents to exercise their parental duties?

9.18 The issue of disclosure to parents is likely to arise in situations involving health information, which the young person considers to be personal and sensitive in nature, for example those relating to reproduction and sexual health, drug dependency and depression. A young person is unlikely to object to his or her parents being informed about a treatment for a common cold. Clearly, the type of health information involved is significant in problems concerning confidentiality. If a test involving an expectation of non-disclosure were adopted, the nature of the health information in question could simply be a relevant factor in assessing whether or not the test has been met. An alternative approach would be to argue that the content of a right of confidentiality should be based on the type of health information involved. That is, young people should have a right not to disclose to their parents only certain types of health information.

Issue 9.1

(a) Should young people have the right to keep their health information confidential from their parents?

(b) If so, should such a right be confined to situations where a young person can validly consent to their medical treatment? Or should it extend to situations where the young person, while not competent to consent to the treatment in question, had an understanding of the concept of secrecy and gave information to the medical practitioner with an expectation that it would not be disclosed?

(c) What should be the significance of the nature of the health information? Should young person's right to keep their health information confidential from their parents apply only to certain classes of health information, for example those relating to reproduction and sexual health?

Consent

9.19 The realities of medical practice dictate that it is often necessary for information about patients to be shared among a number of health professionals. For example, a team of health professionals, comprising medical practitioners, nurses and social workers, may share responsibility for a patient who is receiving treatment in a hospital. In order to facilitate the necessary information sharing, the law recognises that disclosure of confidential information will not breach the duty of confidentiality if it is done with the patient's consent.[29] Consensual disclosure also enables

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29. *Austen v Civil Aviation Authority* (1994) 50 FCR 272 at 277.

information to be given to other third parties, such as family members, insurance companies or legal advisers.

9.20 An issue that arises in relation to under-age patients is whether, and in what circumstances, they have the capacity to consent to the disclosure of their medical information. In considering this issue, it may be appropriate to distinguish between a situation where a young person was competent to consent to the medical treatment in question and one where he or she was not. As regards the first situation, it is probable that capacity to consent to disclose health information depends on whether the young person was competent to and in fact gave consent to the treatment in question. There appears to be no justification for requiring a higher degree of competency in the area of disclosure than in that of treatment.

9.21 With regard to the situation where a young person is adjudged incompetent to consent to a treatment, it may be appropriate to shift the focus from capacity to consent to treatment to capacity to comprehend the notion of secrecy coupled by an expectation of confidentiality. On this approach, a young person who is incompetent to consent to a particular treatment but who nevertheless had an understanding and expectation of confidentiality when he or she disclosed the information to the medical practitioner is competent to consent to disclosure. A possible objection to this argument is that the potential implications and consequences of disclosure are more complicated than the concept of secrecy. It follows from this view that it is inappropriate to equate capacity to comprehend confidentiality with capacity to consent to disclosure. These concerns appear to be reflected in the *Health Records and Information Privacy Act 2002* (NSW), which indirectly provides that an individual is incapable of providing valid consent to disclosure if that individual does not understand the general nature and effect of giving consent.[30] Accordingly, even though a young person may understand the idea of secrecy, he or she will nevertheless be unable to provide valid consent to disclosure under the Act if the consequences of that consent are not understood.

Issue 9.2

(a) What should be the test in determining whether or not a young person can give a valid consent to disclose his or her health information?

(b) Should young people who are competent to consent to medical treatment automatically be competent to consent to the disclosure of the health information obtained from that particular treatment?

(c) Should young people who are not competent to consent to medical treatment be able to provide a valid consent to the disclosure of their health information? If so, in what circumstances?

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[30] *Health Records and Information Privacy Act 2002* (NSW) s 7(1).

(d) Should the nature of the health information affect the response to any of these issues?

9.22 Where a young person is incapable of consenting to disclosure of medical information, a parent may wish to provide consent on his or her behalf. The *Health Records and Information Privacy Act 2002* (NSW) provides statutory recognition of a parent's ability to consent in these circumstances; under that statute, an authorised representative of an individual may do an act on behalf of an individual who is incapable of doing that act.[31] A person who has parental responsibility for a young person is automatically recognised as his or her authorised representative.[32] This parental ability to consent on behalf of a young person is not limited by the Act, with no conditions being placed on the exercise of the power. It is arguably desirable for the exercise of parental consent to be conditional upon disclosure being in the young person's best interests or some other test.

Issue 9.3

(a) Where a young person cannot consent to disclosure of his or her health information, should the young person's parents have the authority to do so?
(b) If so, should there be any limitations on the exercise of such authority?

Health Records and Information Privacy Act 2002 (NSW)

9.23 In addition to providing statutory authorisation for consensual disclosure, the *Health Records and Information Privacy Act 2002* (NSW) specifies a range of circumstances in which non-consensual disclosure of health information is permissible. These circumstances are:

- where the purpose of disclosure (the secondary purpose) is directly related to the primary purpose for which the information was collected and the individual would reasonably expect the organisation to disclose the information for that secondary purpose;[33]

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[31] *Health Records and Information Privacy Act 2002* (NSW) s 7(2). The issue of capacity is addressed by *Health Records and Information Privacy Act 2002* (NSW) s 7(1).

[32] Section 8(1)(c).

[33] For example, if information is collected in order to provide a health service to the individual, the disclosure of the information to provide a further health service to the individual is a secondary purpose directly related to the primary purpose: *Health Records and Information Privacy Act 2002* (NSW) Sch 1 Health Privacy Principle 11 (1)(b) *Note.*

- where disclosure is reasonably believed to be necessary to lessen or prevent a serious and imminent threat to the life, health or safety of the individual or another person;
- where disclosure is reasonably believed to be necessary to lessen or prevent a serious threat to public health or public safety;
- where disclosure is reasonably necessary for the funding, management, planning or evaluation of health services and reasonable steps are taken to de-identify the information or, if the information cannot serve its purpose if it is de-identified, it is not published in a generally available publication;
- where disclosure is reasonably necessary for the training of employees of the organisation or persons working with the organisation and reasonable steps are taken to de-identify the information or, if the information cannot serve its purpose if it is de-identified, it is not published in a generally available publication;
- where disclosure is reasonably necessary for research, or the compilation or analysis of statistics, in the public interest and reasonable steps are taken to de-identify the information or, if the information cannot serve its purpose if it is de-identified, the research will not be published in a form that identifies particular individuals or from which an individual's identity can reasonably be ascertained;
- where the disclosure is to provide the information to an immediate family member of the individual for compassionate reasons and the individual is incapable of giving consent to the disclosure;[34]
- where the disclosure is to a law enforcement agency for the purposes of ascertaining the whereabouts of an individual who has been reported as a missing person;
- where the organisation has reasonable grounds to suspect that a person has engaged in unlawful activity, in conduct that amounts to unsatisfactory professional conduct or professional misconduct under a health registration Act or in conduct that may be grounds for disciplinary action and discloses the information as a necessary part of its investigation of the matter or in reporting its concerns to relevant authorities;
- where the disclosure is reasonably necessary for the exercise of law enforcement functions by law enforcement agencies in circumstances where there are reasonable grounds to believe that an offence may have been, or may be, committed; or

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[34] See also the additional conditions in *Health Records and Information Privacy Act 2002* (NSW) Sch 1 Health Privacy Principle 11(1)(g).

- where the disclosure is reasonably necessary for the exercise of complaint handling functions or investigative functions by investigative agencies.[35]

Issue 9.4

(a) Should non-consensual disclosure of a young person's health information be permitted in any circumstances other than those listed in the *Health Records and Information Privacy Act 2002* (NSW)?
(b) Should the *Health Records and Information Privacy Act 2002* (NSW) impose any additional limitations or controls on non-consensual disclosure of a young person's health information?

Public interest: risk of harm to young people

9.24 A general exception to confidentiality arises where the public interest in disclosure outweighs the interest in confidentiality. English courts have couched the exception in terms of the balancing of competing public interests:

> [T]he process is to consider fairly the strength and value of the interest in preserving confidentiality and the damage which may be caused by breaking it .... This is a more complex process than merely using the scales: it is an exercise in judicial judgement.[36]

9.25 The public interest exception is notable for its flexibility. It can be invoked to justify the disclosure of confidential patient information in a wide range of circumstances. This could include cases where a patient's mental condition presents a danger to public safety,[37] or where a patient's ill health renders him or her unfit to continue certain activities because others would be placed at risk.[38] In the specific context of under-age

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[35] *Health Records and Information Privacy Act 2002* (NSW) Sch 1 Health Privacy Principle 4(1). Disclosure in other circumstances may be authorised by regulation: *Health Records and Information Privacy Act 2002* (NSW) Sch 1 Health Privacy Principle 4(1)(l).

[36] *Science Research Council v Nasse* [1980] AC 1028 at 1067 (Lord Wilberforce); *British Steel Corporation v Granada Television Ltd* [1981] AC 1096 at 1140 (Watkins LJ).

[37] *W v Edgell* [1990] 1 All ER 835 (The patient committed multiple killings under the disability of serious mental illness. A consultant psychiatrist who was asked by the patient's solicitors to examine the patient made his report available to the hospital where the patient was confined, without the patient's consent to the disclosure).

[38] *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 (The patient was a bus driver who suffered two heart attacks and underwent a triple coronary heart bypass. The doctor sought the assistance of police to have the patient's licence revoked and in the process discussed the patient's medical condition with others).

patients, the public interest exception could be invoked to protect the welfare of a young person if there was evidence of abuse, for example.[39]

9.26 In New South Wales, Parliament has effectively recognised a public interest exception to confidentiality where there is a risk of harm to a child. Section 27 of the *Children and Young Persons (Care and Protection Act) 1998* (NSW) provides that medical practitioners (among others) who have reasonable grounds to suspect that a child is at risk of harm, and those grounds arise during the course of or from the person's work, must report to the Director-General of the Department of Youth and Community Services the name, or a description, of the child and the grounds for suspecting that the child is at risk of harm.[40] The Director-General has the power to direct certain bodies, including an area health service and a hospital, to furnish the information concerning the child.[41] The Director-General also has powers to take whatever action is necessary to safeguard or promote the safety, welfare and well-being of a child or young person.[42]

9.27 The mandatory reporting requirement in s 27 of the Act applies to children, defined as persons under the age of 16 years.[43] It does not apply to 16 and 17 years olds, referred to by the Act as young persons.[44]

Issue 9.5

Should the mandatory reporting requirement contained in s 27 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) apply also to 16 and 17 year olds?

9.28 For purposes of the reporting provisions of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), s 23 provides that a child or young person is "at risk of harm" if current concerns exist for the safety, welfare or well-being of the child or young person because of the presence of any one or more of the following circumstances:

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[39] J Montgomery, *Health care law* (Oxford, Oxford University Press, 2003) at 269-270. See para 5.31-5.36.

[40] See also *Health Records and Information Privacy Act 2002* (NSW) Sch 1 Health Privacy Principle 11(1)(c).

[41] *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 248.

[42] Section s 34.

[43] Section 3.

[44] In contrast, s 24 of the Act, which allows (but does not compel) any person to make a report to the Director-General about suspicions of risk of harm, applies to children and young persons.

- the basic physical or psychological needs of a child or young person are not being met or are at risk of not being met;
- the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care;
- the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated;
- the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm; or
- a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm.[45]

Issue 9.6

Are there other situations that should be added to the list in s 23 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW)?

PATIENT ACCESS TO MEDICAL RECORDS

9.29 Medical records are a core feature of most healthcare systems. They ensure that a comprehensive medical history is available to the individual who is the subject of the record and also to those involved in that individual's current and future healthcare. In addition, they provide a record of the diagnosis and treatment in case of future inquiry or dispute. Given these functions and the highly personal nature of the information contained in medical records, patients have an obvious interest in obtaining access to them. However, patient access is not automatic and unlimited. The following discussion seeks to identify the arguments for and against granting patient access to records and to outline the ways in which the law facilitates and controls that access.

Arguments in support of granting patient access

9.30 The information in medical records concerns the personal integrity and autonomy of a patient.[46] Given the nature of the information, the patient has an unquestionable interest in the records, and this constitutes strong justification for being granted access to them. As noted above, medical records ensure that a comprehensive medical history, containing details of diagnosis and treatment, is available to the individual concerned.

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[45] Section 3.

[46] *Breen v Williams* (1994) 35 NSWLR 522 at 547 (Kirby P).

It may be argued that their value in providing such a history would be frustrated if patients could not obtain access to them, either for their own reference or to pass on to a third party such as a legal or medical adviser. The ability to provide medical records to third parties is becoming increasingly important as people become more mobile and have a wider array of choices on health care. Many people, including young people, seek the services of several different healthcare professionals, such as general practitioners, nurses and specialists, as well as of allied healthcare professionals such as physiotherapists, chiropractors, osteopaths, optometrists, pharmacists, psychologists, etc. Patients and their medical advisers need each of the pieces of information held by these various health care professionals to form a whole picture of the patient's health.[47]

9.31 There are other practical reasons for giving patients access to their records. For example, it improves the relationship between patients and medical practitioners, which contributes to better health care for patients. Several studies suggest that sharing medical records with patients improves communication between patients and medical practitioners, increases patients' trust and confidence in their medical practitioners, helps them deal with their condition and increases their compliance with treatments.[48]

Arguments against granting patient access

9.32 A key objection to granting patient access is that the records may be meaningless to the patient or may be misinterpreted. This argument may have particular validity when the patient is a young person. However, it has been said that if the records are in fact meaningless, while they may not help the patient, neither will they cause harm.[49] As regards the risk of misinterpretation, this can be minimised through the use of non-technical terminology or by advising a patient that they should seek assistance in understanding the records from a healthcare professional or other third party, such as a parent.[50]

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47. See the discussion in *McInerney v McDonald* (1992) 93 DLR (4th) 415 at 421 (La Forest J).
48. F Tomson, "Sharing problem cards with patients" (1985) 35 *Journal of the Royal College of General Practitioners* 534; A P Bird and M Walji, "Our patients have access to their medical records" (1986) 292 *British Medical Journal* 595; M Baldry, C Cheal, B Fisher, M Gillet and V Huet, "Giving patients their own records in general practice: experience of patients and staff" (1986) 292 *British Medical Journal* 596.
49. *McInerney v McDonald* (1992) 93 DLR (4th) 415 at 428 (La Forest J).
50. *McInerney v McDonald* (1992) 93 DLR (4th) 415 at 429 (La Forest J) .

9.33 The cost of providing access may be raised as a practical justification for denying or limiting it. However, it has been pointed out that changes in technology, in relation to both information and medical technology, make the provision of a patient's file realistic and inexpensive.[51] Furthermore, access to and copying of the files may be made conditional on payment by the patient of reasonable costs.

9.34 There is a concern that patient access may lead to a decrease in completeness and candour in medical records. However, medical practitioners have an obligation to keep accurate records and failure to do so may make them liable for professional misconduct or negligence.[52] Given this background, it is unlikely that a responsible and ethical medical practitioner would omit from a medical record information that, in the interests of medical care, belonged in it merely because of the possibility that the patient may ask to inspect it.[53] Indeed, some studies suggest that recording of patient information is not materially affected by the knowledge that patients may be given access to the records.[54]

9.35 A further common concern is that in certain circumstances, granting access to records may cause distress to the patient to an extent that may hinder treatment. The argument is that patients may become so emotionally distraught on disclosure of medical information that they may not be able to make a rational decision about their treatment or may suffer psychological damage. However, some studies indicate that access to records does not make patients unduly anxious. On the contrary, access to their health information is reassuring, informative and helpful to patients.[55]

The common law position

9.36 In Australia, a patient has no right of access to his or her medical records apart from statute.[56] However, an exception to this general position

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[51] *Breen v Williams* (1994) 35 NSWLR 522 at 547 (Kirby P).

[52] *McInerney v McDonald* (1992) 93 DLR (4th) 415 at 429 (La Forest J).

[53] See Ontario, Commission of Inquiry into the Confidentiality of Health Information, *Report of the commission of inquiry into the confidentiality of health information* (Toronto, 1980) vol 2 at 487.

[54] A P Bird and M Walji, "Our patients have access to their medical records" (1986) 292 *British Medical Journal* 595; S Bloch, C Riddell and T Sleep, "Can patients safely be allowed to look after their own medical records?" (1994) 161 *Medical Journal of Australia* 665.

[55] See studies cited in M Gilhooly and S McGhee, "Medical records: practicalities and principles of patient possession" (1991) 17 *Journal of Medical Ethics* 138 at 140-141.

[56] *Breen v Williams* (1996) 186 CLR 71.

may arise if the records are documents that the medical practitioner obtained on behalf of the patient, such as x-ray photographs:

> Documents created merely for the purposes of the doctor, for example, as records of his practice, as material from which to assess charges and the like will be the property of the doctor. On the other hand, some documents created for the purpose of enabling the doctor to diagnose and to determine the treatment to be recommended may be the property of the patient. Thus, a document, though held by the doctor, may be the property of the patient because it was procured by or for the patient and has been paid for by her. X-rays, pathology reports and some reports by consultant specialists may be such .... Correspondence with consultant specialists or with treating hospitals may, if of this kind, be the property of the patient.[57]

9.37 The position in Australia is in contrast to that in Canada[58] and England,[59] where courts have held that patients have a right of access to their medical records at common law.

Legislation allowing access to medical records

9.38 Although there is no common law right of access to medical records, legislation in New South Wales allows patients to obtain access to their records, subject to certain limitations.

Freedom of Information Act 1989 (NSW)

9.39 Patients of State hospitals or other public sector healthcare providers may invoke the *Freedom of Information Act 1989* (NSW), which gives a person "a legally enforceable right to be given access to [a public sector] agency's documents in accordance with this Act."[60] It is acceptable for a parent to make an application on behalf of a child.[61] However, where

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[57] *Breen v Williams* (1994) 35 NSWLR 522 at 560-561 (Mahoney JA); see also *Breen v Williams* (1996) 186 CLR 71 at 88 (Dawson and Toohey JJ).

[58] *McInerney v MacDonald* [1992] 2 SCR 138.

[59] *R v Mid Glamorgan Family Health Services Authority; ex parte Martin* [1995] 1 WLR 110. The right of patients in the UK is also recognised in legislation: see *Access to Health Records Act 1990* (UK).

[60] *Freedom of Information Act 1989* (NSW) s 16. Patients in public hospitals may also invoke s 14 of the *Privacy and Personal Information Act 1988* (NSW), which requires a public sector agency that holds personal information about an individual to provide that individual with access to the information. However, when the *Health Records and Information Privacy Act 2002* (NSW) becomes effective, the definition of "personal information" in *Privacy and Personal Information Act* will not include health information within the meaning of the new Act.

[61] NSW Premier's Department, *Freedom of information procedure manual* (3rd ed, 1994) at para 4.3.1.

disclosure of a young person's medical records would prejudice his or her interests or otherwise be "unreasonable", a parent may be denied access.[62] Young people may also make an independent application for access to their medical records under this Act, although the *Freedom of Information Procedure Manual*, issued by the NSW Premier's Department, advises that if the young person cannot understand the nature of the Freedom of Information Act process, the agency may decide to grant access via a third party, such as the young person's parent.[63]

9.40 Access to medical records is subject to a significant condition. The Act provides that in the case of documents containing information of a medical or psychiatric nature, if the agency considers that disclosure of the information may have an adverse effect on the physical or mental health of the applicant, it is sufficient compliance if access to the document is given to a registered medical practitioner nominated by the applicant.[64]

Issue 9.7

(a) Should the *Freedom of Information Act 1989* (NSW) contain additional limitations on access to medical records by a young person, such as those found in the NSW Premier's Department's *Freedom of Information Procedure Manual*?
(b) Is the "unreasonable" disclosure provision in the *Freedom of Information Act 1989* (NSW) a sufficient control on parental access to medical records?

Private Hospitals Regulation 1996 (NSW)

9.41 Patients in private hospitals have an express right of access to their medical records. The *Private Hospitals Regulation 1996* (NSW) requires private hospitals to maintain clinical records of every patient. Access to these records can be requested by and granted to a patient or a patient's representative.[65] If the patient is under the age of 16 years, his or her parents are automatically considered to be a "patient's representative" and can therefore request and be granted access to the patient's medical record without the consent of the patient.[66] However, the hospital may refuse access to a patient's representative, as well as to the patient, if:

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[62] *Freedom of Information Act 1989* (NSW) Sch 1 Pt 2 cl 6.

[63] NSW Premier's Department, *Freedom of information procedure manual* (3rd edn, 1994) at para 4.3.2.1.

[64] *Freedom of Information Act 1989* (NSW) s 31(4). Section 25 of the Act lists the general grounds for refusing access to personal information (for example, if it is a document that is usually available for purchase or is an exempt document under the Act) but they do not seem to apply to medical records.

[65] *Private Hospitals Regulation 1996* (NSW) Sch 1 cl 42(1) and (2).

[66] Clause 4(1).

- the medical practitioner or dentist in charge of the care of the patient advises that the request should be refused; and
- the licensee of the private hospital is satisfied that access by the patient or representative would be prejudicial to the patient's physical or mental health.[67]

Issue 9.8

(a) Should the *Private Hospitals Regulation 1996* (NSW) contain any additional limits on the right of young people to access their clinical records? For example, should the ability to request access be limited by a test of capacity?
(b) Should the *Private Hospitals Regulation 1996* (NSW) contain additional grounds of refusal to grant access to a young person's parent, in their capacity as a patient's representative? For example, should access by a parent be dependent upon access being in the under-age patient's best interests or some other test?

Health Records and Information Privacy Act 2002 (NSW)

9.42 The *Health Records and Information Privacy Act 2002* (NSW) confers a general right of patient access to medical records. In so doing, it extends the scope of patient access beyond records held by public or private hospitals to records held by general practitioners and specialists who have their own practice. The Act provides that "[a]n organisation that holds health information must, at the request of the individual to whom the information relates and without excessive delay or expense, provide the individual with access to the information."[68] For public sector agencies, the limitations and conditions under the *Freedom of Information Act 1989* (NSW) continue to apply.[69] More detailed scope to deny access is given to private sector organisations. A private sector health professional is not required to provide an individual with access to their medical records if:

- providing access would pose a serious threat to the life or health of the individual or any other person and refusing access is in accordance with guidelines issued by the Privacy Commissioner;[70]

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[67] Schedule 1 cl 42(3). A similar right is given to residents of nursing homes: *Nursing Homes Regulations 1990* (NSW) Sch 1 cl 47.

[68] *Health Records and Information Privacy Act 2002* (NSW) Sch 1 Health Privacy Principle 7(1).

[69] *Health Records and Information Privacy Act 2002* (NSW) s 22.

[70] If the refusal is based on the ground of serious threat to the life or health of the individual who requested access, the individual may request that access to the information be given to their nominated registered medical practitioner: *Health Records and Information Privacy Act 2002* (NSW) s 30.

- providing access would have an unreasonable impact on the privacy of other individuals and refusing access is in accordance with guidelines issued by the Privacy Commissioner;
- the information relates to existing or anticipated legal proceedings between the private sector person and the individual and the information would not be accessible by the process of discovery in those proceedings or is subject to legal professional privilege;
- providing access would reveal the intentions of the private sector person in relation to negotiations, other than about the provision of a health service, with the individual in such a way as to expose the private sector person unreasonably to disadvantage;
- providing access would be unlawful;
- denying access is required or authorised by or under law;
- providing access would be likely to prejudice an investigation of possible unlawful activity;
- providing access would be likely to prejudice a law enforcement function by or on behalf of a law enforcement agency;
- a law enforcement agency performing a lawful security function asks the private sector person not to provide access to the information on the basis that providing access would be likely to cause damage to the security of Australia;
- the request for access is of a kind that has been made unsuccessfully on at least one previous occasion and there are no reasonable grounds for making the request again; or
- the individual has been provided with access to the health information in accordance with this Act and is making an unreasonable, repeated request for access to the same information in the same manner.[71]

9.43 The Act does not expressly deal with access to young people's medical records. However, the legislation has a general provision on capacity. The Act provides that where an individual is incapable, by reason of their age or other stated factor, of understanding the general nature and effect of an act, or is incapable of communicating their intentions with respect to the act, they are incapable of doing that act.[72] Accordingly, a young person who does not understand the implications or consequences of requesting access to their medical records is not capable of making such a request under the *Health Records and Information Privacy Act 2002.* In this type of situation, an authorised representative of the individual, such as a parent,[73] may

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[71] Section 29.

[72] Section 7(1).

[73] Section 8(1)(c).

make the request on his or her behalf.[74] An authorised representative is prohibited from acting on behalf of a capable individual, unless the individual grants express authorisation for the representative to do so.[75]

Issue 9.9

(a) Should the right of access to medical records, conferred by the *Health Records and Information Privacy Act 2002* (NSW), be extended to all young people?
(b) If not, is the statutory test of capacity an appropriate limitation on access or would some other test be more appropriate?
(c) Should the *Health Records and Information Privacy Act 2002* (NSW) contain any additional limitations on the exercise of the right of access by those young people who have that right?
(d) Should parents have an independent right of access to their children's medical records in circumstances where the young person is capable of exercising his or her own right of access? If so, under what circumstances?

RETENTION OF YOUNG PEOPLE'S HEALTH INFORMATION

9.44 The *Health Records and Information Privacy Act 2002* (NSW) provides general principles on the retention of health information:

- The information is kept for no longer than is necessary for the purposes for which the information may lawfully be used.
- The information is to be disposed of securely and in accordance with any requirements for the retention and disposal of health information.[76]

9.45 There are minimum time limits on the retention of health information. In the case of health information collected while an individual was under the age of 18 years, a private health service provider (for example, general practitioners and specialists in private practice, and private hospitals) must retain the information until the individual has attained the age of 25 years.[77]

9.46 The rules that apply to public health service providers are different and are governed by regulations issued pursuant to the *State Records Act 1998* (NSW). The time limits depend on the nature of the information and the agency that holds it:

- records relating to patients admitted to a hospital - 15 years after young person turns 18;

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[74] Section 7(2).
[75] Section 7(3).
[76] Schedule 1 (Health Privacy Principle 5).
[77] Section 25(1).

- records of attendance and treatment of patients presenting to accident and emergency/casualty - 7 years after young person turns 18;
- records of attendance and treatment of clients of a community health centre – 7 years after young person turns 18;
- records maintained by school screening nurses to monitor the health of school children
  - retain until the child leaves school if no abnormality was detected,
  - retain as a community health record if abnormality was detected.[78]

Issue 9.10

Is the law dealing with the retention of young people's health information adequate?

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[78] *General Disposal Authority – Public Health Services: Patient/Client Records (GDA5) (1999)* (NSW). This Disposal Authority was issued under Part 3, s 21(2)(c) of the *State Records Act 1998* (NSW). It has been approved by the Board of the State Records Authority in accordance with Part 3, s 21(3) of the *State Records Act 1998* (NSW).

10.

Consolidation or codification?

10.1 The law governing the consent of young people to medical treatment is a complex combination of legislation and common law. As is explained in Chapter 2, this current legal framework lacks both clarity and consistency, with definitions of core concepts varying[1] or, in some instances, lacking.[2] In addition to these definitional problems, the framework is piecemeal in nature and lacks a coherent policy direction. These problems are largely attributable to the limited scope of statutory regulation and the separate development of the common law.

10.2 The absence of a clear legal framework may leave medical practitioners unable to provide medical treatment with the relative certainty of the law. Similarly, young people and their parents may encounter difficulties when medical treatment is sought. In recognition of these concerns, the terms of reference direct the Commission to consider whether the law should be codified or whether amendment is appropriate.

10.3 Codification would entail replacing all existing statute and common law with a statute, or group of statutes, that dealt with young people's consent to medical treatment in a comprehensive and self-contained manner. The self-contained nature of codified legislation means that recourse to other sources of law, including the common law, would be excluded. This would provide easier access to and greater clarity of the law. In addition, principles and guidelines could be included in the codified legislation to enhance its value as a practical tool for individuals on both sides of the doctor-patient relationship. However, while codification offers significant advantages, it is not without disadvantages. One of the most compelling objections to codification is that a statutory code is less able to evolve with society than the common law.

10.4 If it is determined that the law should not be codified, an option would be to consolidate the law. Consolidation would involve bringing together all relevant statutory provisions in one statute or in a group of statutes. Significantly, the common law principles would continue to apply in conjunction with the consolidated legislation. While this would create a potential lack of clarity, retention of the common law would enable development of the law without the need for statutory amendment.

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[1] Compare, for example, the definitions of "medical treatment" in s 49(4) of the *Minors (Property and Contracts) Act 1970* (NSW) and s 33(1) of the *Guardianship Act 1987* (NSW).

[2] There is no comprehensive definition of "consent" in either statute or common law.

Issue 10.1

(a) Is the law that governs the consent of young people to medical treatment obscure?

(b) Should the law that governs the consent of young people to medical treatment be codified?

(c) If not, should the law that governs the consent of young people to medical treatment be consolidated?

Appendix A.

Summary table of models for reform

Model One	**Assess individual's level of understanding**
Test to decide legal competence	**Basic model:** Young person understands the nature and possible consequences of the treatment. **Possible additional criteria:** ▪ Treatment is in young person's best interests. ▪ Presumption of competence for young person above certain age (eg, 14). ▪ Written support for treating medical practitioner's opinion from a second medical practitioner.
Advantages	▪ Recognises young people as individuals with varying degrees of maturity in respect of each other and in respect of the type of treatment in question. ▪ Additional criteria provide safeguards against medical practitioner's error of judgment and against young people acting to their own detriment.
Disadvantages	▪ Uncertainty about the appropriate level of understanding required, with possible need for guidelines to promote consistency in assessment. ▪ Reliance on individual medical practitioner's ability to make fair assessment, where medical practitioners vary in degrees of training and experience in treating young people. ▪ Difficult to challenge medical practitioner's decision before the effects of that decision are made known. ▪ Question the practical effectiveness of the additional criteria as safeguards.
Discussion in Issues Paper	See para 3.10-3.21.

Model Two	**Fixed cut-off age**
Test to decide legal competence	**Basic model:** Young person is above a certain age (eg, 14). **Possible additional criteria:** General rule could be subject to exceptions for certain types of treatment to which a person of any age could consent (eg treatment for a sexually transmitted disease).
Advantages	▪ Certainty and consistency in application of test, without reliance on individual medical practitioner's judgment. ▪ Exceptions for specified types of treatment would ensure that certain types of treatment are available to all young people, where public policy dictates that it should be.
Disadvantages	▪ Does not accommodate individual rates of maturity and deprives some young people of the right to make their own decisions about particular types of treatment when they have a sufficient level of maturity to do so in respect of the particular type of treatment in question.
Discussion in Issues Paper	See para 3.22-3.23.

Model Three	**Combination test**
Test to decide legal competence	Young people over a certain age (eg, 14) may be competent to decide if the treating medical practitioner considers that they have sufficient understanding of the nature and possible consequences of the treatment.
Advantages	Strikes balance between accommodating rates of individual development and consequences of a medical practitioner wrongly deciding that a young person is legally competent to decide.
Disadvantages	• May be too complicated to operate effectively in practice. • Deprives individuals below the cut-off age of the right to make decisions where they may be sufficiently mature to do so in respect of the particular type of treatment in question.
Discussion in Issues Paper	See para 3.24-3.26.

Model Four	**Assess competence according to type of medical treatment**
Test to decide legal competence	Young person of any age can consent to (or, possibly, refuse) specified types of treatment (eg, termination of pregnancy, certain types of contraception).
Advantages	• Certainty and consistency in application of test. • Easy for medical practitioners to know and apply. • Ensures that no young people are deprived of certain types of treatment that, for public policy reasons, they should have ready access to.
Disadvantages	• Question whether it is adequate, as the sole test for legal competence, to recognise young people's right to make decisions about their lives and provide them with access to appropriate health care. • Difficulties in identifying and agreeing on all the types of treatment to which young people should be able to consent (or refuse).
Discussion in Issues Paper	See para 3.27-3.29.

Model Five	**Assess competence according to specific groups of young people**
Test to decide legal competence	**Basic model:** Young people who fall within a particular category are automatically considered competent, eg, young people who are married or living in de facto relationships, who are parents or who are estranged from their parents. **Possible additional criteria:** Treating medical practitioner considers that proposed treatment is in the young person's best interests.
Advantages	• Overcomes practical difficulties in providing health care to these groups of young people, where it may not be appropriate or possible to seek their parents' consent. • Additional "best interests" criterion provides safeguards against young people in these groups acting to their own detriment.
Disadvantages	• Test may be considered arbitrary: membership of one of these groups does not necessarily connote maturity and other young people not in these groups may be sufficiently mature to understand the treatment in question.
Discussion in Issues Paper	See para 3.30-3.31.

Appendix B.

List of Submissions

List of Submissions

1. Androgen Insensitivity Syndrome Support Group, 22 January 2003
2. Commissioner for Children and Young People, February 2001
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Select Bibliography

Abrams, R, *Electroconvulsive Therapy* (Oxford University Press, New York, 1997)

Adhikari, P and Summerill, A, *1998 National Drug Strategy Household Survey: Detailed Findings* (Drug Statistics Series No. 6, Australian Institute of Health and Welfare, Canberra, 1998)

Alberta Institute Of Law Research And Reform, *Consent of Minors to Health Care* (Report, 1975)

Alderson, P, *Children's Consent to Surgery* (Open University Press, Buckingham, 1993)

Al-Yaman, Bryant, M and Sargeant, H, *Australia's Children: Their Health and Wellbeing 2002* (AIHW, Canberra, 2002)

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* (American Psychiatric Association, Washington DC, 2000)

Australian Bureau of Statistics and Australian Institute Of Health and Welfare, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2003* (ABS, Canberra, 2003)

Australian Bureau of Statistics, "Selected Risks Faced by Teenagers" in *Australian Social Trends* (Commonwealth of Australia, Canberra, 2002)

Australian Human Rights And Equal Opportunity Commission, *Background Paper for the National Inquiry Concerning the Human Rights of People with Mental Illness* (Canberra, AGPS, 1992)

Australian, Human Rights And Equal Opportunity Commission, *Our Homeless Children: Report of the National Inquiry Into Homeless Children* (AGPS, Canberra, 1989)

Australian Institute of Criminology, *Australian Crime: Facts and Figures 2002* (AIC, Canberra, 2002)

Australian Institute of Health and Welfare, *Young Homeless People in Australia 2001–2002* (AIHW, Canberra, 2003)

Bain, K, "Children with Severe Disabilities: Options for Residential Care" (1998) 169 *Medical Journal of Australia* 598

Bainham, A, "The Judge and the Competent Minor" (1992) 108 *Law Quarterly Review* 194

Baldry, M, Cheal, C, Fisher, B, Gillet, M and Huet, V, "Giving Patients Their Own Records in General Practice: Experience of Patients and Staff" (1986) 292 *British Medical Journal* 596

Bartholomew, T and Paxton, S, "General Practitioners' Perspectives Regarding Competence and Confidentiality in an Adolescent with Suspected Anorexia

Nervosa: Legal and Ethical Considerations" (2003) 10 *Journal of Law and Medicine* 308

Bennett, D and Rowe, L, *What to Do When Your Children Turn into Teenagers* (Doubleday, Sydney, 2003)

Bird, A P and Walji, M, "Our Patients Have Access to their Medical Records" (1986) 292 *British Medical Journal* 595

Blackstone, W, *Commentaries on the Laws of England* (17th edition, Sweet & Maxwell, London, 1830)

Bloch, S, Riddell, C and Sleep, T, "Can Patients Safely be Allowed to Look After their Own Medical Records?" (1994) 161 *Medical Journal of Australia* 665

Boyle, G, "Electroconvulsive Shock Treatment: Does It Induce Brain Damage and Memory Loss?" (1988) 23 *Australian Psychologist* 62

Brady, S and Grover, S, *The Sterilisation of Girls and Young Women in Australia: A Legal, Medical and Social Context* (Human Rights and Equal Opportunity Commission, Sydney, 1997)

Brady, S, Briton, J and Glover, S, *The Sterilisation of Girls and Young Women in Australia: Issues and Progress* (Human Rights and Equal Opportunity Commission, Sydney, 2001)

Bunney, L, "The Capacity of Competent Minors to Consent to and Refuse Medical Treatment" (1997) 5 *Journal of Law and Medicine* 52

Canada, Uniform Law Conference, *Proceedings of the Fifty-Seventh Annual Meeting of the Uniform Law Conference of Canada* (1975)

Carney, T and Tait, D, *The Adult Guardianship Experiment: Tribunals and Popular Justice* (Federation Press, Sydney, 1997)

Carney, T, "Regulation of treatment of severe anorexia nervosa: assessing the options" (2002) 11 *AHLB* 25

Cauffman and Steinberg, "The Cognitive and Affective Influences on Adolescent Decision-Making" (1995) 68 *Temple Law Review* 1763

Centre For Mental Health, *Mental Health Act Guide Book* (NSW Institute of Psychiatry, Parramatta, 2003)

Chamberlain, C and Mackenzie, D, *Counting the Homeless, 2001* (Australian Bureau of Statistics, cat. no. 2050.0, 2001)

Chamberlain, C and Mackenzie, D, *Youth Homelessness 2001* (RMIT, Melbourne, 2002)

Chambon, A, "Refugee Families' Experiences: Three Family Themes – Family Disruption, Violent Trauma and Acculturation" (1989) 8 *Bonus Issue* 3

Council on the Cost of Government, *NSW Government Programs for Aboriginal People: Service Efforts and Accomplishments 1998* (Council on the Cost of Government, Sydney, 1998)

De Cruz, S P, "Parents, Doctors and Children: The *Gillick* Case and Beyond" [1987] *Journal of Social Welfare Law* 93

Duffett, R, Hill, P and Lelliott, P, "Use of Electroconvulsive Therapy in Young People" (1999) 175 *British Journal of Psychiatry* 228

England and Wales, Law Commission, *Report of the Committee on the Age of Majority* (Cmnd 3342, HMSO, London, 1967)

Family Court of Australia, *A Question of Right Treatment, The Family Court and Special Medical Procedures for Children – An Introductory Guide* (1998) (Victorian version) (as at 9 March 2004)
«www.familycourt.gov.au/html/medical_procedures.html»

Family Law Council, *Sterilisation and Other Medical Procedures on Children: A Report to the Attorney General* (AGPS, Canberra, 1994)

Frankel, F, "Electroconvulsive Therapy in Massachusetts: A Task Force Report" (1973) 3 *Massachusetts Journal of Mental Health* 3

Freckleton, I and Wilson, B, "Electroconvulsive Therapy: Law, History and Practice" (2001) 8 *Journal of Law and Medicine* 389

Gething, L, Poynter, T and Reynolds, F, *Disability Awareness Package - Manual* (Community Disability and Ageing Program, University of Sydney, 1991)

Gilhooly, M and Mcghee, S, "Medical Records: Practicalities and Principles of Patient Possession" (1991) 17 *Journal of Medical Ethics* 138

Grisso, T and Vierling, L, "Minors' Consent to Treatment: A Developmental Perspective" (1978) 9 *Professional Psychology* 412

Hong Kong Law Reform Commission, *Young Persons - Effects of Age in Civil Law* (Topic 11, 1986)

Institute of Law Research and Reform, University of Alberta, *Consent of Minors to Health Care* (Report 19, 1975)

Kennedy, I, "The Doctor, the Pill and the Fifteen Year Old Girl" in Kennedy, I, (ed) *Treat Me Right* (Oxford, Clarendon Press, 1988)

Koocher and De Maso, "Children's Competence to Consent to Medical Procedures" (1990) 7 *Pediatrician* 68

Law Reform Commission of Western Australia, *Consent to Sterilisation of Minors* (Project 77 Part 2, 1994)

Law Reform Commission of Western Australia, *Medical Treatment for Minors* (Discussion Paper, Project 77, 1988)

Llewellyn, G, Dunn, P, Fante, M, et al, *Families with Young Children with Disabilities and High Support Needs* (Sydney: University of Sydney Family Support and Services Project, 1996)

Lloyd, G (ed), *Hippocratic Writings* (Penguin, Harmondsworth, 1978)

Loughrey, J, "Medical Information, Confidentiality and a Child's Right to Privacy" (2003) 23 *Legal Studies* 510

Luntz, J, *Report on the Usage of Child and Adolescent Mental Health Services by NESB Adolescents and their Families* (Child and Adolescent Mental Health Services, 1998) (as at 9 March 2004) «www.mmha.org.au/library/services/specialist_reports/camhs_main.html».

Manitoba Law Reform Commission, *Minors' Consent to Health Care* (Report 91, 1995)

Martin, G, "Depression in Teenagers" (1996) 37 *Current Therapeutics* 57

Martin, R, *Sterilisation of People with Intellectual Disability: A Discussion Paper* (Intellectual Disability Services Council, Adelaide, unpublished paper, 1998)

Mccabe, M, "Involving Children in Medical Decision Making: Developmental and Clinical Considerations" (1996) 4 *Journal of Pediatric Psychology* 505

Mendelson, D, "Historical Evolution and Modern Implications of Concepts of Consent to, and Refusal of, Medical Treatment in the Law of Trespass" (1996) 17 *Journal of Legal Medicine* 1

Mitchell, P, *Valuing young lives: Evaluation of the National Youth Suicide Prevention Strategy* (Australian Institute of Family Studies, Commonwealth of Australia, 2000)

Montgomery, J, *Health Care Law* (Oxford, Oxford University Press, 2003)

Moon, L, Meyer, P and Grau, J, *Australia's Young People: Their Health and Wellbeing 1999* (Australian Institute of Health and Welfare, Canberra, 1999)

Murray, K, "Medical Procedures – Is the Law Effective?" (Paper presented at the 3rd National Family Court Conference, Melbourne, 20-24 October 1998)

National Institutes of Health and National Institute of Mental Health, *Electroconvulsive Therapy: Consensus Development Conference and Statement, No 11* (1985)

Newman, A, "Adolescent Consent to Routine Medical and Surgical Treatment: A Proposal to Simplify the Law of Teenage Medical Decision-Making" (2001) 22 *Journal of Legal Medicine* 501

Nicholson, A, Harrison, M And Sandor, D, "The Role of the Family Court in Medical Procedure Cases" (1996) 2 *Australian Journal of Human Rights* 242

NSW Centre For The Advancement of Adolescent Health, Children's Hospital At Westmead, *Access to Health Care Among NSW Adolescents* (Phase 1, Final Report, Research Report, May 2002)

NSW Department of Community Services, *Out of Home Care: Fact Sheet* (2002)

NSW Health, *Caring for Mental Health in a Multicultural Society: A Strategy for the Mental Health Care of People from Culturally and Linguistically Diverse Backgrounds* (NSW Department of Health, Sydney 1998)

NSW Health, *NSW Strategy: Making Mental Health Better for Children and Adolescents* (NSW Department of Health, Sydney 1999)

NSW Health, *Prevention Initiatives for Child and Adolescent Mental Health: NSW Resource Document* (NSW Department of Health, Sydney, 2002)

NSW Law Reform Commission, *Infancy in Relation to Contracts and Property* (Report 6, 1969)

NSW Law Reform Commission, *People with an Intellectual Disability and the Criminal Justice System: Courts and Sentencing Issues* (Discussion Paper 35, 1994)

O'Connor, I and Mcmillan, A, "Youth, the Law and Health: Emerging Issue in Service Delivery (April 1987) *Queensland Law Society Journal* 95

Ontario Commission of Inquiry into the Confidentiality of Health Information, *Report of the Commission of Inquiry into the Confidentiality of Health Information* (Toronto, 1980)

Parkinson, P, "Children's Rights and Doctors' Immunities: The Implications of the High Court's Decision in Re Marion" (1992) 6 *Australian Journal of Family Law* 101

Piaget, J and Inhelder, B, *The Psychology of the Child* (Basic Books, New York, 1969)

Queensland Law Reform Commission, *Consent to Health Care of Young People* (Report 51, 1996)

Queensland Law Reform Commission, *Consent to Medical Treatment of Young People* (Discussion Paper, WP 44, 1995)

Reddy, D, Fleming, R and Swain, C, "Effect of Mandatory Parental Notification on Adolescent Girls Use of Sexual Health Care Services (2002) 288 *Journal of American Medical Association* 710

Rice, P, Rice, A and Dhamarak, P, "'Some day, when my health is good ...': The Experiences of Young Southeast Asian Refugees in Australian Schools" (1993) *Youth Studies Australia* 39

Roberts, L, "Informed Consent and the Capacity for Voluntarism" (2002) 159 *American Journal of Psychiatry* 705

Saskatchewan Law Reform Commission, *Proposals for a Consent of Minors to Health Care Act* (Report to the Attorney General, February 1980)

Sawyer, M G, Arney, F M, Baghurst, P A, Clark, J J, Graetz, B W, Kosky, R J, Nurcombe, B, Patton, G C, Prior, M R, Raphael, B, Rey, J, Whaites, L C and Zubrick, S R, *Mental Health of Young People in Australia* (Commonwealth Department of Health and Aged Care, Canberra, 2000)

Scottish Law Commission, *Report on the Legal Capacity and Responsibility of Minors and Pupils* (Scot Law Com No.110, HMSO, Edinburgh, 1987)

Skene, L, *Law and Medical Practice: Rights, Duties, Claims and Defences* (2nd ed, LexisNexis Butterworths, Sydney, 2004)

Susman, E, "Participation in Biomedical Research: The Consent Process as Viewed by Children, Adolescents, Young Adults and Physicians" (1992) 121 *Journal of Pediatrics* 547

Tait, D, Carney, T and Deane, K, "Legal Resolution of Sterilisation: The Role of Guardianship Tribunals in NSW and Victoria" (1994) 8 *Australian Journal of Family Law* 141

Tomson, F, "Sharing Problem Cards with Patients" (1985) 35 *Journal of the Royal College of General Practitioners* 534

United Nations Committee on the Rights of the Child, *Adolescent health and development in the context of the Convention on the Rights of the Child* (General Comment No.4, 2003, CRC/GC/2003/4)

Wallace, M, *Health Care and the Law* (3rd edition, Lawbook Co, Sydney, 2001)

Weithorn, L A and Campbell, S B, "The Competency of Children and Adolescents to Make Informed Treatment Decisions" (1983) 9 *Child Development* 285

Western Melbourne Division of General Practice, *Enhancing Refugee Young People's Access to Health Services* (2000)

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