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Young People and Consent to Health Care

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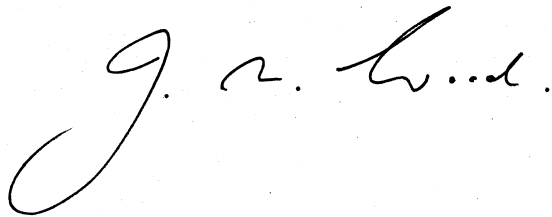
Letter to the Attorney General

To the Hon John Hatzistergos
Attorney General for New South Wales

Dear Attorney

Young People and Consent to Health Care

We make this Report pursuant to the reference to this Commission received 14 August 2002.

A handwritten signature in black ink, appearing to read 'J. Wood', is centered on the page. The signature is written in a cursive style with a large initial 'J' and a period after the last name.

The Hon James Wood AO QC

Chairperson

October 2008

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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

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The recommendations in this report are those of the Commission and do not necessarily reflect the views of the members of the National Expert Advisory Panel.

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PREVIOUS PUBLICATIONS

Minors' Consent To Medical Treatment, Issues Paper 24 (2004).

SUBMISSIONS AND CONSULTATIONS

In response to Issues Paper 24, the Commission received 13 written submissions. These are listed in Appendix A to this report. We also conducted a number of face-to-face consultations with individuals and groups whom we identified as having a specific interest or experience in this area. These are listed in Appendix B to this report.

PUBLIC FORUMS AND SEMINARS

The Commission held a seminar, "Minors' Consent to Medical Treatment" at Parliament House, Sydney, as part of Law Week in May 2004.

In November 2004, the Commission participated in a seminar, "Consent to Medical Treatment of Young People in Detention" organised by the Institute of Criminology, University of Sydney, and the Australasian Chapter of the International Academy of Law and Mental Health.

In collaboration with the Faculty of Law, Macquarie University, the Commission conducted a public forum on Minors' Consent To Medical Treatment at Parliament House, Sydney, in November 2006. A number of experts in this area spoke at the forum. The program of the forum appears in Appendix C to this report.

The Commission led a session, “Consent of Young People to Medical Treatment”, at a paediatric postgraduate seminar for general practitioners at the Children’s Hospital at Westmead in August 2007. Seminar attendants completed a survey aimed at gaining insight into the perspective of the GP population in treating young people.

LIST OF RECOMMENDATIONS

Recommendation 1 - *see page 11*

Legislation should regulate the decision-making process for young people's health care. The legislation should contain rules for determining:

- when a young person is legally entitled to make a decision about his or her health care generally;
- when a young person is legally entitled to make a decision about particular types of health care; and
- when a young person's parent, legal guardian, caregiver or other substitute decision-maker is legally entitled to override a young person's decision about his or her health care.

The legislation should also provide:

- for the legal consequences of compliance or non-compliance with its provisions;
- definitions of key terms; and
- a statement of principles to guide the interpretation and application of the legislation.

Recommendation 2 - *see page 60*

The legislation should include a provision setting out the following principles to be applied in the interpretation and application of the legislation:

- Young people should be informed about matters relating to their health care, to the extent and in a manner appropriate to their age and maturity, and should be given the opportunity to express their views freely about these matters, and their views should be given due weight in accordance with their age and maturity.
- The developing autonomy of the young person should be acknowledged.
- Respect should be given to the responsibilities and role of parents in the health care of their child or, where applicable, the members of the extended family or persons legally responsible for the young person, in a manner consistent with the evolving capacities of the young person.
- Account should be taken of the culture, disability, language, religion and sexuality of the young person and, if relevant, those with parental responsibility for the young person.
- Access by young people to appropriate health care should be promoted.
- The best interests of the young person should be the primary consideration.

Recommendation 3 - see page 62

The legislation should adopt the following definitions:

a *young person* means a person who is under the age of 18 years,

a *parent* means a person having parental responsibility for the young person,

parental responsibility means all the duties, powers, responsibilities and authority which, by law, parents have in relation to their children,

a *health practitioner* means a natural person who is registered under a health registration Act,

a *health registration Act* means any of the following Acts:

Chiropractors Act 2001

Dental Technicians Registration Act 1975

Dental Practice Act 2001

Medical Practice Act 1992

Nurses and Midwives Act 1991

Optical Dispensers Act 1963

Optometrists Act 2002

Osteopaths Act 2001

Pharmacy Practice Act 2006

Physiotherapists Act 2001

Podiatrists Act 2003

Psychologists Act 2001

or an Act prescribed by regulations as a health registration Act.

a *health service* is a service provided by a health practitioner and includes the following services, whether provided as public or private services:

- (a) medical, hospital and nursing services,
- (b) dental services,
- (c) mental health services,
- (d) pharmaceutical services,
- (e) ambulance services,
- (f) community health services,
- (g) health education services,
- (h) welfare services necessary to implement any services referred to in paragraphs (a)-(g),
- (i) alternative health care services,
- (j) forensic pathology services,
- (k) a service prescribed by the regulations as a health service for the purposes of this legislation.

Recommendation 4 - *see page 126*

The legislation should provide that:

- a competent young person may accept or refuse health care and it is not necessary to obtain an acceptance or refusal of the health care from the young person's parent or other legal guardian;
- a young person is competent to accept or refuse health care if, in the opinion of the health practitioner offering the health care, the young person understands the information that is relevant to making a decision about the health care, and appreciates the reasonably foreseeable consequences of that decision.

Recommendation 5 - *see page 126*

The legislation should provide that a health practitioner must not rely on the acceptance or refusal of health care of a parent or guardian on a young person's behalf if that acceptance or refusal conflicts with the young person's decision where the young person is competent to make a decision about his or her health care according to Recommendation 4.

Recommendation 6 - *see page 127*

The legislation should provide that:

- a young person who is aged 16 or over is presumed to be competent to make a decision about his or her health care according to Recommendation 4,
- that presumption can be rebutted if, in the opinion of the health practitioner, the young person does not understand the information that is relevant to making a decision about the health care and does not appreciate the reasonably foreseeable consequences of the decision.

Recommendation 7 - *see page 127*

Nothing in Recommendations 4-6 prevents a parent from giving consent to health care on behalf of or in relation to a young person who is not competent to give consent or to decide to accept or refuse health care for reasons other than immaturity, such as unconsciousness or cognitive impairment.

Recommendation 8 - *see page 133*

Section 49 of the *Minors (Property and Contracts) Act 1970* (NSW) should be repealed.

Recommendation 9 - *see page 133*

The definition of incapacity in s 33(2) in Part 5 of the *Guardianship Act 1987* (NSW) should be amended to exclude from its operation any person who cannot consent solely by reason of his or her immaturity.

Recommendation 10 - *see page 133*

The legislative scheme that is recommended in Recommendation 1 should make it clear that it does not apply to people who are incapable of consenting for reasons that bring them within the scope of Part 5 of the *Guardianship Act 1987* (NSW) following amendment according to Recommendation 9.

Recommendation 11 - *see page 146*

The legislation should provide that a young person is competent to accept or refuse health care for his or her children if, in the opinion of the health practitioner offering the care, the young person understands the information relevant to making a decision about the health care, and appreciates the reasonably foreseeable consequences of that decision.

Recommendation 12 - *see page 158*

The legislation should provide a hierarchy of “persons responsible” who are authorised to make decisions concerning the health care of a young person where that young person is not competent to accept or refuse health care and no person having parental responsibility for the young person is available or competent to exercise that parental responsibility.

The list should be expressed in descending order, commencing with:

- a guardian of the young person appointed under law;
- a spouse of the young person;
- a person who has the care of the young person;
- a close friend or relative of the young person;

or where none of the above exist, or are available to make a decision as a person responsible,

- the Guardianship Tribunal.

The legislation should define a person who has the care of a young person as a person who provides, without payment, domestic services and support for the young person on a regular basis or who arranges for the young person to be provided with such services and support.

The legislation should define close friend or relative of the young person as a person who has a close personal relationship with the young person through frequent personal contact, and has a personal interest in the young person’s welfare.

In ascertaining the “person responsible” for the young person, the legislation should recognise the importance of:

- the cultural traditions of young Aboriginal and Torres Strait Islander people; and
- the cultural, linguistic and religious background of young people.

Recommendation 13 - *see page 174*

The legislation should provide that a medical, nurse, midwife or dental practitioner may provide certain treatment to a young person without consent where, in the opinion of the medical, nurse, midwife or dental practitioner:

- the treatment is necessary; and

- the form of treatment will most successfully promote the young person's health and well-being; and
- the young person does not object to the treatment.

Regulations should specify the treatment that practitioners can provide without consent pursuant to this recommendation.

Recommendation 14 - see page 181

The legislation should provide for emergency health care for all young persons to the same effect as s 174(1), (2), (4) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), and should additionally authorise the administration of emergency treatment to prevent the patient from suffering or continuing to suffer significant pain or distress (except in the case of special medical treatment).

Recommendation 15 - see page 181

For the purposes of Recommendation 14, "health care" means medical or dental treatment provided respectively by a medical practitioner registered under the *Medical Practice Act 1992* (NSW) or by a dental practitioner registered under the *Dental Practice Act 2001* (NSW) or treatment by any person pursuant to directions given in the course of the practice of, respectively, medicine or surgery or dentistry by a practitioner so registered.

Recommendation 16 - see page 195

The legislation should provide that a person not carry out special medical treatment on a young person under the age of 16 unless the Guardianship Tribunal consents to the carrying out of the treatment, or unless the treatment is carried out in accordance with the regulations.

The legislation should provide that a person not carry out special medical treatment on a young person aged 16 or over but less than 18 who does not meet the test for competence in Recommendation 4 unless the Guardianship Tribunal consents to the carrying out of the treatment, or unless the treatment is carried out in accordance with the regulations.

The definitions of "special medical treatment", "medical treatment" and "Guardianship Tribunal" should be in similar terms to those appearing in sub-section 175(5) of the current *Children and Young Persons (Care and Protection) Act 1998* (NSW).

Recommendation 17 - see page 197

The Government should appoint a panel of experts to consider from time to time, or as needed, the medical treatments that should be declared to be special medical treatments in the regulations.

Recommendation 18 - see page 212

The legislation should provide that the Guardianship Tribunal must not consent to the carrying out of special medical treatment on a young person under the age of 16, or a young

person aged 16 or 17 who is not competent to consent to health care, unless the Tribunal is satisfied that in all the circumstances it is in the best interests of the young person.

Recommendation 19 - *see page 212*

If Recommendations 16-18 are implemented, Chapter 9 Part 1 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), should be restricted in its application to young persons in need of care and protection.

Recommendation 20 - *see page 213*

The legislation should contain a provision stating that nothing in the Act limits the jurisdiction of the Supreme Court.

Recommendation 21 - *see page 222*

The legislation should provide for it to be a ground for complaint to the Health Care Complaints Commission and/or to the relevant health registration authority that a health practitioner acted in breach of the provisions of the legislation. The legislation should make it clear that any action available to the Health Care Complaints Commission and/or to a health registration authority under the *Health Care Complaints Act 1993* (NSW) or a health registration Act (as defined in Recommendation 3), including alternative dispute resolution, is available to resolve complaints about breaches of this legislation relating to young people's competence.

Recommendation 22 - *see page 222*

The legislation should make it clear that nothing in Recommendation 21 affects any other grounds of liability that might arise from a complaint against a practitioner for breaching the provisions of the legislation.

Recommendation 23 - *see page 222*

The legislation should provide for a defence for health practitioners from civil or criminal liability, or from a complaint made to the Health Care Complaints Commission or a health registration authority, where such action is based on a practitioner's assessment of a young person's competence, according to Recommendation 4 (but not where it is based on grounds other than competence, such as negligence). The defence should be available if the health practitioner reasonably but mistakenly believes that the young person is competent or incompetent, according to the criteria set out in Recommendation 4.

1. Reviewing the Law of Young People's Consent to Health Care

- This report
- The meaning of consent
- The reasons for requiring consent
- The current law relating to consent: a patchwork
- Reforming the law on consent
- Privacy and consent to health care
- Order of discussion of the Commission's reforms

THIS REPORT

1.1 This report is about young people, meaning people below 18 years of age, and the laws that determine when they can make decisions about their health care and when others can make those decisions for them. Young people are not necessarily free to consent to or refuse health care on their own, but are instead constrained by rules that decide when they can do so, and when their parents or guardians, or the State (through its courts and tribunals) can do so for them. By contrast, adults are generally much freer to make these types of decisions on their own, even if those decisions might sometimes seem foolish or harmful to them.

1.2 The Law Reform Commission has reviewed the rules that regulate and impose restrictions on the decision-making process for young people's health care in New South Wales. This report marks the final stage of that review.¹ We have concluded that the current law seems to have gained general support but is, at the same time, disparate, fragmented, often incomplete or uncertain, and sometimes out-of-date and obsolete. There is confusion about its interpretation, and perhaps – although this is difficult to ascertain in any empirically demonstrable way – inconsistency in its application. More fundamentally, the incremental developments of the law have meant that it lacks any considered and uniform statement about the rights and interests of young people, their parents, and others involved in the decision-making process.

1.3 We have re-examined the justifications for the current law, including the restrictions imposed on young people and their parents, and consulted on its practical operation. We have paid special attention to whether or not the law appropriately recognises the rights and interests of young people and their parents or guardians, at the same time as adequately protecting health practitioners.² Central to the recommendations in this report is the implementation of a new legislative framework to regulate the assessment of a young person's competence to consent to or refuse health care, and to delineate the extent of a parent's and the State's involvement in the decision-making after that assessment. The scope and purposes of this legislative framework are set out in Recommendation 1 below, and the details of its provisions are contained in the ensuing recommendations of this report.

1.4 A number of preliminary matters, which are basic to an understanding of this area of the law and to the Commission's recommendations, are addressed in this introductory chapter. They consist of a discussion of:

- the legal concept of consent (what it means and why it is required in a health care setting);
- the patchwork nature of the current law dealing with consent; and
- our general approach towards reform of this area.

1. See also NSW Law Reform Commission, *Minors' Consent To Medical Treatment*, Issues Paper 24 (2004).

2. For the terms of the Commission's reference, see p ix.

THE MEANING OF CONSENT

1.5 “Consent” is a word that is central to the terms of the Commission’s review. But as a legal concept, consent to health care can mean several things. Put more precisely, there are several factors that together make up the legal concept of consent. While the Commission was asked to report on the law relating to young people’s “consent” to medical treatment, it is clear that we were intended to focus on one aspect of consent, that is, capacity to consent.

1.6 It is a general principle of law that a person must consent to health care before it can be lawfully provided.³ A practitioner who treats someone without first gaining a valid consent for the treatment exposes himself or herself to legal liability, at least where the treatment has involved physical contact. In order for a person to be able to give a valid consent to health care (that is, one that can be legally acted upon), that person must:

- have the legal capacity to consent, and
- give the consent voluntarily.

Capacity to consent is the focus of this report

1.7 Capacity sets a minimum standard of decision-making skills that is required in order to recognise the validity of a person’s decision. If these skills are diminished in a particular individual because of some impairment and do not reach this minimum standard, then the law will not allow that person’s decision to be acted upon because it cannot be said to reflect a real choice made by a free-thinking individual. The law generally assumes that adults have capacity, or competence, to make decisions about health care, and for this reason capacity to consent is not usually in issue. That assumption can be rebutted if an adult’s capacity can be shown to be impaired in some way, for example, by mental illness, intellectual disability, or some temporary cause such as unconsciousness. The presence of an impairment such as these does not in itself mean that the adult lacks capacity: he or she will still be considered competent if he or she is capable of understanding in broad terms the nature of what is proposed.⁴

1.8 For young people, however, capacity to consent is a real issue because the law has traditionally assumed that young people lack capacity to make health care decisions by reason of their immaturity. Their parents have generally been given the responsibility of making those decisions on their behalf. The law has developed to a point where it is willing to recognise that young people may have sufficient maturity to be given decision-

3. For situations where consent to health care is not a legal prerequisite, see Chapter 7.

4. *Rogers v Whitaker* (1992) 175 CLR 479, 490, approving *Chatterton v Gerson* [1981] 1 QB 432, 443 (“[O]nce the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real”) (Bristow J). See also *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 115 (“What is required is that the patient knew in broad terms the nature and effect of the procedure to which consent (or refusal) was given”) (Lord Donaldson MR). Compare *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290, 295 (where Bristow J suggested a higher test for refusal cases).

making responsibility in relation to their own health care. But, unlike adults, the law requires something more than a broad understanding in order to recognise a young person's competence: the young person must have sufficient understanding and intelligence to enable him or her to understand fully what is proposed.⁵ It is this standard for legal competence that has come under increasing scrutiny in the context of a broader discussion of the appropriate role for young people in making decisions about health care, and it is this aspect of consent that is central to the Commission's present review.

Voluntariness is another feature of consent

1.9 The requirement that consent be given voluntarily is another way of ensuring that legal force is given only to those decisions that reflect a person's real choice, free from interference by others. This second aspect of consent is outside the terms of this reference. In brief, it means that, before treating a patient, a health practitioner must be satisfied that the patient's apparent consent really represents the will of the patient, rather than that of a third person who has overborne the patient's will.⁶

Consent must also be informed

1.10 There is another legal principle that requires a health practitioner to inform a patient of the material risks of a treatment or procedure before obtaining the patient's consent to it. 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 practitioner is, or should reasonably be, aware that the particular patient would be likely to attach significance to it.⁷ This is sometimes known as the requirement for "informed consent", a term derived from American jurisprudence. The term is misleading in so far as it suggests that the duty to inform is a factor that affects the validity of a patient's consent.⁸ In fact, failure to disclose all the material risks does not mean that the patient has not given a valid consent to the health care in question. Instead, it means that the practitioner may be found to have breached his or her duty of care to the patient, and may be liable in negligence, provided it can be shown that, if properly informed, the patient would have reached a different decision.⁹

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5. *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218, 237, approving *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, especially 189 (Lord Scarman).
 6. See *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 113-114 (Lord Donaldson MR).
 7. See *Rogers v Whitaker* (1992) 175 CLR 479, 490.
 8. *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).
 9. By contrast, a claim that a patient's consent was not valid because the patient was not competent to consent requires proof only of that incompetence, and not that the patient would have chosen differently: *Chatterton v Gerson* [1981] QB 432, 442-443.

Sometimes the distinction between capacity to consent and “informed consent” becomes blurred

1.11 The requirement for capacity to consent focuses on the quality of a patient's understanding of a proposed treatment or procedure. By contrast, the duty to disclose (or gain “informed consent”) focuses on the information that a practitioner must communicate to the patient. These are two clearly distinct concepts, with different consequences: lack of capacity means that the law will not recognise ostensible consent to a health care procedure, whereas failure to inform does not affect the validity of consent but may mean that the practitioner has been negligent in the discharge of his or her duty of care and, accordingly, may be liable for damages for breach of that duty.

1.12 This report is not concerned with the law relating to the duty to disclose, or “informed consent”. We mention it here only to acknowledge that at times the distinction between capacity to consent and informed consent may become blurred. This is particularly so when the assessment of a person's capacity to consent is formulated in terms of his or her understanding of “the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question”.¹⁰ An understanding of the “likely consequences” of a procedure could include an understanding of its “material risks”. But while there may sometimes be an overlap in the framing of the tests, there will generally need to be a greater failure of communication between doctor and patient to render a patient incapable of consenting than that necessary to indicate a breach of the doctor's duty to inform.¹¹

THE REASONS FOR REQUIRING CONSENT

1.13 Consent serves more than one purpose in health law.¹² For instance, it can operate as a defence or immunity in order to validate conduct that would otherwise be unlawful. This conception of consent applies most easily to situations where a practitioner is providing health care that involves physical contact with a patient. The common law, on which our current law is based,¹³ considers this kind of contact to be an unlawful trespass to the person, amounting either to a battery, assault, or false imprisonment. The only way in which such contact is legally permissible is if a valid consent to the contact has been first obtained.¹⁴ Consent therefore serves a straightforward and easily defined purpose in this context: it is the mechanism by which physical contact with a patient is made lawful in order for a practitioner to avoid liability for trespass.

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10. *Re MB (An Adult: Medical Treatment)* [1997] 2 FCR 541, 553 (Butler-Sloss LJ). Consider also British Columbia, *Infants Act*, RSBC 1996, c. 223 s 17 (defining “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).
 11. *Chatterton v Gerson* [1981] QB 432, 442 (Bristow J).
 12. As, indeed, it does in the law more generally: see D Beyleveld and R Brownsword, *Consent In The Law* (2007) 5-7 and Ch 3.
 13. See Chapter 4.
 14. There are exceptions to this general rule where contact will be lawful without prior consent: see Chapter 7.

1.14 In the context of young people's health care, consent can serve a broader purpose beyond acting as a defence.¹⁵ It can be used to assert a positive entitlement where there is a dispute about the substantive rights of those involved in the health care decision-making process.¹⁶ In particular, it can signify an entitlement of a parent or a young person to be involved in or to be ultimately responsible for that decision-making. The leading case of *Gillick v West Norfolk and Wisbech Area Health Authority*¹⁷ is an example. The case concerned a guidance issued to local authorities by the relevant government department about the circumstances in which it was appropriate to give advice about contraception to girls under the age of 16, including the circumstances in which such advice could be given without the knowledge and consent of the girls' parents. A mother of teenage daughters sought a declaration from her local authority that it would give no contraceptive advice to her girls under the age of 16 without her knowledge and consent. The availability of the declaration depended, among other things, on whether or not girls under the age of 16 had the capacity to consent themselves to medical treatment of this nature. The House of Lords held, by majority, that they did, provided they passed the legal test for capacity set down by the House of Lords in the case.

1.15 *Gillick* was not a case where a specific treatment or procedure had already been carried out on a particular person, for which proof of a valid consent was sought as a defence to a claim for trespass. Nor did the type of health care in question (contraceptive treatment and advice) necessarily involve any suggestion of bodily contact that might expose a practitioner to liability for trespass.¹⁸ Instead, the dispute turned on whether a parent could lawfully veto the provision of contraceptive services consented to by his or her child.

1.16 Whether it is being relied on defensively, in order to avoid liability for trespass, or whether it is asserted as a means of claiming involvement in a health care decision concerning a young person, consent may ultimately be described as acting as an expression of individual autonomy. "Autonomy" is a word that is used often in the literature in relation to consent.¹⁹ Although it is seldom precisely defined, it clearly entails notions of

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15. For the application of this conception of consent beyond young people, see M Blake, "Religious beliefs and medical treatment: the challenge to patient consent" (2007) 19 *Bond Law Review* 26, 28-29.
 16. As Beyleveld and Brownsword put it, "while consent can function as a defence against a breach of right or duty, it can also function to create new rights and duties": see D Beyleveld and R Brownsword, *Consent In The Law* (2007), 7.
 17. [1986] AC 112.
 18. The treatment could consist of or include a physical examination (see Lord Brandon at 195), but the majority's decisions did not depend on physical contact being made. See, for example, Lord Fraser at 162: "... the main question in this appeal is whether a doctor can lawfully prescribe contraception for a girl under 16 years of age, without the consent of her parents", and Lord Scarman at 180-181: "... the guidance clearly implies that ... the parental right to make decisions as to the care of their children ... can lawfully be overridden, and that in such cases the doctor may without parental consultation or consent prescribe contraceptive treatment ...".
 19. For example, *Schloendorff v Society of New York Hospital* (1914) 105 NE 92 (Cardozo J); *Re T* [1992] 3 WLR 782, 786 (Lord Donaldson MR); *Marion's case* (1992) 175 CLR 218, 233 (Mason CJ, Dawson, Toohey and Gaudron JJ), 265-69

liberty, privacy, dignity, and self-respect. These are themselves amorphous concepts, which many have attempted to define and some have criticised as incoherent and unhelpful in legal discourse.²⁰ They nevertheless reflect values that have traditionally been given importance in our law, even though their precise meanings may vary depending on the situation. The general prohibition against unauthorised physical contact with another person is one manifestation of the notion of individual autonomy, in this context conceived of in terms of physical integrity and inviolability. The law protects the individual from physical interference by another, and recognises his or her choice whether to allow such contact to be made. The decision in *Gillick* reflects a different conception of autonomy, one that is not so much concerned with protecting a person's physical integrity, but nonetheless refers back to the notion of individual liberty as this notion ought to be applied to young people and their freedom to choose or to decide about their health care themselves.

1.17 Australian law, derived from the common law tradition, has tended to view consent to health care in terms of a defence for health practitioners who might otherwise be liable for unauthorised physical contact.²¹ A problem which the Commission has had to face in devising a new legislative scheme for this area is in finding a way to move beyond this traditionally narrow focus of the law, based strongly on the notion of bodily integrity as the foundation for the requirement for consent to health care (and therefore requiring physical contact in order for the provision of unauthorised health care to be redressed in any legally meaningful way), towards a broader conception of the purposes served by the law of consent. This problem has been compounded by the fact that much of the literature on this topic, as well as more recent case law overseas, reflect this broader conception of consent as a means of asserting certain entitlements, which tend to be framed in terms of "human rights" or simply "rights": the "right" to choose, the "right" to autonomy, or, on the other hand, a parent's "right" to be involved in or to control the raising of his or her child. While health law in other common law countries originated from the same narrow

(Brennan J), 309-11 (McHugh J). For an historical overview of the law of trespass and the notion of autonomy, see D Mendelson, "Historical evolution and modern implications of the concept of consent to and refusal of medical treatment in the context of the law of trespass" (1996) 17 *Journal of Legal Medicine* 1. For general discussion, see, for example, A Hockton, *The Law Of Consent To Medical Treatment* (2002), [2-001]; L Thomson, "Whose right to choose? A competent child's right to consent to and refuse medical treatment in New Zealand" (2001) 8 *Canterbury Law Review* 145, 146-147; L Bunney, "The capacity of competent minors to consent to and refuse medical treatment" (1997) 5 *Journal of Law and Medicine* 52, 54. For recent examples of Australian commentators, see M Blake, "Religious beliefs and medical treatment: the challenge to patient consent" (2007) 19 *Bond Law Review* 26, 28-29; J Potter, "Rewriting the competency rules for children: full recognition of the young person as rights-bearer" (2006) 14 *Journal of Law and Medicine* 64; E Jackson, *Medical Law: Text, Cases, And Materials* (2006), especially Ch 4. See also D Beyleveld and R Brownsword, *Consent In The Law* (2007).

20. For example, see J Ashcroft, "Making sense of dignity" (2005) 31 *Journal of Medical Ethics* 679; L Kass, *Life, Liberty, And The Defense Of Dignity: The Challenge Of Bioethics* (2004); D Beyleveld and R Brownsword, *Human Dignity In Bioethics And Biolaw* (2001).

21. *Rogers v Whitaker* (1992) 175 CLR 479, 490.

conception of consent grounded in protecting physical integrity, many of these countries can now more easily facilitate a discussion of a broader conception of consent in the context of such “rights”, since they now have human rights instruments. While in Australia we also commonly refer to patients’ rights, young people’s rights, and parents’ rights, these do not necessarily amount to legally enforceable entitlements. A further challenge for the Commission has therefore been to adapt the modern language of consent that now pervades the case law and more general discussions in the common law world to the Australian context, which does not necessarily recognise any legal claim to the rights relied on as part of this broader conception of consent.

THE CURRENT LAW RELATING TO CONSENT: A PATCHWORK

1.18 In Chapter 4 of this report, we discuss the current law relating to young people’s consent to health care in detail. At this stage, it is enough to make brief reference to the mixture of common law (or judge-made law) and statute that make up the law in this area. The patchwork nature of the law makes it confusing because the interaction of the various disparate rules can be uncertain. Consequently, it can be difficult for practitioners and others involved in the area to know with any certainty what the rules are and how exactly to apply them.

1.19 In New South Wales, s 49 of the *Minors (Property and Contracts) Act 1970* (NSW) relates to the general question of young people’s capacity to consent to medical and dental treatment. Section 49 sets out the situations where a medical or dental practitioner may rely on a young person’s or a parent’s consent to avoid civil liability for trespass when providing treatment to a young person. The section does not set down an exhaustive test for determining young people’s competence to consent to health care. Its purpose is much more limited, and is derived from legal reforms relating to young people’s capacity to enter into commercial transactions rather than from detailed policies concerning their rights and role in health care decision-making.

1.20 In addition to s 49, the common law has developed its own rules for determining when a young person or his or her parent can consent to health care. A major source of confusion about the current law in New South Wales relates to the interaction of s 49 of the *Minors (Property and Contracts) Act 1970* with the common law. Because s 49 is very limited in its purpose and scope, the common law still plays an important part in the law relating to young people’s consent. Indeed, the common law in its current form developed *after* the enactment of s 49 and has mostly surpassed the limitations of the statutory provision in so far as it contains a broader statement about the roles and responsibilities of young people and their parents in making decisions about health care. The developments of the common law have meant that s 49 of the *Minors (Property and Contracts) Act 1970* is now to a large extent redundant, but continues to cause confusion among practitioners.

1.21 In addition to these general rules relating to competence to consent, there are a number of legislative provisions that relate to young people’s involvement in health care decision-making in specific situations. These provisions can be found in the *Children and Young Persons (Care and Protection) Act 1998* (NSW), the *Guardianship Act 1987* (NSW), the *Mental Health Act 2007* and the *Human Tissue Act 1983* (NSW). As well, both the State’s Supreme Court, through its inherent jurisdiction, and the Family Court, under the *Family Law Act 1975* (Cth), have broad powers to intervene in decisions about young

people's health care. These powers potentially act as constraints on the ability of young people and parents to consent to or refuse health care.

REFORMING THE LAW ON CONSENT

Recommendation 1

Legislation should regulate the decision-making process for young people's health care. The legislation should contain rules for determining:

- when a young person is legally entitled to make a decision about his or her health care generally;
- when a young person is legally entitled to make a decision about particular types of health care; and
- when a young person's parent, legal guardian, caregiver or other substitute decision-maker is legally entitled to override a young person's decision about his or her health care.

The legislation should also provide:

- for the legal consequences of compliance or non-compliance with its provisions;
- definitions of key terms; and
- a statement of principles to guide the interpretation and application of the legislation.

Establishing a new statutory framework

1.22 The uncertainty in the relationship between the common law and statute, as well as in the interrelationship of the various statutory provisions, is reason enough to reform the law in this area. Such reform could seek to clarify and consolidate as much as possible the disparate rules that currently govern young people's consent to health care. But more than this, it could delineate the roles and responsibilities of those involved in the decision-making process, based more soundly than the current law on considered policies that have tested the validity of old assumptions.

1.23 Recommendation 1 above proposes a new statutory framework to regulate the general roles of young people and their parents, or other substitute decision-makers, in the decision-making process for young people's health care. This framework, supported in submissions,²² is the central reform of this report, on which the rest of its reforms are based. Recommendation 1 articulates the scope and purposes of this framework. Ensuing recommendations will deal with its substance.

1.24 Before dealing specifically with the details of our recommendations, there are a number of preliminary matters that we should first address here. These relate to:

- the extent to which the statutory framework is intended to interact with the common law, rather than replace it;
- the extent to which the framework will consolidate existing statutory provisions versus leaving some specific areas of existing statutory regulation untouched; and

22. NSW Commission for Children & Young People, *Submission*, [2.4-2.6]; Youth Action Policy Association, *Submission*, 2; Redfern Legal Centre, *Submission*, [7.3].

- the appropriate location of the new framework, that is, whether it should be implemented through the enactment of a separate Act or inserted into existing legislation.

The interaction of the common law with the new framework

1.25 The Commission's recommended legislation is not intended to replace entirely the operation of the common law. In agreement with all submissions that addressed this issue,²³ we are not aiming to codify the law in this area, to the exclusion of the common law. Our statutory framework generally aims to clarify the existing law, including the common law, and in many respects to modify or build on the current law. But the common law will continue to supplement the new legislation with the application of general doctrines. For example, the overarching jurisdiction under which the courts have a supervisory power to protect young people's best interests will continue to operate.²⁴

The extent of consolidation of statutory provisions within the new framework

1.26 As for the consolidation of statutory provisions, we have noted the number of disparate provisions dealing with health care decision-making for young people that currently exist in New South Wales. There is at least a superficial attraction in the idea of drawing all of these provisions together in a single piece of legislation to regulate all aspects of consent to young people's health care. This would make the law simpler and more readily understandable.²⁵

1.27 The Commission has, however, ultimately concluded that consolidation to this extent is undesirable. While rules relating to the general assessment of young people's competence to consent to or refuse health care can, appropriately, be consolidated in the new legislative framework that we are recommending, a number of the statutory provisions to which we referred in paragraph 1.21 relate to specific legislative regimes set up to deal with specific health or other issues. Questions of capacity may require different approaches or special rules in the context of such legislative regimes. We agree with the NSW Commission for Children and Young People that it is appropriate that any such rules should continue to appear in the legislation in question.²⁶

1.28 In our Issues Paper, we discussed special rules of consent that may affect young people in a number of statutory contexts: those who suffer from mental illness;²⁷ those

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- 23. NSW Commission for Children & Young People, *Submission*, [2.4-2.6]; Shopfront Youth Legal Centre, *Submission*, 13; S Siedleckly, *Submission*, 21.
 - 24. See para 2.52-2.65 for a discussion of the principles relating to the best interests of the child.
 - 25. See Shopfront Youth Legal Centre, *Submission*, 13.
 - 26. NSW Commission for Children & Young People, *Submission*, [2.4-2.6].
 - 27. NSW Law Reform Commission, *Minors' Consent To Medical Treatment*, Issues Paper 24 (2004) Ch 6.

who are subject to the provisions of the *Guardianship Act*,²⁸ those who are in need of care and protection or are in out-of-home care;²⁹ and those who donate tissue under the *Human Tissue Act 1983* (NSW).³⁰ Concerns have also arisen recently about the apparent ease with which young people are able to consent to cosmetic treatments. Following extensive research and consultation, we have concluded that it is inappropriate to relocate into our proposed legislative regime statutory provisions that apply to aspects of young people's consent to health care in these areas of law. We discuss below some of the concerns that have come to our attention in relation to these specific statutory regimes as well as aspects of these regimes that are in possible need of reform. We conclude with our reasons for deciding ultimately not to recommend any such reform in the course of this present review.

Matters excluded from the new framework

Statutory provisions relating to young people's consent and mental illness, guardianship, and children in need of care and protection or in out-of-home care

1.29 The *Mental Health Act 2007* (NSW) contains provisions dealing with the voluntary admission of "children" to mental health facilities.³¹ "Children" refers to persons below the age of 16, and different admission rules apply depending on whether the person is 14 or 15 years of age, or under 14 years of age. There is no reason why such rules should necessarily be the same as those relating to the general rules of consent to health care. Their evaluation must necessarily reflect the extent to which they facilitate the objectives of a statutory regime designed to provide for the care, treatment and control of mentally ill or mentally disordered people.

1.30 Similarly, the special rules governing consent to the medical and dental treatment of persons subject to the *Guardianship Act 1987* (NSW) must necessarily depend on the extent to which they promote the health and well-being of people over 16 who lack the ability to consent to such treatment and who are subject to the control of the Guardianship Tribunal.³²

1.31 Again, the special consent provisions dealing with children in need of care and protection or in out-of-home care must necessarily reflect the general policy of the State in ensuring that all young persons receive such care and protection as is necessary for their safety, welfare and well-being and, specifically, for facilitating the provision of such care and protection where the young person is in out-of-home care.³³

28. NSW Law Reform Commission, *Minors' Consent To Medical Treatment*, Issues Paper 24 (2004) [2.35-2.46].

29. NSW Law Reform Commission, *Minors' Consent To Medical Treatment*, Issues Paper 24 (2004) [7.3-7.12].

30. NSW Law Reform Commission, *Minors' Consent To Medical Treatment*, Issues Paper 24 (2004) [4.26].

31. *Mental Health Act 2007* (NSW) s 6.

32. *Guardianship Act 1987* (NSW) Pt 5.

33. *Children and Young Persons (Care and Protection) Act 1998* (NSW) Ch 9.

Statutory provisions relating to the donation of tissue and blood

1.32 The *Human Tissue Act 1983* (NSW) (the “*Human Tissue Act*”) allows a parent of a child to consent to the removal from a living child's body of specified regenerative tissue for the purpose of its transplantation to the body of a parent (being a biological parent, step-parent or adoptive parent), brother or sister of the child.³⁴ A child is defined as any person below the age of 18 and who is not married.³⁵ Regenerative tissue is defined as tissue which, after injury or removal, is replaced in the body of a living person by natural processes of growth or repair.³⁶ Bone marrow is the prime example of regenerative tissue that is the subject of transplantation.

1.33 Parental consent alone is not sufficient authority for the removal of a child's regenerative tissue. A further requirement under the *Human Tissue Act* is certification by a medical practitioner that:

- the consent of a parent was given in the presence of the medical practitioner,
- the medical practitioner explained to the parent and to the child the nature and effect of the removal from the child's body of the tissue and the intended effect of its proposed transplantation, and
- the medical practitioner is satisfied that, at the time the consent was given: the parent and the child were each of sound mind; the parent and the child each understood the nature and effect of the removal of the tissue and the intended effect of its proposed transplantation; the consent was freely given; and the child was in agreement with the proposed removal and transplantation of the tissue.³⁷

1.34 These provisions do not conform to the general rules relating to young people's consent to health care that are discussed in this report. Nor should they necessarily do so, since they involve “a non-therapeutic procedure the purpose of which is not to promote the physical welfare of the donor but that of a third party.”³⁸ They nevertheless give rise to important questions, including whether:

- the current legal requirements for tissue donation by a child are sufficient to safeguard the interests of the child donor or whether a more rigorous independent assessment should be adopted;
- certain children (for example, older adolescents who understand the nature and effect of the proposed tissue donation) should be able to give their personal consent to the procedure;
- provision should be made to allow the removal of non-regenerative tissue (for example, a kidney, liver or lung lobe) from a living child for transplantation purposes;

34. *Human Tissue Act 1983* (NSW) s 10.

35. *Human Tissue Act 1983* (NSW) s 2.

36. *Human Tissue Act 1983* (NSW) s 4.

37. *Human Tissue Act 1983* (NSW) s 11. The medical practitioner who gives this certificate must not be the practitioner who is to remove the tissue from the child: s 14.

38. *Northern Sydney and Central Coast Area Health Service v CT* [2005] NSWSC 551, [8] (dealing with the donation of peripheral blood cells or bone marrow cells).

- the range of allowable recipients should be widened beyond the child's biological parent, step-parent, adoptive parent, brother or sister.³⁹

1.35 The *Human Tissue Act* separately regulates the donation of blood. The Act does not define the term "blood", although it defines "blood product" as "a product or extract derived or extracted from blood by any process of manufacture." The Act allows a person over the age of 16 to consent in writing to the removal of blood from that person for the purposes of

(a) *its transfusion to another person, or*

(b) *its use, or the use of any of its constituents, for other therapeutic purposes or for medical or scientific purposes, other than for the purpose of the treatment of the person from whom the blood is removed.*⁴⁰

1.36 The rules with respect to children under the age of 16 years are found in s 20 of the *Human Tissue Act*, which provides:

A parent or guardian of a child who is under the age of 16 years may consent in writing to the removal of blood from the child's body for a purpose referred to in section 19 (a) or (b), but that consent is only effective if at the time the consent is given:

(a) *the child is in agreement with the removal of the blood from the child's body, and*

(b) *a medical practitioner advises the parent or guardian that any risk to the child's health (including psychological and emotional health) caused by the removal of the blood is minimal.*

1.37 If a child below the age of 16 years is unable to agree to the donation, a parent or guardian of the child may still consent on the child's behalf provided certain conditions are met. Section 20A of the *Human Tissue Act* provides:

A parent or guardian of a child who is under the age of 16 years may consent in writing to the removal of blood from the child's body without the consent of the child for the purpose of using the blood in the treatment of the child's parent (being the biological parent, step-parent or adoptive parent), brother or sister, but that consent is only effective if:

(a) *a medical practitioner (other than the medical practitioner responsible for treating the child's parent, brother or sister) certifies in writing that, in the opinion of the medical practitioner:*

39. See T O'Brien, "Bone Marrow Transplantation" (Paper presented at the Public Forum on Minors' Consent to Medical Treatment, Parliament House, Sydney, 20 November 2006).

40. *Human Tissue Act 1983* (NSW) s 19.

- (i) *the child is unable to understand the nature and effect of the removal of blood from the child's body, and*
- (ii) *any risk to the child's health (including psychological and emotional health) caused by the removal of the blood is minimal, and*
- (b) *a medical practitioner certifies in writing that the parent, brother or sister is likely to die or suffer serious damage to his or her health unless blood removed from the child is used in the treatment.*

1.38 Section 20B of the *Human Tissue Act* provides that an “effective consent under s 19, 20 or 20A is sufficient authority for the removal of blood from the body of the person who has given the consent, or from the body of the child to whom the consent relates, as the case may be.”

1.39 The current provisions of s 19 to 20B of the *Human Tissue Act* are the result of amendments by the *Health Legislation Amendment Act 2004* (NSW), which effectively lowered the age of consent for blood donation from 18 to 16. The amendments reflect the recommendations by the NSW Department of Health in a 2002 report which reviewed the provisions of the *Human Tissue Act* on blood donation. The report said

*The majority of submissions were of the view that there should be no parental consent requirement in respect of 16 and 17 year old children donating blood. It was argued that society and the law recognise that, at such an age, children are capable of consenting to their own medical treatment.*⁴¹

1.40 The Australian Red Cross Blood Service (“ARCBS”) has advised the Commission that preliminary statistics indicate that the 2004 amendments have had a positive impact on blood donations. However, the ARCBS is still in the process of amending its procedures and documentation in New South Wales to align them with the 2004 amendments. The ARCBS said that the 2004 amendments harmonised the law in New South Wales with those in South Australia, the Australian Capital Territory and the Northern Territory and add weight to its proposals for the other Australian jurisdictions to adopt the same rules.⁴²

1.41 The provisions relating to consent to the donation of blood are not the same as those relating to the donation of regenerative tissue. This issue is of importance in relation to the donation of peripheral blood stem cells, which can be used as an alternative to bone marrow transplantation for some cancer patients and others with medical conditions requiring transplantation of hematopoietic stem cells. It is unclear whether this type of donation is, for the purposes of the consent rules, donation of regenerative tissue or whether it is blood donation. If the latter, 16- and 17-year-olds can consent to the donation for the purposes listed in paragraph 1.35, but not if the donation is classified as one of regenerative tissue.

41. NSW Department of Health, *Review Of The Human Tissue Act 1983: Report – Blood Donation And The Supply Of Blood And Blood Products* (April 2002), [2.3].

42. Letter from Mr Garry Wolfe, Operations Manager (NSW/ACT), Australian Red Cross Blood Service, 13 June 2007.

1.42 Clearly this issue, and the others identified in the preceding paragraphs, need to be addressed, but in the context of an overall review of the *Human Tissue Act*, which is now an old piece of legislation, though one that has been subject to some amendment. It is only such a review that could determine whether the general rules relating to consent to health care provide a relevant analogy that facilitates the attainment of the objectives of that particular legislation.

Cosmetic surgery

1.43 Since the publication of our Issues Paper in 2004, media reports have suggested that there is a growing demand for cosmetic surgery among young people.⁴³ At least two State governments have taken these claims seriously enough to flag the possibility of legislative action. The Queensland Health Department recently released a discussion paper seeking the public's views on young people using cosmetic surgery and solariums.⁴⁴ It states cautiously "there is some evidence that there may be an increasing number of children and young people in Queensland and Australia who are using cosmetic surgery," and adds that there are no official statistics as to the amount of cosmetic surgery performed in the country. It notes that, apart from media reporting, including the results of a survey published in an Australian young girls magazine, no other evidence is offered. In 2006, the NSW government was said to be considering introducing legislation to make it more difficult for teenagers to undergo cosmetic surgery following revelations by a contestant on a television reality program.⁴⁵

1.44 As there appears to be no statistical research backing up claims of an increasing number of young people seeking such procedures as breast implants, liposuction and botox injections, it is impossible to know if there really is cause for concern. It should be noted that certain procedures that could be described as cosmetic have been performed on young people for many years, in the Commission's view reasonably and without controversy. Procedures such as rhinoplasty ("nose job"), otoplasty (ear pinning) and removal of birthmarks are often performed to prevent embarrassment and social withdrawal. Any moves to restrict access by young people to cosmetic surgery would need to be mindful of whether this places unnecessary obstacles in the path of procuring commonly performed and unobjectionable procedures. The Commission is not suggesting that any procedure that reduces embarrassment is thereby reasonable and acceptable.

1.45 Regulating this discrete area of treatment may be a more complicated task than might appear to be the case. What exactly constitutes "cosmetic surgery", what circumstances define whether it is acceptable or not, and who should be empowered to make the necessary decisions? A simple answer may be to require parental consent for

43. For recent examples, see M T Reist, "Body fix the wrong answer for teens", *Sydney Morning Herald* (Sydney), 9 May 2008, 13; C Marriner, "Teenage cosmetic surgery queried", *The Age* (Melbourne), 31 October 2007, 3; S Das, "Dear doctor, can you make me look like this please?", *The Age* (Melbourne), 10 March 2007, 3.

44. Queensland Health, *Have Your Say: Children and Young People Using Cosmetic Surgery and Solariums in Queensland* <http://www.health.qld.gov.au/publications/cos_surg_child.pdf> at 19 November 2007.

45. News-Medical.Net, *Reality Show Prompts Stricter Laws for Cosmetic Surgery for Australian Teens* (2006) <http://www.news-medical.net/print_article.asp?id=19647> at 13 February 2007.

such surgery. However, the reality is that little if any cosmetic surgery would be carried out today on young people without parental consent, given both the costs – running into thousands of dollars and for which Medicare rebates are not available if for non-medical reasons – and the period of convalescence that follows.⁴⁶ It can be reasonably inferred that most cosmetic surgery being performed on young people would already have parental consent.

1.46 In 1999, the report was published of a Committee of Inquiry (“the Committee”) appointed by the NSW Health Minister to investigate cosmetic surgery and make recommendations with regard to consumer safeguards.⁴⁷ This comprehensive inquiry was prompted by concerns about the way cosmetic surgery procedures were being promoted and their quality and safety.⁴⁸ Among the issues identified was the way in which cosmetic surgery operates outside the framework for organised medicine in a number of ways. For example, it “does not come under the auspices of any particular professional body that can establish competency standards and appropriate training and qualifications.”⁴⁹ Furthermore, any registered doctor can call himself or herself a surgeon, and there is no legal requirement to have specialised skills and knowledge to be called a “cosmetic surgeon” or specialist. The report’s recommendations favoured the regulation of the “industry”, and included a call to establish a Cosmetic Surgery Credentialling Council. In finding that there appeared to be a lack of literature on patients who are not appropriate candidates for breast implants “for psychological reasons and by reasons of youth”, the Committee recommended that such a council develop a code of ethics on appropriate patient selection.⁵⁰

1.47 Although a Credentialling Council was established two years after the report’s release, it was disbanded without reaching agreement.⁵¹ None of the Committee’s recommendations have yet been implemented. Although the inquiry made no specific mention of young people with regard to cosmetic surgery, the Commission believes that the first step in safeguarding their interests, along with those of all potential consumers, should be the introduction of measures to regulate the industry along the lines recommended by the Committee. While it is outside the scope of the Commission’s terms of reference to make recommendations regarding the operation of the cosmetic surgery industry, in the Commission’s view the interests of young people coincide with those of the wider community and would be well-served by a holistic approach to regulation of this area. In the context of cosmetic surgery, it is difficult to understand how the well-being of young people can be protected without implementing industry-wide safeguards.

Medical and scientific research and clinical trials

1.48 This report does not make any recommendations relating to the involvement of young people in medical and scientific research or clinical trials. We are aware that this is

46. See Medicare, <http://www.medicareaustralia.gov.au/yourhealth/our_services/medicare/about_medicare/what_mc_covers.shtml> at 20 November 2007.

47. See NSW Department of Health, *Cosmetic Surgery Report* (1999).

48. *Cosmetic Surgery Report*, 1.

49. *Cosmetic Surgery Report*, 21.

50. *Cosmetic Surgery Report*, Rec 18.

51. Meeting with Marilyn Walton, Inquiry Chairperson, 10 January 2007.

an issue that is attracting increasing public attention and debate.⁵² The practical consequence of uncertainty surrounding the legality of involving young people in research is the stultifying effect this may have on the advancement of research in treatment that may benefit young people and a limited availability on the market of many drugs that have not been properly tested on young people. While we acknowledge the benefits in achieving clarity in the law surrounding this sometimes controversial issue, we do not consider it appropriate to consider young people's involvement in research in this report. Strictly speaking, this issue is outside the terms of the Commission's reference, since it does not focus on the provision of treatment or health care. More fundamentally, we do not consider that this is an appropriate forum to discuss the question of young people's involvement in research. This is an area that is largely regulated by its own separate body of guidelines and ethics committees, and is subject to the overarching role of the National Health and Medical Research Council and the National Statement on Ethical Conduct in Human Research. It is far more appropriate that this issue be debated within the context of the development of additional guidelines, if necessary, overseen by the NH&MRC.

The location of statutory reform

1.49 The next preliminary matter is the appropriate location of the new legislative framework. That is, should the Commission's recommendations be enacted as a new and separate piece of legislation dealing with consent to young people's health care, or should they be included within an existing piece of legislation? At present, there is no general Act that deals broadly with issues of consent to and refusal of health care, applicable both to adults as well as young people. Consequently, it is difficult to justify the introduction of a separate Act dealing with these issues solely as they relate to young people, unless such an Act was used as a precursor to a more comprehensive overhaul of the laws relating to the decision-making process in health care. We would certainly favour this kind of initiative. But in its absence, there is no obvious place to insert our statutory reforms within existing legislation in New South Wales. The most likely candidates are Acts relating to "young people" or "children", or Acts relating to health.

Acts dealing with children

1.50 Our recommended statutory reforms could be included within the *Minors (Property and Contracts) Act 1970* (NSW), which contains general provisions relating to young people's capacity to enter commercial transactions. However, we consider that the terminology of this Act is now fairly dated, and the focus of the Act is essentially the commercial world and young people's place in it. It is no longer a suitable Act to deal with a broader consideration of young people's health care than is currently provided in s 49 of that Act.⁵³

1.51 Our statutory reforms could be inserted into the *Children and Young Persons (Care and Protection) Act 1998*. Our reforms probably relate the closest to the subject matter of this Act. However, while this Act contains provisions of general application to young

52. See NSW Law Reform Commission, *Minors' Consent To Medical Treatment*, Issues Paper 24 (2004), [1.48]; L Sancu, S Sawyer, P Weller, L Bond, G Patton, "Youth health research ethics: time for a mature minor clause?" (2004) 180(7) *Medical Journal of Australia* 336.

53. See para 4.26-4.32.

people, its focus is clearly on children and young people who come into contact with the State's child welfare services. Moreover, while the use of the distinction between "child" and "young person" was progressive at the time of its inclusion in this Act, marking a separate period of development in adolescence where a person was not yet an adult but no longer a child,⁵⁴ we would not wish to see the continuation of this distinction in terminology in our statutory reforms. The use of the two terms makes the Act unnecessarily complicated and less accessible because it does not make restrictions on the application of particular provisions explicit, and is also not a distinction that is used uniformly throughout the Act.⁵⁵ We consider "young person" now a more appropriate term to use to refer to all people below the age of 18, since "child" may be considered by some as patronising. "Young person" better emphasises the individuality and humanity of all young people. If our statutory reforms were inserted into this Act, we would prefer that the Act be amended to extend the definition of young person to anybody below the age of 18, and that the use of "child" be removed. The Act would also need to be renamed to reflect its broader scope.

Acts dealing with health

1.52 Alternatively, our recommended provisions for the general assessment of competence could be inserted into an existing piece of legislation relating to health, such as the *Health Care Liability Act 2001* (NSW) or the *Health Care Complaints Act 1993* (NSW). Neither of these is really satisfactory because each has essentially a narrower focus on legal liability of practitioners and mechanisms for complaining about misconduct, rather than a more general statement about patients' entitlements. Ideally, a separate piece of legislation should be enacted to deal with the general question of patients' rights to consent to and refuse health care, relating both to adults and young people, such as operates in South Australia.⁵⁶ An Act of this kind could consider the issue of consent in general situations and in relation to more specific instances, such as consent to palliative care and advance care directives. However, it is beyond the terms of the Commission's reference to consider the question of consent for the general population.

The Commission's approach

1.53 In the absence of a separate Act that sets out a general framework for health care decision-making for adults and young people, we take the view that the location of our statutory framework is properly a matter for Parliamentary Counsel to consider, and we make no recommendation relating to this issue. For the purposes of this report, our recommendations refer to our reform simply as "legislation", whatever form that legislation ultimately takes.

54. See NSW Department of Community Services, Community Welfare Legislation Review, *Review of the Children (Care and Protection) Act 1987: Recommendations for Law Reform* (1997), Rec 1.3, 9-10.

55. Generally, a "child" is defined in the Act as a person below the age of 16: see *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 3. But for the purposes of Chapter 13 of the Act (children's employment), a "child" is defined as a person below the age of 15: see *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 221.

56. See *Consent to Medical Treatment and Palliative Care 1995* (SA). See para 5.6-5.19.

PRIVACY AND CONSENT TO HEALTH CARE

1.54 Our Issues Paper canvassed at length the relationship between the law relating to young people's consent to health care and the law of privacy.⁵⁷ We identified four circumstances in which the law concerning permissible disclosure of a young person's health information may stand in need of reform:

- 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.

1.55 We also identified patient access to medical records as a potential concern for young people.

1.56 Since the publication of our Issues Paper, the Commission has received a reference to inquire more broadly into the law of privacy.⁵⁸ We have published two Consultation Papers pursuant to this reference: one that explores the possible introduction of a statutory cause of action for invasion of privacy in New South Wales;⁵⁹ another that surveys the protection afforded privacy by current legislation in New South Wales.⁶⁰ The Australian Law Reform Commission has also published a comprehensive report on the law of privacy in Australia.⁶¹ We plan to issue a final report on privacy in 2009.

1.57 Of the topics identified in our Issues Paper, we have no doubt that, with one possible exception, they are better considered in the context of our review of the law of privacy. This is because the topics relate essentially to the protection of a very sensitive type of private information, that relating to the health of an individual. The way in which that information is stored or protected does not generally depend on the age of the individual, and in particular on whether the individual is a minor or an adult.

1.58 The possible exception relates to the extent to which young people should be able to keep medical information from their parents. The prevailing view in the literature is that if a young person has sufficient understanding to consent to a particular medical treatment, the medical practitioner is obliged not only to give such advice but also to keep the consultation confidential from the young person's parents.⁶² The rationale for this view

57. See NSW Law Reform Commission, *Minors' Consent To Medical Treatment*, Issues Paper 24 (2004) Ch 9.

58. For the terms of reference of this inquiry, see www.lawlink.nsw.gov.au/lawlink/lrc/ll_lrc.nsf/pages/LRC_cref113.

59. NSW Law Reform Commission, *Invasion of Privacy*, Consultation Paper 1 (June 2007).

60. NSW Law Reform Commission, *Privacy Legislation In NSW*, Consultation Paper 3 (May 2008).

61. Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice*, Report 108 (May 2008).

62. I O'Connor and A McMillan, "Youth, the law and health: emerging issues in service delivery" (April 1987) *Queensland Law Society Journal* 95; S P De Cruz, "Parents,

is that if parents do not have the power to consent to a medical treatment that their child seeks, they do not have the power to obtain medical information about that treatment.

1.59 Other considerations arise concerning young people who lack capacity to consent to a particular medical treatment. There are two competing views. One view is 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.⁶³ Two arguments support this view. First, 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 not capable of exercising autonomy as regards the treatment he or she wanted. Secondly, parents need to know information relevant to the effective discharge of their parental duties of care.⁶⁴ 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.

1.60 The alternative view is that even where a young person is found to lack the capacity to consent to a particular 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.⁶⁵ In support of this view, it is argued that the preservation of confidentiality is not based solely on the recognition of the autonomy of young people. It is also founded on young people's needs 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.⁶⁶

1.61 The issue of disclosure to parents is likely to arise in situations involving health information that the young person considers to be personal and sensitive in nature, for example information relating to reproduction and sexual health, drug dependency and depression. If a test involving an expectation of non-disclosure were adopted, the nature

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* (1988). In the UK, the General Medical Council's guidance on confidentiality titled *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.

63. See I Kennedy, "The doctor, the pill and the fifteen year old girl" in I Kennedy (ed), *Treat Me Right* (1988), 111-114.

64. See *Family Law Act 1975* (Cth) s 61C(1) regarding the concept of "parental responsibility".

65. J Loughrey, "Medical Information, confidentiality and a child's right to privacy" (2003) 23 *Legal Studies* 510.

66. 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, 314.

of the health information in question could simply be a relevant factor in assessing whether or not the test has been met.

1.62 A third approach would be to argue that confidentiality should be based on the type of health information involved. That is, young people should be able to withhold only certain types of health information from their parents.

1.63 With exceptions relating to mandatory reporting laws (such as apply to child abuse), all submissions and consultations argued that medical practitioners should generally respect the confidentiality of information that young people disclosed to them in the course of a medical consultation or proposed medical treatment whether or not the young person was competent to consent to that treatment.⁶⁷ Some submissions added somewhat indeterminate reservations in cases where the young person lacked competence to consent or a parent had consented on behalf of the child. The reservations were expressed in terms that, in such cases, parents should be informed in general terms of the nature and progress of the treatment of their child, though not necessarily in respect of all types of treatment.⁶⁸

1.64 The Commission recognises that, to a degree at least, respect for the privacy of young people's health care information, notwithstanding the desire of a parent to have access to that information, is integral to the effective operation of the law relating to young people's consent to health care. Bearing in mind the principles that underpin the legislative regime that we recommend, we incline to the view that doctors should, at least generally, respect the confidentiality of their consultations and the nature of treatment or proposed treatment of young people whether or not the young person understands the nature of the treatment proposed. However, we prefer to reserve our position on this until we have considered all relevant aspects of the law of privacy, particularly how questions of capacity have generally been addressed in the context of privacy law.⁶⁹

ORDER OF DISCUSSION OF THE COMMISSION'S REFORMS

1.65 The rest of this report is concerned with discussing the details of the reforms set up by the proposed legislative framework. These reforms will be discussed in the following order:

- the general principles that the Commission has applied in devising its legislative framework and that should govern its interpretation and application;
- the definitions of key terms of the proposed legislation;

67. NSW Commission for Children & Young People, *Submission*, [13.1]-[13.3], [13.5]; Youth Justice Coalition, *Submission*, 5; Shopfront Youth Legal Centre, *Submission*, 11; Doctors Reform Society, *Submission*, 6; S Siedlecky, *Submission*, 17-18; Youth Action Policy Association, *Submission*, 4.

68. Shopfront Youth Legal Centre, *Submission*, 11; S Siedlecky, *Submission*, 18; Doctors Reform Society, *Submission*, 6.

69. Consider Australian Law Reform Commission, *For Your Information: Australian Privacy Law and Practice, Report 108 (May 2008)*.

- the general criteria for determining a young person's competence to make a health care decision, which have been formulated in response to the operation of the current law and its deficiencies;
- the scheme set up for making a health care decision on behalf of a young person who is not competent to make that decision according to the general criteria for competence, including a system for nominating substitute decision-makers to make that decision as well as identifying non-urgent situations where a practitioner may lawfully provide health care which has not been consented to by the person having the decision-making authority;
- the powers of a practitioner to act in emergencies to provide health care to a young person without first obtaining a valid consent;
- legislative prohibitions on the provision of particular types of health care without prior authorisation from a court or tribunal; and
- the consequences of non-compliance with the proposed legislation.

2. Guiding principles of the new legislation

- The debate about young people's consent
- Protecting young people from unwise choices: the traditional approach
- Moving beyond a protective framework?
- The practical benefits of involving the young patient
- The role and responsibilities of parents and other caregivers
- Serving the young person's "best interests"
- Conclusions

THE DEBATE ABOUT YOUNG PEOPLE'S CONSENT

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 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 a good enough reason not to have a heart transplant, even if it saved my life.

2.1 These were the reasons given by a 15-year-old girl for refusing a life-saving heart transplant in the English case of *Re M*.¹ The English High Court intervened in the decision and authorised the young woman's doctors to carry out the transplant regardless. A heart donor was eventually found, and she survived.

2.2 If the young woman in this case had been an adult, her decision to refuse the heart transplant would have been respected² and, based on the medical evidence presented in the case, she would likely have died. Although many people may not agree with them, her views on what amounts to an unacceptable cost in choosing to stay alive would have been acknowledged as legitimate and would not have attracted the intervention of the courts or anyone else.

2.3 But since the young woman in this case was not yet an adult, the law allowed the Court to reject her views in substitution for its own (although this was done with great sensitivity and consideration of her wishes). As a result, the young woman's life was saved. Did the outcome justify the means, and to what extent should the law have deferred to her views?

2.4 In Chapter 1, the Commission recommended the introduction of legislation to regulate health care decision-making for young people in New South Wales, with particular attention paid to delineating the entitlements of young people and the proper roles and responsibilities of parents and other caregivers, as well as the State, in the decision-making process. But as the example above illustrates, this is an area where there are no easy answers about who should have a say and who should not. It evokes ethical and moral considerations and value judgments about life, death, the power of the individual young person to determine his or her own way of living (or dying), what some may see as a foolish waste of life, and a parent's grief. The law is a blunt instrument to have to deal with these sorts of considerations, and the formulation of an appropriate legislative framework to fall back on in these situations is particularly challenging. Any attempt at devising such a framework should acknowledge from the start the moral and emotional dimensions of this area of the law, and its controversial nature which is susceptible to provoking at times heated debate.

2.5 The examples of situations that may provoke such debate are wide-ranging. Choices about life-saving treatment, palliative care, blood and organ donation, sterilisation of young people with significant intellectual disabilities, predictive genetic testing for a

1. *Re M* [1999] 2 FCR 577, 581.

2. This assumes that her competency went unchallenged; see para 1.7.

hereditary disease, sexual health, contraceptive advice, termination of pregnancy, ante-natal care, treatment for eating disorders and mental illnesses, are all instances that have been brought to the Commission's attention in the course of this review as areas where there may be strong disagreement about who should have a right to decide.³ While these situations involve consideration of their own particular issues, there are several recurring concerns that resonate throughout them all. These concerns need to be taken into account in the attempt at formulating legislative policies.

2.6 A first concern is that decisions about health care are often life-changing, sometimes life-saving. The stakes are high in terms of devising appropriate legislation to govern who can make those decisions. There is growing public concern about the state of young Australians' health over a range of health issues: increases in the incidence of chronic illnesses such as juvenile diabetes and asthma, a rise in childhood obesity, the effects of substance use and abuse, and worsening trends in young people's mental health, are just some examples. The need to improve young people's access to appropriate health care is the backdrop against which this discussion about decision-making rights and responsibilities takes place, and highlights the impact that the decision-making process will have on many young lives. As well, technological and medical advances in the types of testing and treatment available, and continued growth in alternative means of treating conditions, provide an increasing range of choices to be made in addressing specific health concerns. In short, decisions about health care often involve consideration of several options, and the consequences of making a choice can have a significant and sometimes irreversible effect on a young person's life.

2.7 Another concern is that these types of situations typically bring into focus the appropriate role of parents and other caregivers in the lives of their children. Questions about who should be able to have a say in a young person's health care can challenge a parent's responsibility and privilege to control not just the physical care of their child, but his or her moral and emotional care as well. Intervention in parents' decisions about their children's health care by the State, or recognition of a young person's right to make that decision on his or her own, may be considered by some to undermine the privacy and sanctity of the family unit.

2.8 A last concern, and perhaps the most difficult one to respond to, is that these situations highlight an ambiguity in the way we perceive, and should perceive, our younger generation. On the one hand, we are aware of young people's vulnerability, and the need to protect them from bad decisions made either by others or by themselves. On the other hand, we acknowledge them as human beings in the full sense of what that means, respecting their integrity, their claim to autonomy, and their need to make their own mistakes. How can we reconcile these views in a practical way in determining who should be able to decide about their health care?

3. See consultations with Dr S Towns, Department of Adolescent Medicine, Children's Hospital at Westmead; Dr M Kang, Department of General Practice, University of Sydney; Department of Psychological Medicine, Children's Hospital at Westmead; Dr S Trethewie, Department of Palliative Care, Sydney Children's Hospital at Randwick; Department of Pain and Palliative Care, Children's Hospital at Westmead. And see Public Forum on Minors' Consent to Medical Treatment, Parliament House, Sydney, 20 November 2006.

2.9 The law can seek to respond to these three central concerns in a number of ways. It can aim to:

- promote good health care among young people by ensuring their ready access to appropriate care;
- acknowledge the involvement of parents and other family members in their children's health care and decisions about what is appropriate for their child;
- ensure that young people are free to make a choice about what is done to their bodies;
- recognise the responsibility of the State and of parents to protect young people from harm; and
- allow health practitioners to treat young people according to clear guidelines which are consistent with any professional ethics under which they work.

2.10 Most of these aims have been recognised internationally and domestically as reflecting important human rights,⁴ but it will not always be possible for a single piece of legislation to fulfil one without compromising another. The law could not have protected the young woman in *Re M* from harm but at the same time have assured her of the freedom to make her own choice about what was done to her body.

2.11 In the preceding chapter, Recommendation 1 spelled out the purposes and scope of the Commission's proposed legislative framework, including the articulation of principles to guide its interpretation and application. This chapter traces the considerations that have gone into formulating those principles, which appear in Recommendation 2 below, and which we have applied in trying to find a sensible balance between the various concerns and competing interests in this area.

PROTECTING YOUNG PEOPLE FROM UNWISE CHOICES: THE TRADITIONAL APPROACH

2.12 In Chapter 1, the Commission considered the meaning and purposes of consent as a legal concept in health law. We noted that this review focuses on the assessment of

4. See, for example, United Nations, *Convention on the Rights of the Child*, opened for signature 20 November 1989 (entered into force 2 September 1990), particularly arts 5, 12, 24. See declaration of the Commonwealth Attorney-General 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: Commonwealth of Australia Gazette (No GN1, 13 January 1993), 85-107. See too *Commission for Children and Young Persons Act 1998* (NSW) s 10. The European Convention on Human Rights also recognises and protects many of these interests as human rights: see *Convention for the Protection of Human Rights and Fundamental Freedoms*, art 1 (right to life), art 8 (right to privacy and family life), art 10 (right to freedom of expression). See discussion of the European Convention by Justice Silber in *Axon v Secretary of State for Health and Family Planning Association* [2006] QB 539 (Queen's Bench Division, Administrative Court, Silber J).

young people's capacity to consent and that, unlike adults, young people have been traditionally assumed to lack capacity to consent to their own health care because of their assumed immaturity. We also noted that the law's insistence on consent as a general prerequisite to the provision of health care reflects the importance that the law historically places on the principle of individual autonomy, however that notion may be defined. By assuming that young people lack capacity to consent, the law has traditionally refused to recognise them as autonomous individuals and has instead applied to them more protective principles aimed at shielding them from their own foolish choices.⁵

2.13 The English case of *Gillick*, to which we referred in paragraph 1.14, involving a teenager's right to seek contraceptive treatment and advice, provided an opportunity to transform the traditionally protective role of the law. The House of Lords there recognised the potential for young people to be sufficiently mature to make their own choices about their medical treatment. The Australian High Court approved the House of Lords' decision in the case of *Marion* and, in doing so, opened the way for Australian law in this area to be rethought. Since the decision in *Gillick*, the English courts have been criticised for retreating to a more conservative, paternalistic approach towards young people's decision-making capacities.⁶ However, with the exception of a recent decision,⁷ most of the English cases since *Gillick* have involved serious life-threatening illnesses, with the central issue turning on a young person's right to refuse life-saving treatment, rather than a right to consent to treatment. In Australia, there has been a dearth of case law on the issue, with consequently very little opportunity to develop the law further.

2.14 The ambiguities in the case law reflect the difficulty that lies at the centre of this debate, to which the Commission initially referred. To what extent should the law entrust young people with the responsibility of making their own decisions about their health care? In formulating its draft legislation, should the Commission follow on from the direction set in *Gillick*, and, if so, to what extent should it then reject the traditionally protective approach of the law?

MOVING BEYOND A PROTECTIVE FRAMEWORK?

The impact of the rise of children's rights

The common law, however, while generally immutable in its principles, unless different principles are laid down by statute, is not immutable in the way in which it adapts, develops and applies those principles in a radically

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5. For a fuller discussion of the history of the current law, see Chapter 4, especially para 4.7-4.8.
 6. See J Bridgeman, "Young people and sexual health: Whose rights? Whose responsibilities?" [2006] *Medical Law Review* 418; A Morris, "*Gillick*, 20 years on: arrested development or growing pains?" (2005) 21 *Professional Negligence* 158; G Douglas, "The retreat from *Gillick*" (1992) 55 *Modern Law Review* 569.
 7. See *Axon v Secretary of State for Health and Family Planning Association* [2006] QB 539, (Queen's Bench Division, Administrative Court, Silber J). See para 4.21.

*changing world and against the background of radically changed social conventions and conditions.*⁸

2.15 The debate concerning young people's right to decide about their health care must be seen against the backdrop of society's changing conception of young people. Centuries ago, young people's role in society was minimal: they were conceived of almost as property, certainly not as individuals, as people separate from their parents. Now, the notion of parental control over one's child has developed into a notion of parental responsibility to promote a child's best interests. While people below the age of majority (which in New South Wales is 18) still do not enjoy what could be seen as the full rights of adulthood, there is increasing attention internationally and domestically to them as individuals with a right to exercise their own free will as active participants of society.

2.16 This shift in attitude in the way society looks at its young people is reflected in the rise of the children's rights movement in the law, both internationally and domestically. Internationally, the United Nations' *Convention on the Rights of the Child* afforded formal recognition to young people as rights-bearers. The Convention focused not only on young people's right to have their basic needs met, but also emphasised their right to have a voice in society.⁹ Since then, the children's rights movement, as a world-wide phenomenon, has grown and been given constitutional and legislative recognition, with a focus not simply on the fulfilment of young people's basic needs for shelter and food, but also on recognition of their individuality and participation in society.¹⁰

2.17 Australia has witnessed a gradual evolution in the notion of children's rights, with federal and State legislation relating to young people now emphasising the importance of involving young people in decisions which affect them. A clear example is the *Children and Young Persons (Care and Protection) Act 1998* (NSW). This Act identifies as one of its guiding principles the principle of participation, which asserts the right of young people and children to participate in matters affecting them under the Act. The principle of participation was described at the time of its enactment as a radical and foundational principle of the legislation.¹¹ It is reflective of the changing policies of government

8. *R v D* [1984] AC 778, 804-805 (Lord Brandon).

9. See United Nations, *Convention on the Rights of the Child*, art 12.

10. See, for example, the *European Convention on the Exercise of Children's Rights*, opened for signature 25 January 1996, CETS No 160; *African Charter on the Rights and Welfare of the Child*, OAU Doc. CAB/LEG/24.9/49 (1990) (entered into force 29 November 1999). For a discussion of the children's rights movement as an international social phenomenon, see, for example, G Van Bueren, "The international law on the rights of the child" (1995) 35 *International Studies in Human Rights*, Ch 1; D Hodgson, "The historical development and 'internationalisation' of the children's rights movement" (1992) 6 *Australian Journal of Family Law* 252; J Eekelaar, "The emergence of children's rights" (1986) 6 *Oxford Journal of Legal Studies* 161.

11. P Parkinson, "The child participation principle in child protection law in New South Wales" (2001) 9 *International Journal of Children's Rights* 259.

agencies dealing with young people, which adhere now to the principle that young people be heard as well as seen, and their opinions sought and given weight to.¹²

2.18 Clearly, we as a society now consider our young people in a different light from the way they were seen even just over half a century ago. There is a growing awareness of young people as individuals with legitimate views to be heard. These changes in social attitudes are reflected and approved in legislation and government policies. Against this backdrop, we must scrutinise the validity of the law's approach in generally denying young people a right to decide about health care.

2.19 Of course, rhetoric about young people's rights, the importance of respecting their autonomy and freedom of choice is one thing. Does it match up with the realities of being young, and in particular the reality of surviving the various challenges that adolescence can offer? Should the law be prepared to hand over responsibility for making important, sometimes life-changing decisions about young people's health to young people themselves, or are there still good grounds for denying them, even as they mature, a right to decide?

Do young people need protecting?: the characteristics of being young

*And these children that you spit on/ As they try to change their worlds/ Are immune
to your consultations/ They're quite aware of what they're going through ...*

David Bowie, Changes

2.20 The law's assumptions about young people's competence, or incompetence, have tended to be based on intuition rather than scientific, psychological or empirical research. The same could be said about the assumptions made about the legal competence of adults. Even in *Gillick*, in the United Kingdom, and *Marion*, in Australia, where the courts were prepared to recognise the possibility of a young person being sufficiently mature to consent to medical treatment, there was little discussion about any psychological or empirical basis to support this, nor consideration of what might constitute sufficient maturity according to theories of cognitive or psychological development.¹³

2.21 There appears now to be a growing trend, at least in the legal literature, towards questioning the validity of the assumptions underlying the law's traditionally protective approach, and to condemn it as unduly restrictive and paternalistic. Critics of the current law argue that there is not a sufficient difference between adults and (at least, older) adolescents to justify any distinction in their legal competence to make decisions. For example, one legal writer in New Zealand argues:

Children are now more mature, self-aware and financially independent than in the past. The stereotypical family unit is increasingly becoming the exception

12. See, for example, NSW, Office of the Children's Guardian, Benchmark policies, *Philosophy of care statement, program objectives, and program criteria*.

13. The majority in *Marion's case* approved the *Gillick* test on the basis that it "accords with experience and with psychology": see *Marion's case* (1992) 175 CLR 218, 237-238 (Mason CJ, Dawson, Toohey, and Gaudron JJ).

*rather than the rule in modern society, with younger persons becoming self-sufficient or estranged from their parents.*¹⁴

2.22 And an Australian legal writer has recently claimed:

*... Australia's obligations under the [Convention on the Rights of the Child], and a growing understanding of the competency of young people in all areas of life, demand the implementation of a test that reduces, if not eliminates, the paternalism that has pervaded the assessment of children's competency.*¹⁵

2.23 But, as with the traditional assumptions of the common law, these criticisms have tended to be based on assertions rather than on a discussion of any psychological or empirical basis for claiming greater decision-making autonomy for young people.

2.24 In fact, over the last few decades, there has been a growing body of research into young people's decision-making processes, taking account of the physiological developments of the brain, as well as the cognitive and social developments that characterise childhood and adolescence.¹⁶ Our interest in this research lies in what it

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14. L Thomson, "Whose right to choose? A competent child's right to consent to and refuse medical treatment in New Zealand" (2001) 8 *Canterbury Law Review* 145, 161.
 15. J Potter, "Rewriting the competency rules for children: full recognition of the young person as rights-bearer" (2006) 14 *Journal of Law and Medicine* 64, 85.
 16. The literature in this area is extensive. See, for example, J Piaget and B Inhelder, *The Psychology of the Child* (1969); L A Weithorn and S B Campbell, "The competency of children and adolescents to make informed treatment decisions" (1982) 53 *Child Development* 1589; T Grisso and L Vierling, "Minors' consent to treatment: a developmental perspective" (August 1978) *Professional Psychology* 412; L F Ross, "Health care decision-making by children: is it in their best interests?" (1997) 27 *Hastings Centre Report* 41; R Duncan, *Holding your breath: predictive genetic testing in young people* (Doctoral thesis, Departments of Paediatrics and Public Health, The University of Melbourne, July 2005) especially Ch 3; F H Richards, "Maturity of judgement in decision making for predictive testing for nontreatable adult-onset neurogenetic conditions: a case against predictive testing of minors" (2006) 70 *Clinical Genetics* 396; T O'Lonergan and J Zodrow, "Pediatric assent: subject protection issues among adolescent females enrolled in research" (Summer 2006) *Journal of Law, Medicine, and Ethics* 451; T Fundudis, "Consent issues in medico-legal procedures: how competent are children to make their own decisions?" (2003) 8 *Child and Adolescent Mental Health* 18; L Steinberg and E Cauffman, "Maturity of judgment in adolescence: psychosocial factors in adolescent decision making" (1996) 20 *Law and Human Behaviour* 249; L Steinberg and E Cauffman, "(Im)maturity of judgment in adolescence: why adolescents may be less culpable than adults" (2000) 18 *Behavioral Sciences and the Law* 741; V Reyna and F Farley, "Risk and rationality in adolescent decision making: implications for theory, practice and public policy" (Sep 2006) 7 *Psychological Science in the Public Interest* 1; E Scott, N D Reppucci and J Woolard, "Evaluating adolescent decision making in legal contexts" (1995) 19 *Law and Human Behavior* 221.

suggests about the differences and similarities in decision-making skills of young people and adults.

The physical developments of the brain

2.25 The human brain is not fully formed at birth, but continues to grow and develop from that time into adolescence. These physical developments can to some extent be affected and shaped by a person's environment. They are also said to have an impact on behaviour and thought processes.

2.26 The brain is divided into two hemispheres and within each of these hemispheres are four lobes. Three of these lobes continue to develop during adolescence. They are the parietal, the temporal, and the frontal lobes.¹⁷ The parietal lobe is associated with problem solving, the temporal lobe is associated with language development, and the frontal lobe is associated with the more complex or higher order processes of the brain known as its "executive functioning", relating to planning, organising, ordering behaviour and impulse control. The frontal lobe is the last part of the brain to develop, and is said to continue to mature into late adolescence. Based on preliminary findings, a recent Australian study also posited that the release of hormones associated with the onset of puberty can cause a temporary deficit in the brain's executive functioning which may consequently have an effect on a teenager's behavioural control.¹⁸

2.27 The period from childhood to adolescence is also a time of development for neurones in the brain. People are born with a great excess of neurones. From the age of around two through to adolescence, neurones which are not being used and strengthened die off, and other neurones form connections with each other. This process has been termed "synaptic pruning". The connections that are formed are strengthened and protected through another process known as myelinisation. As noted, brain development is susceptible to influence by its environment so that, without the right environment, correct development will not occur.

2.28 In short, it appears clear that the brain continues to undergo major physical growth and development through to late adolescence and early adulthood. There is some evidence that suggests that this ongoing development can affect a teenager's behaviour, such as his or her impulse control and organisational skills. However, more research into such effects is needed in order to have a clearer idea of their impact (if any) on young people's decision-making skills.

Theories on the development of decision-making skills

2.29 Early research into young people's decision-making capacities focused on theories of cognitive development. Jean Piaget devised empirical means of studying the differences in cognitive abilities between young people and adults as a basis for his theories on the development of the mental processes of the brain. Based on his research, he argued that young people from around the ages of 11 to 14 are capable of complex

17. The fourth lobe, the occipital lobe, is associated with the brain's sensory functions, particularly vision, and is the most developed of the lobes from an early age.

18. See S Czech, "Explanations for antisocial behaviour in adolescents: the role of hormones on mental processes" (Paper presented at the Annual Australian and New Zealand Adolescent Health Conference, Sydney, 2006).

mental operations, that is, they are able to think hypothetically and in abstract terms, to consider the future, and weigh up alternative options. Subsequent researchers have claimed that young people from the age of about 14 do not differ significantly from adults in their ability to understand and reason, for the purposes of making decisions about medical treatment,¹⁹ and that young people aged 15 and above are usually no less competent than adults.²⁰

2.30 If decision-making capacity is assessed according to cognitive abilities, then these studies point strongly to recognising an entitlement in young people, at least from their early to mid teens, to make their own health care decisions, because they suggest that there is no significant difference in cognitive abilities between this age group and adults. That is, there is no need, or justification, for treating young people, at least from their mid teens and up, differently from adults.

2.31 By contrast, other theorists on child development have considered young people's decision-making capacity according to a wider range of factors extending beyond cognitive ability. These theorists argue for a broader notion of what is meant by mature judgment. Decision-making capacity should take account not only of young people's cognitive capacities, but also their emotional and social development.²¹ A measure of competence should incorporate factors such as those relating to a person's development of self-identity and an ability to appreciate risk and weigh up long-term consequences. Young people's competence to make health care decisions should require not only an ability to understand information relating to the proposed health care, and to consider multiple options, but also to choose voluntarily (that is, independently of authority figures such as parents and physicians, and of peers), and to appreciate the nature of the decision (its gravity, immediacy, and the permanency of the choice). Decision-making competence should be linked not just with developing cognition, but also to life experience and experience in making decisions.²²

2.32 There are grounds for asserting general differences in young people's social and emotional skills compared with those of adults. Adolescence has been described according to three developmental stages. The first stage (around the age of 10 to 14) involves a shift of attachment from parents to peers, the middle stage (around 15 to 17) involves the consolidation of self-image, experimentation and advancement of logical

19. L Weithorn and S Campbell, "The competency of children and adolescents to make informed treatment decisions" (1982) 53 *Child Development* 1589.

20. T Grisso and L Vierling, "Minors' consent to treatment: a developmental perspective" (1978) 9 *Professional Psychology* 412. See also A E Buchanan and D W Brock, *Deciding for others: the ethics of surrogate decision making* (1990) Ch 5. See the discussion of the literature in R Duncan, *Holding Your Breath: Predictive Genetic Testing In Young People* (Doctoral thesis, Departments of Paediatrics and Public Health, The University of Melbourne, July 2005), [3.2.2.1].

21. See E Cauffman and L Steinberg, "(Im)maturity of judgment in adolescence: why adolescents may be less culpable than adults" (2000) 18 *Behavioral Sciences and the Law* 741.

22. See J Santelli, A S Rogers, W Rosenfeld, R DuRant, N Dubler, M Morreale, A English, S Lyss, Y Wimberly, A Schissel, "Guidelines for adolescent health research: a position paper of the Society for Adolescent Medicine" (2003) 33 *Journal of Adolescent Health* 396, especially 399.

thought, and the final stage (which may extend to the age of 20 and above) involves an increasing sense of comfort with oneself, awareness of others, and an appreciation for meaningful relationships. These stages mark a process of separation from one's parents towards an adult sense of oneself as an independent individual.

2.33 Young people's progress through these developmental stages of adolescence is marked by a number of common features that can have an effect on their behaviour. For example, in the struggle for a stronger sense of self-identity, young people's self-esteem can become particularly vulnerable. Their desire to conform with peers typically increases, peaking at around the age of 15. Adolescence can be a time for increased risk-taking behaviour, particularly in relation to experimentation with drugs, alcohol, and sex. It has been noted that teenagers often place more importance on the short-term consequences of a decision rather than the longer-term consequences of a more distant future. This explains why a teenager, fully aware of the long-term health risks involved, may decide to take up smoking because of the immediate benefits of peer acceptance and avoiding social ostracism.²³ It might also help to explain why the young woman in the case quoted at the beginning of this chapter was refusing a heart transplant, placing more importance on her desire not to be the odd one out, than increasing her prospects of survival, something which might seem completely rational for a person of her age, although an older person may have different priorities.

2.34 One American study, published in 2000,²⁴ compared a group of high school students (in their mid to late teens) with college students (over 18) in order to assess any general differences in each group's emotional and social development. Based on its findings, the study concluded that, some time during late adolescence, important progress occurs in the development of individuals' self-reliance (rather than reliance on peers), sense of individual identity, ability to appreciate long-term consequences of actions, and an ability to control impulsive or aggressive behaviour. No appreciable development of these characteristics was said to be evident past the age of 19. At the same time, the study emphasised that individuals of the same age may differ significantly in the development of these characteristics, making it difficult to mark a general chronological boundary for this level of maturity. The differences in maturity in young people of similar ages may be due not just to individual differences in personality, but also to differences in their situations and previous experiences with the health system. This explains why, for example, young people who are chronically or terminally ill are often described as having a level of maturity beyond their years, shaped to a large extent by their previous

23. E Scott, N D Reppucci and J Woolard, "Evaluating adolescent decision making in legal contexts" (1995) 19 *Law and Human Behavior* 221, 230-231.

24. The study relied on data obtained from questionnaires answered by a group of eighth, 10th, and 12th grade high school students and college students, all from Philadelphia. Overall, the sample consisted of more than 1,000 adolescents and adults aged between 12 and 48. The conclusions flowing on from this study were directed specifically at any implications it may have for policies relating to juvenile offenders. See E Cauffman and L Steinberg, "(Im)maturity of judgment in adolescence: why adolescents may be less culpable than adults" (2000) 18 *Behavioral Sciences and the Law* 741.

experiences with the health system, and with the necessity of facing situations and decisions which most young people of the same age will never have to experience.²⁵

Conclusions

2.35 Certain conclusions can be drawn with reasonable confidence based on the empirical and psychological research. First, groups of young people from their mid-teens have been shown to demonstrate cognitive or intellectual skills similar to those of the average adult for the purpose of understanding information relating to health care and weighing up alternative options for care. Secondly, the human brain is still developing physically during adolescence, and the effects, if any, of these physical developments on a teenager's decision-making skills are not clear. Thirdly, there are a number of common characteristics of being young which can be explained according to theories of young people's social and emotional development. These characteristics include an emphasis on peer acceptance and on the short-term consequences of actions, and a tendency towards impulsive or risk-taking behaviour. The effects of these characteristics on young people's decision-making skills are not clear, although some studies suggest that they do tend to detract from a young person's ability to make independent decisions and exercise a "wise" or "mature" choice.

2.36 It is clear that there is still much more that is not known about young people's decision-making capacities than is known. There is no conclusive or definitive answer to the question of whether empirical evidence justifies limiting young people's right to make health care decisions. To a large degree, the answer depends on the criteria to be applied in assessing decision-making competence. To what extent should a legal threshold for competence look beyond young people's cognitive or intellectual abilities to a broader notion of their social and emotional maturity? After all, the assessment of an adult's legal competence to consent to treatment focuses on his or her intellectual abilities, that is, the ability to understand information, at least in a broad way, and make a choice based on that information. An assessment of legal incompetence in an adult may be based on a finding that the adult's ability to choose was impeded because of, for example, a delusion or some other form of mental illness.²⁶ But the extent to which an adult's choice is affected by his or her emotional and social maturity and life experience is not a matter for consideration.

Recognising young people's decision-making capacity in other areas of the law

2.37 The law limits young people's ability to make choices in other areas of their lives beyond their health care. These restrictions are based on the same belief that young people need protecting from their own immature judgment. However, there is

25. See D R Freyer, "Care of the dying adolescent: special considerations" (2004) 113 *Pediatrics* 381. See also Dr S Trethewie, Department of Palliative Care, Sydney Children's Hospital at Randwick, *Consultation*; and Department of Pain and Palliative Care, Children's Hospital at Westmead, *Consultation*.

26. See, for example, *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290; *Re JT (Adult: Refusal of Medical Treatment)* [1998] 1 FLR 48; *Rochdale Healthcare (N.H.S.) Trust v C* [1997] 1 FCR 274; *Re W* [1993] Fam 64.

inconsistency in the ages set by the law for recognising young people's right to decide about these various aspects of their lives. Below are a few examples.

2.38 **The age of consent to sex.** In New South Wales, it is an offence to have sex with a person who is below the age of 16, whether that person is of the same or the opposite sex, and it is no defence that the person consented.²⁷ Fixing an age below which the law will not recognise the validity of a young person's consent to sex has been described as an attempt to protect young people from physical and psychological harm caused by engaging in sex before they are mature enough to make a proper judgment about it, as well as preventing their sexual exploitation by older people.²⁸ The age of consent is said to amount to a determination about when young people should be allowed to exercise autonomy and freedom of choice in sexual relationships.²⁹ There continues to be disagreement about the age at which the law should recognise the validity of a young person's consent to sex, with suggestions that the age should be lowered to 15, or even 14.³⁰

2.39 **Consent to marriage.** A person must usually be 18 (that is, an adult) to be allowed to marry. Young people between the ages of 16 and 18 may be allowed to marry if they have the consent of their parents or guardians, as well as authorisation from a court. The court may dispense with the need for parental consent.³¹

2.40 **Alcohol.** There is no absolute prohibition on young people drinking alcohol. It is an offence, however, for a person below the age of 18 to possess or consume alcohol in a public place without a reasonable excuse or without the supervision of a responsible

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27. See *Crimes Act 1900* (NSW) s 66A-66D. Section 77 of the *Crimes Act* provides that it is no defence to a charge under a number of sections, including s 66A-66D, that the victim gave consent.
 28. Australia, Standing Committee of Attorneys General, Model Criminal Code Officers Committee, *Model Criminal Code, Chapter 5, Sexual Offences Against The Person*, Report (1999) 119.
 29. Australia, Standing Committee of Attorneys General, Model Criminal Code Officers Committee, *Model Criminal Code, Chapter 5, Sexual Offences Against The Person*, Report (1999) 119.
 30. The Model Criminal Code Officers Committee initially suggested that the general age of capacity to consent to sex be fixed at 16. It subsequently decided against trying to fix an age because of the strong and passionate disagreement that any age suggested invoked. It concluded that the issue was a matter of intense debate in the community, and that it was a moral as well as a legal question: see Australia, Standing Committee of Attorneys General, Model Criminal Code Officers Committee, *Model Criminal Code, Chapter 5, Sexual Offences Against The Person*, Report (1999) 122-123. In previous years, the Royal Commission on Human Relationships had recommended a general age of consent to sex be fixed at 14: see Australia, Royal Commission on Human Relationships, *Final Report* (1977) vol 5, 210.
 31. See *Marriage Act 1961* (Cth) s 11-13.

adult.³² It is also an offence for a person below the age of 18 to be in a restricted area of a licensed premise,³³ and to be served or consume alcohol on a licensed premise.³⁴

2.41 **Cigarettes.** Young people do not commit an offence by smoking cigarettes. However, a young person in possession of cigarettes in a public place may have them seized by the police.³⁵ A person who buys cigarettes for a person below the age of 18, or who sells cigarettes to a person below the age of 18, is guilty of an offence.³⁶

2.42 **Driving.** A young person is eligible for a learner's permit to drive a car under adult supervision at the age of 16, and a provisional licence at 17. Recent changes to the P-plate system in New South Wales impose tighter restrictions on provisional drivers, such as restricting the number of passengers driven by a P-plate driver at night time. These changes are aimed at reducing the disproportionately high number of fatalities and serious injuries among drivers in the 17-25 year age group, which have been partly attributed to inexperience, diminished perception of risk, and dangerous driving under peer pressure.³⁷

2.43 **The age of criminal responsibility.** A person below the age of 10 cannot be charged with a criminal offence.³⁸ A person between the ages of 10 and 14 cannot be convicted of an offence unless it is shown (among other things) that the person knew that what he or she was doing was seriously wrong and not just naughty. This is the principle of *doli incapax*. There have been recent campaigns in the media to lower the age of criminal responsibility, in response to a couple of cases involving children committing what were described as particularly heinous, "adult" crimes.³⁹

2.44 **Instructing a legal representative in care proceedings.** The *Children and Young Persons (Care and Protection) Act 1998* (NSW) provides that a person below the age of 12 is to be presumed incapable of giving proper instructions to his or her legal

32. See *Summary Offences Act 1988* (NSW) s 11.

33. See *Liquor Act 1982* (NSW) s 116A.

34. See *Liquor Act 1982* (NSW) s 114-115.

35. See *Public Health Act 1991* (NSW) s 58(1).

36. See *Public Health Act 1991* (NSW) s 58A, 59.

37. See *Road Transport (Driver Licensing) Regulation 1999* (NSW) cl 15CA. See also NSW Road Traffic Authority, *Annual Report 2007*, 48; "P-plate restrictions to be considered" *Sydney Morning Herald* (Sydney), 25 November 2006, 1-2; "Over 25s to be exempt from P-plate restrictions" *ABC News Online*, 10 June 2007. See also NSW Law Reform Commission, *Young Offenders*, Report 104 (2005) [1.4]-[1.7].

38. *Children (Criminal Proceedings) Act 1987* (NSW) s 5. For the special rules that apply to sentencing young offenders (offenders below 18), see NSW Law Reform Commission, *Young Offenders*, Report 104 (2005).

39. These campaigns culminated in a review by the Criminal Law Review Division of the law relating to *doli incapax*: see NSW, Attorney General's Department, Criminal Law Review Division, *Review Of The Law On The Age Of Criminal Responsibility Of Children* (2000). See also H Figgis, *Juvenile Justice: Some Recent Developments* (Briefing Paper No 5/99, NSW Parliamentary Library Research Service, March 1999) and, more recently, "NSW Opposition wants criminal responsibility lowered to 10" *ABC News Online*, 2 March 2007.

representative in care proceedings in the Children's Court, and that a person aged 12 or above is presumed capable of doing so. Both presumptions are rebuttable.⁴⁰

2.45 These examples indicate that the law does consistently limit young people's exercise of choice because of a belief that it is necessary to do so in order to protect them from their immaturity, but that it also consistently recognises that they are capable of maturing to a sufficient level to allow them to act autonomously below the age of adulthood. The law is not consistent, however, in the ages it identifies as signifying sufficient maturity. Perhaps the discrepancies in the ages of consent may be explained on the basis that the level of maturity required to exercise choice properly differs according to the particular type of activity in question. Or perhaps these discrepancies can be explained on the basis that they reflect an essentially moral choice about when young people should be given responsibility, for example, to be sexually active, or criminally liable. Or perhaps they reflect pragmatic policy decisions made to respond to the realities of young people's lives (for example, that many people below the age of adulthood are sexually active).

THE PRACTICAL BENEFITS OF INVOLVING THE YOUNG PATIENT

2.46 Irrespective of young people's current legal entitlements, it is consistently argued in the literature,⁴¹ and reiterated in the Commission's consultations with health practitioners,⁴² that it is best practice to involve young people in making decisions about their health care, as well as their parents and other family members. Agreement with the decision by both the young patient and his or her family is usually crucial to ensuring co-operation with the treatment plan. Opposition to the treatment decision, either by the young person affected, or his or her family, or both, generally hinders the effectiveness of the treatment. This may be especially so when the treatment involves long-term follow-up care, such as taking medication for the rest of the young person's life. Perhaps particularly in the case of mental illness or emotional or behavioural disturbances, improvement in a young person's health can be obstructed if the young person or a parent refuses to accept that the young person has a problem that will benefit from professional help.⁴³ While the

40. See *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 99B and 99C.

41. For example, see M Kang and P Chown, *GP Resource Kit: Enhancing The Skills Of General Practitioners In Caring For Young People From Culturally Diverse Backgrounds* (NSW Transcultural Mental Health Centre and NSW Centre For The Advancement Of Adolescent Health, May 2004), 33-34, 87; NSW Centre for the Advancement of Adolescent Health, *NSW Roundtable On Youth Development* (September 2006); NSW Centre for the Advancement of Adolescent Health, NSW Department of Health, *Access Study: Youth Health Better Practice Framework* (2005); L Sanci, *Adolescent Health Care Principles* (Centre for Adolescent Health, Melbourne, 2001).

42. Department of Psychological Medicine, Children's Hospital at Westmead, *Consultation*; Dr S Towns, Department of Adolescent Medicine, Children's Hospital at Westmead, *Consultation*; Dr M Kang, Department of General Practice, University of Sydney, *Consultation*.

43. See Department of Psychological Medicine, Children's Hospital at Westmead, *Consultation*. It was noted in this consultation that it is more often the parents who

law allows health practitioners to use reasonable force to provide a young person with treatment for which a valid consent has been obtained (either by the young person's parents or by a court), there are likely to be practical difficulties in administering treatment that the young person opposes. For this reason, whatever the law's approach may be in delineating the entitlements of young people and their families in the decision-making process, the best therapeutic benefits for the young person will usually be gained by engaging him or her in the treatment decision.

THE ROLE AND RESPONSIBILITIES OF PARENTS AND OTHER CAREGIVERS

*Ideally the relationship between parent and infant involves an awareness of a kind of union between people which is perhaps more suitably described in poetic-spiritual language than in analytic moral terminology. We share our selves with those with whom we are intimate and are aware that they do the same with us.*⁴⁴

2.47 Legislation which allows decisions about a young person's health care to be made by someone other than a parent (whether that person be the young person himself or herself, or someone representing the State) must consider the implications this has for the responsibilities and role of parents.

2.48 Most loving parents would see themselves as playing a pivotal role in their children's health care, just as they would consider themselves to be primarily responsible for ensuring that their children's health needs are appropriately met. Families from non-Western cultures may find the notion of recognising a young person's autonomy particularly puzzling if their own culture emphasises the parent's role as decision-maker in the family, and tends not to view adolescence as a stage of natural separation from one's parents.⁴⁵

2.49 Australian law recognises the primacy of a parent's responsibilities and authority, as against the rest of the world, over his or her child, if that child is below the age of 18.⁴⁶ But it has also made clear that parents' authority over their minor children is not absolute, and that their right to control their children does not exist for their benefit but rather for the benefit of their children while their children's immaturity requires their control and

refuse to accept that their child needs professional help. See also *Director General, New South Wales Department of Community Services v Y* [1999] NSWSC 644.

44. F Schoeman, "Rights of children, rights of parents, and the moral basis of the family" (1980) *Ethics* 6, 8.

45. Interview with J Zou, sessional clinician, Transcultural Mental Health Centre (Telephone interview, 21 September 2006).

46. See *Family Law Act 1975* (Cth) s 61B, 61C. See also *Secretary, Department of Health and Community Services v JWB (Marion's case)* (1992) 175 CLR 218, 235 (Mason CJ, Dawson, Toohey and Gaudron JJ) which identified the predecessor of these provisions of the *Family Law Act*, s 63E, as defining a young person's guardian as the person with responsibility for that young person, as against the rest of the world.

protection.⁴⁷ The law will generally recognise the validity of parents' consent because it considers them to be the most appropriate people to decide on behalf of their children who lack capacity to make that decision themselves. Any right to decide on behalf of their child derives from a parental duty to care for their child, and exists only as long as it is needed to protect him or her, and provided it can be seen as promoting the child's best interests.⁴⁸ As such, it cannot be said that parents have an inalienable and legally enforceable right relating to the upbringing of their children.⁴⁹ While the courts continue to emphasise the role of parents as the adults primarily responsible for their child's safety, health and well-being, it is also now expected that family life, and a parent's role in that family, will accommodate respect for young people's growing maturity and their right to participate in decisions affecting them.⁵⁰

2.50 Of course, not everyone may agree with the courts' views of modern family dynamics. At its best, the family provides its individual members with a strong sense of identity and belonging, and satisfies a fundamental human desire for intimacy and tenderness. By focusing on the individual entitlements of the maturing young person, the law arguably detracts from the crucial role that the parent-child relationship plays in that child's development and in the well-being of the family as a whole. It has been said that, instead, the law should give loving parents a wide discretion to guide their children and pursue family goals that extend beyond the goals of its individual members.⁵¹ Those who argue for legal recognition of the decision-making rights of mature young people may be misguided to the extent that they assume that maturity and decision-making capacity can be measured and defined according to a single, fool-proof standard. In reality, denial of the parent's right to decide may come down to the treating health practitioner making a personal judgment about a young person's maturity, and whether the care in question serves that young person's best interests. This effectively replaces the judgment of parents, who care for their child on a daily basis, with that of a health practitioner, who is much less involved, and has less of a vested emotional interest, in the young person's well-being. A law which imposes some threshold level of competency for allowing young people to make their own health care decisions arguably denies parents the opportunity to help their children develop life skills necessary for their longer-term autonomy. The same

47. See *Secretary, Department of Health and Community Services v JWB (Marion's case)* (1992) 175 CLR 218 at 237 (Mason C J, Dawson, Toohey and Gaudron JJ) citing *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112. See also *T and F and Ors* [1999] FLC 92-855, [66]. See generally Chapter 8 (special medical treatment).

48. See *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 170 (Lord Fraser); *Marion's case* (1992) 175 CLR 218, 315-316 (McHugh J).

49. The Court of Appeal in *Gillick* [1985] 1 All ER 533, 2 WLR 413 found that any doctor giving contraceptive treatment to a girl below the age of 16 would be infringing the inalienable and legally enforceable right of parents relating to the custody and upbringing of their children. The House of Lords reversed this decision: [1986] AC 112. The High Court of Australia followed the House of Lords' decision, considering it to be of persuasive authority and as forming part of the common law of Australia: see *Marion's case* (1992) 175 CLR 218.

50. See *Axon v Secretary of State for Health and Family Planning Association* [2006] QB 539.

51. See L F Ross, "Health care decisionmaking by children: is it in their best interests?" (1997) 27 *Hastings Center Report* 41, 43.

objection could be applied to the intervention of the State, through its courts, in decisions affecting a young person's health care. To many lay people, the idea that an individual judge, to whom a young person is a complete stranger, might know better than a loving parent what decision will best serve that young person's welfare will seem ludicrous.

2.51 In response, it can be argued that respect for a young person's autonomy and the role of parents in guiding their children are not necessarily mutually exclusive. While parents' responsibilities and roles may change to meet their maturing child's attempts at asserting independence, they can nevertheless continue to play a pivotal, though different, part in their child's life. It is true that the intimate and intense nature of the parent-child relationship must necessarily mean that parents will usually intuitively judge what is in their child's best interests. The law recognises this, and for this reason appoints parents as the primary decision-makers for their children. But there must also be times when a parent's emotional involvement in his or her child's life can cloud that parent's judgment about what serves the young person's best interests. An example of this is where a young person is terminally ill, and decisions must be made about whether to provide him or her with palliative care or pursue a more aggressive form of treatment. Faced with that choice, what parent's first reaction would not be to want to fight to keep his or her child alive, on the chance, no matter how miniscule, of a cure? But such a decision may not be considered by many, such as the treating practitioners or even the young person himself or herself, to serve the young person's best interests. In situations like this, it may be useful to be able to resort to a less emotionally involved arbiter, such as the court, to weigh up the choices.⁵²

SERVING THE YOUNG PERSON'S "BEST INTERESTS"

2.52 There is a principle now well established in Australian and international⁵³ law that the application of a law or decision relating to a young person must serve his or her best interests or, put differently, that the young person's welfare is to be the paramount consideration. For example, at the federal level, the *Family Law Act 1975* (Cth) stipulates that the application of that Act in relation to children, including the making of various orders regarding residence and contact with parents, are to serve the child's best interests as the paramount concern.⁵⁴ The State's child protection legislation also expressly nominates as its first priority the best interests of the child.⁵⁵ In addition to specific expressions of the best interests principle in legislation, the State's Supreme Court retains

52. See Dr S Trethewie, Department of Palliative Care, Sydney Children's Hospital at Randwick, *Consultation*; Department of Pain and Palliative Care, Children's Hospital at Westmead, *Consultation*.

53. The paramountcy of the child's best interests is enshrined in the United Nations, *Convention on the Rights of the Child*, opened for signature 20 November 1989, art 3 (entered into force 2 September 1990).

54. See, for example, *Family Law Act 1975* (Cth) s 60B, 60CA, 67V.

55. See *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 9(a).

a general power, derived from the common law, to intervene in decisions affecting young people in order to protect their best interests or ensure that their welfare is protected.⁵⁶

2.53 The Supreme Court's general power allows it to intervene in decisions about a young person's health care in order to ensure that a particular health care decision serves the young person's best interests. The application of the best interests principle to the health care setting has resulted in the Supreme Court overriding a parent's or young person's decision if it considered it to be contrary to the young person's long-term physical health. To refer again to the example cited at the beginning of this chapter, the Court ultimately rejected the young girl's decision to refuse a heart transplant and itself authorised the hospital to carry out the operation on the basis that this was what was best for the young patient. Similarly, in cases where young people or their parents have refused life-saving health care for the young person because it is contrary to their religious beliefs, the courts have overridden that decision and authorised the procedure.⁵⁷ It seems that the courts will typically err on the side of preserving the young person's life even if this means going against his or her spiritual convictions. This has been justified on the basis that a young person may later change his or her mind, and that the court should allow him or her the chance to survive in anticipation of that possibility:

*When making this decision, which is a decision of life or death, I have to take account of the fact that teenagers often express views with vehemence and conviction – all the vehemence and conviction of youth! Those of us who have passed beyond callow youth can all remember convictions we have loudly proclaimed which now we find somewhat embarrassing. I respect this boy's profession of faith, but I cannot discount at least the possibility that he may in later years suffer some diminution in his convictions ...*⁵⁸

2.54 Likewise, the courts will usually authorise life-saving treatment that a young person's parent has refused because it is contrary to the family's religious beliefs. In these situations, the courts generally find that it is in the best interests of the young person to be given the chance to survive, rather than to abide by what his or her parents believe to be in their child's spiritual best interests.⁵⁹

2.55 Sometimes, the operation of the best interests principle requires the courts to make a judgment about whether a young person's quality of life is worth saving, or whether death would better serve his or her interests. This predicament has usually arisen in cases

56. For a fuller discussion of the Supreme Court's *parens patriae* jurisdiction as it relates to the law concerning young people's consent to health care, see para 4.47-4.51.

57. For example, *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386; *Re S* [1994] 2 FLR 1065; *Minister for Health v AS and Anor* [2004] WASC 286 (teenaged Jehovah's Witnesses refused blood transfusions); *Re A* [2001] Fam 147 (parents, who were Catholic, refused to authorise the separation of their conjoined twins on religious grounds). See also *Re Paul* [2008] NSWSC 960.

58. See *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386, 393 (Ward J). See too M Blake, "Religious beliefs and medical treatment: the challenge to patient consent" (2007) 19 *Bond Law Review* 26.

59. See M Blake, "Religious beliefs and medical treatment: the challenge to patient consent" (2007) 19 *Bond Law Review* 26.

involving very young children who suffer gross disabilities that greatly impede their quality of life. While Australian law does not countenance positive steps to be taken to end another person's life, in some instances life-saving treatment may be lawfully refused. The courts may intervene in a decision either to refuse or accept such treatment where a young person is terminally ill or severely physically disabled and suffering pain as a result, with small prospects of long-term survival or improvement. There are no clear-cut rules about the degree of pain and suffering or level of disability that will give rise to a court authorising the end of life-saving treatment. It has been said that the presumption in favour of preserving life is strong, but that there are extreme cases where to prolong treatment would be so cruel as to be intolerable. A child suffering from Down syndrome has not been considered such an extreme case as to justify the rejection of life-saving treatment.⁶⁰ But in other instances, a court has authorised the refusal of such treatment for a child suffering severe brain damage, without mobility, sight, speech or hearing,⁶¹ or for a terminally ill child who requires ventilation causing increasing distress.⁶² Judges vary in the ways they approach the task of deciding whether or not it is in the best interests of a young person to be allowed to die. Some have considered whether life would be intolerable to this particular child, while others have used phrases such as "demonstrably awful" as a requirement which must be shown to apply to a child's life before the court will allow that life not to be saved.⁶³

2.56 In protecting a young person's best interests, the Supreme Court is empowered to use reasonable force and detention in order to ensure that a young person receives treatment which he or she is refusing but which the Court has decided should occur.⁶⁴ The Court also has the power to order a hospital or health practitioner to take positive steps to provide treatment to a patient, even if the hospital or health practitioner does not agree with the administration or continuation of such treatment.⁶⁵

2.57 It is a common criticism of the best interests principle that it is too vague or indeterminate. While in theory many might support the notion that decisions concerning young people should seek to further their best interests, what does that term really mean and who should get to decide on its content? In the absence of any pre-determined criteria, it must be impossible for the person assessing a young person's best interests not to impose his or her own values and beliefs into that assessment:

[T]he best interests principle does no more than identify the person whose interests are in question: it does not assist in identifying the factors which are relevant to the best interests of the child ... in the absence of legal rules or a

60. *In Re B (A Minor) (Wardship: Medical Treatment)* [1981] 1 WLR 1421.

61. *In Re J (A Minor) (Wardship: Medical Treatment)* [1991] Fam 33.

62. *Re C (A Minor) (Medical Treatment)* [1998] Lloyd's Rep Med 1.

63. See E Jackson, *Medical Law: Text, Cases and Materials* (2006), 977.

64. See *Director General, New South Wales Department of Community Services v Y* [1999] NSWSC 644.

65. See *Northridge v Central Sydney Area Health Service* [2000] NSWSC 1241 (NSW Supreme Court, Common Law, O'Keefe J) (area health service ordered to provide necessary and appropriate medical treatment to preserve the life of a brain damaged adult man), cited in *WK v Public Guardian (No 2)* [2006] NSWADT 121 (NSW Administrative Decisions Tribunal General Division, Magistrate Hennessy (Deputy President), [15].

*hierarchy of values, the best interests approach depends upon the value system of the decision-maker. Absent any rule or guideline, that approach simply creates an unexaminable discretion in the repository of the power.*⁶⁶

2.58 Of course, this is not the only area of law where judges must exercise a discretion in the application of imprecise concepts. It is an exceptional discretion, however, because it necessarily involves judgments about moral and ethical matters in situations where there may often be great potential for controversy and legitimate disagreement. In the examples above – and in many of the cases that come to the courts’ attention – the exercise of the courts’ discretion will have life or death consequences, forcing judges to take a position about religious questions or make a decision about the value of continuing a person’s life. Besides these life and death decisions, there are many other situations where consideration of a young person’s best interests could require a court to take a view involving moral considerations. For example, a court might be asked to decide whether it is in the best interests of a young girl to be permitted to undergo a termination of pregnancy, or to refuse a termination.⁶⁷ Or it might be required to decide whether it is in a young person’s best interests to undergo cosmetic surgery that will have no benefits to his or her physical health but is sought for the sake of his or her emotional well-being and self-confidence.

2.59 Some critics of the best interests principle have argued that it should have no place at least in the decision-making process for young people with sufficient maturity to be competent to make their own health care decisions.⁶⁸ Others have suggested that the courts should follow what would be arguably a more honest approach, openly admitting to a public policy which prioritises the protective duty of society towards its young people and which consequently will not allow them to act on decisions which may endanger their physical health. This would be preferable to attempting to justify State intervention by resorting to (and distorting) legal notions of competence and best interests.⁶⁹

2.60 The formulation of new legislation dealing with health care decision-making for young people requires consideration of the place and content of the “best interests” principle in the hierarchy of principles underlying the Commission’s legislative scheme. The best interests principle is firmly entrenched in our laws relating to young people and to the treatment of vulnerable members of society. The Supreme Court’s power, derived from this principle, is a wide-sweeping and general one. Although it could be excluded by legislation from the decision-making process for young people’s health care, or aspects of

66. See *Marion’s case* (1992) 175 CLR 218, 270-271 (Brennan J dissenting). See too P Parkinson, “Comments: The values of parliament and the best interests of children – a response to Professor Chisholm” (2007) 21 *Australian Journal of Family Law* 213.

67. For example, see *Re B (Wardship: Abortion)* [1991] 2 FLR 426. See Chapter 8.

68. For example, see the comments of Madam Justice Russell in *CU (Next friend of) v McGonigle* [2003] ABCA 66, [33], and discussion in L Ferguson, “The end of an age: beyond age restrictions for minors’ medical treatment decisions” *Paper prepared for the Law Commission of Canada* (24 October 2004), 20-12; L Bunney, “The capacity of competent minors to consent to and refuse medical treatment” (1997) 5 *Journal of Law and Medicine* 52, 63.

69. See A Grubb, “Commentary on *Re L (Medical Treatment: Gillick Competency)*” (1999) 7 *Medical Law Review* 58, 61.

it, it would require a sound basis for doing so, given the centrality of the best interests principle to our legal system.

2.61 In other places, legislation has made the best interests principle one of the criteria for determining a young person's decision-making competence, and has given to medical practitioners the responsibility of determining whether a decision or treatment serves a young person's best interests when assessing whether or not the young person in question is competent.⁷⁰ It has been said that the treating health practitioner is the person best placed to make a determination about whether or not a particular treatment is in the young person's best interests,⁷¹ and it seems that courts are generally likely to follow the advice of the treating medical practitioners about whether proposed care serves a young person's best interests.⁷²

2.62 Alternatively, some legislation, such as the *Family Law Act 1975* (Cth), seeks to regulate the exercise of the courts' discretion in determining best interests by providing for guidelines to direct the courts' attention to consider specified matters.⁷³ This approach has gained some support on the basis that, at least in theory, it better reflects general community values, as expressed by Parliament, about what serves a child's best interests rather than relying to such a large degree on the subjective values of the individual judge. It has also been argued that reliance on such guidelines in the exercise of the courts' discretion will allow for greater consistency in similar cases.⁷⁴ On the other hand, the application of legislative guidelines such as those under the *Family Law Act* may prove controversial, generating disagreement and debate about their interpretation and the exact weight that the courts should place on the factors specified in the guidelines.⁷⁵

2.63 Ultimately, we do not see any advantage in modifying or attempting to clarify in legislation the best interests principle as it applies to decisions concerning young people's health care. We understand the objections to the best interests principle. In particular, we accept that the application of the principle is vulnerable to the subjective interpretation of the individual judge who at times cannot help but inject his or her own value system into the decision-making process. Although there are many other areas of the law where

70. For example, *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 12(b)(i); *Infants Act*, RSBC 1996, c.223 (British Columbia) s 17(3)(b).

71. See *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, 174 (Lord Fraser).

72. See E Jackson, *Medical Law: Text, Cases, and Materials* (2006), 977-978 (at least in relation to decisions about prolonging life-sustaining treatment).

73. See *Family Law Act 1975* (Cth) s 60CC.

74. See P Parkinson, "The values of parliament and the best interests of children – a response to Professor Chisholm" (2007) 21 *Australian Journal of Family Law* 213.

75. See the debate between Professors Parkinson and Chisholm about the correct application of the guidelines to hypothetical cases: R Chisholm, "Making it work: the Family Law Amendment (Shared Parental Responsibility) Act 2006" (2007) 21 *Australian Journal of Family Law* 143; P Parkinson, "The values of parliament and the best interests of children – a response to Professor Chisholm" (2007) 21 *Australian Journal of Family Law* 213; R Chisholm, "A brief reply to Professor Parkinson" (2007) 21 *Australian Journal of Family Law* 229. Consider also the interpretation of the legislation by the Full Court of the Family Court in *Goode and Goode* (2006) 36 Fam LR 422; FLC 93-286.

judges exercise a discretion, this area is perhaps unique in so far as it typically involves significant moral and non-legal issues. While we accept these objections, we nonetheless take the view that this is an area where there may sometimes be a need for a third party to intervene in decisions where there is disagreement about a young person's health care, and that, on balance, it is preferable that the third party be a judicial officer who is removed entirely from the circumstances of the particular case. And of course, the judge's discretion is not completely unfettered, in so far as he or she will have regard to any expert evidence relating to the best interests question in a particular case, and will also take account of previous applications of the best interests principle in similar cases. Discretionary decisions are also reviewable on appeal. Although such review is limited in scope, the appeal process is likely to iron out any idiosyncratic approach. We do not think that there is any benefit in recommending the introduction of legislative guidelines to assist in the application of the best interests principle since to do so is more likely to create new disagreement and confusion about their interpretation rather than provide clarification.

2.64 We take the view that the best interests principle should continue to operate, as it does now, as a safety net to protect young people even after they have been found legally competent to make health care decisions for themselves. To do so obviously is to treat them in a way that is different from the way in which the law treats competent adults, whose decisions are generally respected even if they seem foolish or self-destructive. Some may object that the Commission is taking a paternalistic approach, but we have concluded that it is appropriate for the law to take a protective role over young people even as they mature. In the discussion that follows, we discuss the views we have formed based on the psychological evidence, and we refer to the fact that there is good reason to believe that young people, even as they reach the intellectual or cognitive capacities of adults, still as a group tend to lack a certain level of maturity and world experience because of their youth. For this reason, it is appropriate that the law continue to protect them from harmful decisions that may have significant long-term effects, by subjecting their decisions to the potential scrutiny of the courts according to the best interests principle.

CONCLUSIONS

2.65 The preceding discussion has sought to come to terms with the issues at the centre of the debate about the decision-making process for young people's health care. In designing a legislative framework to regulate this process, the Commission must decide whether it should continue the traditionally protective approach of the law, or whether, and to what extent, it should recommend legislation that provides young people with greater decision-making autonomy. In doing so, it must also consider what the appropriate role of parents and caregivers should be under this framework. We have come to the following conclusions.

2.66 A person's right to decide about his or her health care reflects a fundamental principle of the law that we are autonomous beings with an entitlement to make our own choices. This principle is so important to our legal system and to our society that, for adults, it takes precedence over the requirement that the law respect and preserve the sanctity of life.

2.67 Society now perceives young people as individuals with rights and points of view, and it places great emphasis on the right of young people to participate. In the context of

this growing emphasis on young people as rights bearers, and given the importance which we place on individual autonomy, a law that interferes with a young person's autonomy must have strong grounds for doing so.

2.68 The law recognises that young people may be sufficiently mature to make decisions in respect of many aspects of their lives, such as their sexual life. However, there is no single age which the law deems as signifying sufficient maturity for general decision-making autonomy.

2.69 There is strong empirical evidence to suggest that, generally speaking, young people from their mid-teens do not differ significantly in their cognitive abilities from adults, and are as capable as adults of understanding and processing information relating to health care decisions.

2.70 On the other hand, there is also evidence to suggest that teenagers' behaviour can be affected by a number of features that characterise the developmental stages of adolescence. While not conclusive about the impact of these characteristics on their decision-making skills, there is enough evidence to suggest that teenagers are still developing in their social and emotional maturity, and that this may cause them to view their choices in a different way from the average adult. However, the application of the adult test for competence to consent to treatment would not normally focus on these aspects of maturity that go beyond cognitive abilities, and so it is open to question whether the law should apply a separate (and more stringent) test for competence to young people to allow consideration of these other matters.

2.71 On balance, the Commission thinks that it should. We agree that our new legislation should follow in the direction first set in the cases of *Gillick* and *Marion*, and which now forms part of our law. It is consistent with modern social views of young people and with general legislative trends to acknowledge young people's growing maturity by recognising their entitlement to make decisions before they have become legal adults. Our legislative framework should reflect this and, indeed, that position is expressed in the first three principles set out in Recommendation 2. Nevertheless, the new legislation should recognise that entitlement only on satisfaction that young people are capable of exercising their choice with a certain level of maturity, and in doing so we concede that we are expressing a higher level of competence than that spelt out for adults. We have two reasons for doing so.

2.72 First, the law assumes a certain level of social and emotional maturity in adults. In reality, of course, adults might differ significantly in the range of their life experiences and in their experience in decision-making, as well as in other indicators of maturity such as a sense of self and ability to resist peer pressure. But these differences can be explained according to individual temperaments and idiosyncrasies. It would not be feasible to deny adults a claim to autonomy based on these individual differences. By contrast, young people as a class have been shown to be less developed than the average adult in many aspects of maturity.⁷⁶ While they may also demonstrate individual differences in the extent to which they have developed socially and emotionally, many features of adolescent behaviour can be explained by a progress through general developmental stages, and it is

76. See E Scott, N Reppucci, J Woolard, "Evaluating adolescent decision making in legal contexts" (1995) 19 *Law and Human Behavior* 221, 228.

reasonable to believe that as a class of people they will be more likely to exercise immature judgment because of their youth. It is appropriate for the law to protect young people from decisions made with insufficient maturity because they can be considered as a class (rather than just according to individual differences) to have a greater tendency than the general population to have a diminished ability to exercise independent and mature choices.

2.73 A second justification for limiting young people's autonomy in respect of making health care decisions is that in this way the law can better promote their long-term autonomy.⁷⁷ Because decisions about health care can often be life-changing, and the consequences of living with those decisions can be permanent and serious, it is appropriate for the law to protect young people from making decisions made with insufficient maturity which they may later regret and which may hinder their longer life chances. Of course, adults can also live to regret decisions with the benefit of hindsight but, again, those regrets are more likely to result from individual shortcomings rather than reasons attributable to their youth.

2.74 While the Commission's legislative framework seeks to recognise young people's entitlement to autonomy, it is also true that it ultimately errs on the side of protecting them. It does this by imposing a stricter standard of competence and by scrutinising any decision about their health care to see whether it promotes their "best interests", as reflected in the sixth principle appearing in Recommendation 2. The particulars of these aspects of the framework are discussed in Chapter 5.

2.75 The framework also addresses the role of parents and caregivers in the decision-making process by reinforcing and clarifying the law's current views of parents' rights and responsibilities. It acknowledges the primary role of parents in decisions about their children's health care to the extent that this promotes their children's best interests (as defined in subsequent chapters). The third principle included within Recommendation 2 reflects this position.

2.76 Recommendation 2 articulates the principles that we have relied on in drafting our recommendations. These principles have been included within the recommended legislation as an aide in its interpretation and application. The details of these principles have been mostly referred to in the preceding discussion. To a large degree, Recommendation 2 is drawn from the principles articulated in the *Children and Young Persons (Care and Protection) Act 1998* (NSW)⁷⁸ and the United Nations *Convention on the Rights of the Child*,⁷⁹ which both place importance on the notion of respect for young people's developing maturity while at the same time recognising the need to protect their best interests and reinforce the significant role of parents and family in young people's lives. It is worth noting that Recommendation 2 provides for the young person's best interests to be the primary consideration, which is consistent with the wording in s 9 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). This contrasts with Article 3 of the *Convention on the Rights of the Child*, which provides that the best

77. See L F Ross, "Health care decisionmaking by children: is it in their best interests?" (1997) 27 *Hastings Center Report* 41, 42.

78. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 9.

79. See in particular the United Nations, *Convention on the Rights of the Child*, art 3, 5, and 12.

interests of the child shall be a primary consideration. We have deliberately chosen to use “the” instead of “a” in our provision, as we consider the young person’s best interests to be the overriding consideration in the interpretation and application of the recommended legislation, for which there can be no other consideration of equal or greater importance.

Recommendation 2

The legislation should include a provision setting out the following principles to be applied in the interpretation and application of the legislation:

- Young people should be informed about matters relating to their health care, to the extent and in a manner appropriate to their age and maturity, and should be given the opportunity to express their views freely about these matters, and their views should be given due weight in accordance with their age and maturity.
- The developing autonomy of the young person should be acknowledged.
- Respect should be given to the responsibilities and role of parents in the health care of their child or, where applicable, the members of the extended family or persons legally responsible for the young person, in a manner consistent with the evolving capacities of the young person.
- Account should be taken of the culture, disability, language, religion and sexuality of the young person and, if relevant, those with parental responsibility for the young person.
- Access by young people to appropriate health care should be promoted.
- The best interests of the young person should be the primary consideration.

3. Definitions

- The scope of the new legislation
- The meaning of "parent"
- Defining "health practitioner" and "health service"
- Defining a "service"

THE SCOPE OF THE NEW LEGISLATION

3.1 The Commission's proposed legislation will map out a framework for making decisions about a young person's health care. There are four concepts that are central to this framework, and we have adopted the following terminology to refer to them:

- young person
- health practitioner
- health service, and
- parent.

3.2 The scope of our new scheme will be fixed by the way in which these key terms are defined: the definitions will identify the people and the services to be affected by the scheme. For the most part, these terms are self-explanatory and defining them should be uncontroversial, judging from the views put forward in the course of our consultation process. The exceptions are the terms, "health practitioner" and "health service". The Commission has struggled with the question of whether to define these terms narrowly or broadly, having received a diverse range of suggestions for formulating suitable definitions. We have ultimately chosen broad definitions and, in doing so, we have widened the scope of our scheme to apply to a larger group of people and services than originally anticipated.

3.3 Recommendation 3 below sets out the definitions of the new legislation's key terms. The rest of this chapter discusses our approach to formulating these definitions.

RECOMMENDATION 3

The legislation should adopt the following definitions:

a young person means a person who is under the age of 18 years,

a parent means a person having parental responsibility for the young person,

parental responsibility means all the duties, powers, responsibilities and authority which, by law, parents have in relation to their children,

a health practitioner means a natural person who is registered under a health registration Act,

a health registration Act means any of the following Acts:

Chiropractors Act 2001

Dental Technicians Registration Act 1975

Dental Practice Act 2001

Medical Practice Act 1992

Nurses and Midwives Act 1991

Optical Dispensers Act 1963

Optometrists Act 2002

Osteopaths Act 2001

Pharmacy Practice Act 2006

Physiotherapists Act 2001

Podiatrists Act 2003

Psychologists Act 2001

or an Act prescribed by regulations as a health registration Act.

a *health service* is a service provided by a health practitioner and includes the following services, whether provided as public or private services:

- (a) medical, hospital and nursing services,
- (b) dental services,
- (c) mental health services,
- (d) pharmaceutical services,
- (e) ambulance services,
- (f) community health services,
- (g) health education services,
- (h) welfare services necessary to implement any services referred to in paragraphs (a)-(g),
- (i) alternative health care services,
- (j) forensic pathology services,
- (k) a service prescribed by the regulations as a health service for the purposes of this legislation.

THE MEANING OF “PARENT”

3.4 The definitions of “parent” and “parental responsibility” in Recommendation 3 adopt the meanings given to those terms in s 3 of the *Children and Young Persons (Care and Protection) Act 1998*.

3.5 The definition of “parental responsibility” in the *Children and Young Persons (Care and Protection) Act 1998* is in turn taken from the *Family Law Act 1975* (Cth),¹ which adopts this terminology in substitution for terms such as “guardianship” and “custody”, the language of the original legislation which is now considered outmoded in so far as it symbolises notions of ownership over children.²

3.6 Although the definition of a parent in the *Children and Young Persons (Care and Protection) Act 1998* seems quite circular (a parent is a person with the responsibilities, etc of a parent), it can be understood to apply to those whom the law recognises as having parental status in relation to a young person. In most cases, this will be a biological or adoptive parent, subject to any court order limiting the scope of that status or responsibility or allocating aspects of that responsibility to someone else. It will also include a parent of a child artificially conceived.³ It will include the Minister for Community

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1. See *Family Law Act 1975* (Cth) s 61B. See NSW, *Parliamentary Debates – Children and Young Persons (Care and Protection) Bill 1998*, Legislative Assembly, 11 November 1998, 9762 (Faye Lo’ Po).
 2. See *Family Law Reform Act 1995* (Cth) s 31 and Cth, Family Law Council, *Patterns Of Parenting After Separation* (1992) [4.02] – [4.07].
 3. See *Family Law Act 1975* (Cth) s 60H, which recognises the legal status that a person has in relation to a child born to her, or born to the woman to whom that (male) person is married or with whom he lives, through artificial conception procedures.

Services in cases where a young person has been placed in the Minister's care following an order of the Children's Court.⁴

3.7 The definitions of a parent and parental responsibility in the *Children and Young Persons (Care and Protection) Act 1998* (NSW) have proved uncontroversial, and for this reason the Commission has chosen to adopt them in its new legislation. It makes sense to use terms that are already familiar to the courts and to those working in areas relating to child welfare, terms that have been applied and interpreted by State and federal courts for some time. And if the proposed legislation is implemented by way of enacting a new Part in a revamped *Children and Young Persons (Care and Protection) Act 1998*,⁵ then it will be an advantage to have adopted definitions that are consistent with the existing definitions of that Act.

3.8 In Chapter 6, we discuss the extent to which the law should recognise the role of caregivers other than parents in this decision-making process, and we make recommendations in that chapter for additional definitions of people who act in that caregiving role.

DEFINING A "YOUNG PERSON"

3.9 Recommendation 3 recommends that a "young person" be defined as a person below the age of 18. There are two points worth noting about this terminology. First, the Commission has preferred "young person" over "minor", the term appearing in its original terms of reference. Secondly, we have recommended that "young person" be the term generally applied to all people below the age of 18, without use of the term, "child" to refer to a younger age group. In doing so, we have chosen not to adopt the distinction that is made between a child and young person in the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

The legislation should use the term "young person" rather than "minor"

3.10 The Commission was asked to review the law relating to a *minor's* consent to medical treatment, the word "minor" being used to refer to a person who has not yet reached the age of legal adulthood (or the age of majority), which is 18.⁶ The Commission prefers the term "young person" to "minor". Although "minor" is a convenient way to refer to someone whom the law does not yet treat as an adult, it is an overly legalistic term, and one which some (perhaps particularly young people themselves) may find pejorative.⁷

4. See *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 79(1)(b).

5. See para 1.50-1.51.

6. See *Minors (Property and Contracts) Act 1970* (NSW) s 9.

7. See Public Forum on Minors' Consent to Medical Treatment, Parliament House, Sydney, 20 November 2006.

The legislation should not use the term “child”

3.11 “Child” was once the word used to refer to any person below the age of 18 in the predecessor to the *Children and Young Persons (Care and Protection) Act 1998* (NSW). The Act was in fact called the *Children (Care and Protection) Act 1987*.⁸ The term, “young person” was first used in the *Children and Young Persons (Care and Protection) Act 1998* (NSW) as a form of recognition of adolescence as a stage separate from childhood, on the way to adulthood.⁹ The 1998 Act brought in the distinction between a “child” (being a person below the age of 16) and a “young person” (aged 16 or over but below 18).¹⁰

3.12 The Commission does not wish to carry this distinction in terminology through to its proposed legislation. The introduction of the notion of a “young person” was progressive at the time, as it recognised the humanity and developing maturity of those aged below 18. However, we consider that the distinction has added unnecessary complication to the *Children and Young Persons (Care and Protection) Act 1998* because it is not immediately obvious when a section of the legislation applies to a specific age group, or to all people below the age of 18, without referral back to the initial definitions at the beginning of the Act. More fundamentally, we consider “young person” now to be a more appropriate way of referring to all those aged below 18, not just teenagers. Some may now find the word “child” patronising and demeaning, especially perhaps those on the brink of puberty. “Young person” is a term better able to recognise the individuality and humanity of people below the age of 18.

DEFINING “HEALTH PRACTITIONER” AND “HEALTH SERVICE”

Looking beyond doctors and dentists?

3.13 The terms of this reference are limited to a review of the law of consent to *medical treatment*. The Commission focused its initial discussion on medical treatment as that term is conventionally understood, that is, as a service provided by a registered doctor or a person working under the ultimate supervision of a registered doctor.¹¹ We did expand the scope of the review at this initial stage to consider dentists as well (and those working under their supervision), because the existing State legislation dealing with consent to

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8. The *Children (Care and Protection) Act 1987* (NSW) is repealed upon the whole commencement of s 3(1) of the *Children and Young Persons Legislation (Repeal and Amendment) Act 1998* (NSW).
 9. See NSW, Legislation Review Unit, Department of Community Services, *Review of the Children (Care and Protection) Act 1987: Recommendations for Law Reform* (December 1997), 9-10, Rec 1.3. The Review in fact recommended that the term, “young person” be used to refer to a person aged 14 to 17.
 10. The exception is the definition of a child for the purposes of Chapter 13 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) (children’s employment), which provides that a child in this chapter is a person aged below 15: see s 221.
 11. See NSW Law Reform Commission, *Minors’ Consent To Medical Treatment*, Issues Paper 24 (2004) [1.49] and issue 1.1.

treatment includes dentists and dental treatment within its framework.¹² We proceeded on this narrow footing, but we expressed concern that a review conducted according to such limited terms may eventually prove inadequate.¹³

3.14 That concern was reiterated again and again by those responding to the Commission's preliminary suggestions.¹⁴ It was pointed out that a statutory framework which articulated the decision-making process for refusing and consenting to medical and dental treatment would leave largely unregulated the decision-making process in other areas of young people's health care. There are many people who are potentially involved in providing health care to young people, and who may have a significant impact on young people's physical, mental and emotional well-being, but who do not work under the supervision of a doctor or a dentist. Nurse and midwife practitioners, for example, can be responsible for many aspects of the diagnostic and treatment process, including in some cases prescribing medication.¹⁵ Members of a number of other health-related occupations commonly work with young people but are not necessarily supervised by a doctor or dentist, such as psychologists, social workers, and dietitians. There are also a variety of alternative health therapists who often work independently of the medical profession, such as acupuncturists, chiropractors, psychotherapists and other counsellors. None of these occupations would come within the narrow definition of medical treatment initially put forward by the Commission. The question for us now is whether they should be included within the legislative framework, along with the medical and dental professions. The majority of people in submissions and consultation considered that they should be.

3.15 The Commission can see no policy reason for excluding from the scope of regulation certain health-related occupations other than the medical and dental professions. The examples which we have given show a variety of people whose work potentially involves providing health care to young people, whether that work requires physical contact, advice, the sharing of information, or the provision of remedies. Although general practitioners have been identified as the most likely professional group to be approached by young people with health concerns, young people are also said to be

12. See *Minors (Property and Contracts) Act 1970* (NSW) s 49.

13. See NSW Law Reform Commission, *Minors' Consent To Medical Treatment*, Issues Paper 24 (2004) [1.49].

14. See Doctors Reform Society, *Submission*, 2; S Siedlecky, *Submission*, 2; G Tomossy, *Submission*, 3; Commission for Children and Young People, *Submission*, [3.1]-[3.4]; Department of Psychological Medicine, Children's Hospital at Westmead, *Consultation*. But see Shopfront Youth Legal Centre, *Submission*, 2, which, on balance, favoured a narrow approach to defining "medical practitioner" and "medical treatment" to exclude advice, information, education, and counselling provided by counsellors, educators, and allied professionals, so as to allow young people of any age access to such services without first having to obtain parental consent. And see too Youth Action and Policy Association NSW, *Submission*, 2, which seems to limit its discussion to medical practitioner and treatment although does not discuss the possibility of a broader perspective.

15. See *Nurses and Midwives Act 1991* (NSW) s 19A (registration of nurse practitioners), s 20 (registration of midwife practitioners), and s 78A (provision for guidelines for the functions of nurse and midwife practitioners, including the possession, use, supply or prescription of drugs of addiction, restricted substances and poison).

inclined to seek help from a variety of counsellors, such as school counsellors and telephone counsellors, as well as community health services.¹⁶ The same principles require that such care be consented to, by a person competent to give that consent, as those that require a valid consent to medical and dental treatment.

Finding a definition

3.16 It is one thing to agree that legislation dealing with decision-making processes for young people's health care should not be limited to their medical and dental care. It is another thing to devise satisfactory definitions of health care and health practitioner that are neither too limiting nor over-inclusive.

3.17 Elsewhere, similar legislation has attempted to define "health care" and "health practitioner" in ways that look beyond services provided by the medical and dental professions.¹⁷ In Ontario, Canada, the *Health Care Consent Act 1996* defines "health practitioner" according to membership of one of a specified list of professional colleges including, for example, the College of Physicians and Surgeons, and the College of Nurses.¹⁸ By contrast, other jurisdictions have devised definitions according to more general concepts. In British Columbia, Canada, s 17(1) of the *Infants Act 1992* defines "health care" as anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose. The Quebec *Civil Code* articulates a young person's right to consent according to a distinction in care that is or is not required by the young person's "state of health".¹⁹ The Queensland Law Reform Commission recommended a legislative scheme to regulate decision-making for young people's health care, where the notion of "health care" was defined as the care or treatment of, or a service or procedure for, a young person to assess, diagnose, maintain or treat the young person's physical or mental condition, and a "health care provider" was defined as a person who provides health care in the practice of a profession or the ordinary course of

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16. See NSW Health, *Access To Health Care Among NSW Adolescents: Phase 1: Final Report* (NSW Centre for the Advancement of Adolescent Health, The Children's Hospital at Westmead, May 2002), 7.
 17. On the other hand, legislation in several jurisdictions has adopted a narrow definition focusing on medical and dental services: see for example *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4; *Medical Consent of Minors Act*, SNB 1976, c M-6.1 (New Brunswick) s 1. In New Zealand, s 36 of the *Care of Children Act 2004* refers to the right to consent to "medical, surgical or dental treatment or procedure", although s 37 does refer to a "health practitioner" in respect to immunity for the transfusion of blood to a child. "Health practitioner" is defined according to s 5(1) of the *Health Practitioners Competence Assurance Act 2003* (NZ) as a person who is, or deemed to be, registered with an authority as a practitioner of a particular health profession.
 18. See *Health Care Consent Act*, SO 1996, c 2, Sch A (Ontario) s 2. Similarly, although without specifically listing them, s 17(1) of the *Infants Act*, RSBC 1996, c 223 of British Columbia defines a "health care provider" as a person licensed, certified or registered in British Columbia to provide health care.
 19. The distinction applies to a young person aged 14 or over. See *Civil Code*, RSQ c.C-1991 (Quebec) arts 14, 17.

business.²⁰ In New Zealand, the Code of Health and Disability Services Consumers' Rights adopts the term, "health care provider".²¹ This is defined according to a list of specified people, including those who are or who are deemed to be registered with an authority as practitioners of a particular health profession.²² But the term also includes a very broad category of people who provide, or hold themselves out as providing, "health services to the public" whether or not for a charge.²³

3.18 The problem with these more general definitions is that they are uncertain, which potentially leads to disagreements in their interpretation. For example, reference in the British Columbian definition to care that is carried out for a therapeutic purpose immediately invites debate about the validity of the distinction between therapeutic and non-therapeutic procedures.²⁴ Reference in that same definition to cosmetic or other health-related purpose leaves unclear whether a range of acts, such as body-piercing, would be included within the scope of the legislation. Similarly, it could be argued that a tattooist or body-piercer comes within the definition of "health care provider" put forward by the Queensland Law Reform Commission, as a person who treats a young person's physical condition. Any concerns about a young person seeking the services of a tattooist or body-piercer are different from concerns about a young person seeking or requiring health care, and we would consider it neither appropriate nor desirable to address these different concerns in legislation which is essentially aimed at articulating the decision-making responsibilities of those involved in young people's health care. On the other hand, legislation which defines the notion of "health care" according to a specified list of services and service providers, while reducing the potential for disagreement in interpretation, runs the risk of excluding those who should be included within the notion of health care.

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20. See *Health Care Authorisation for Young People Bill 1996* (Qld) (DRAFT) cl 18, 19, in Queensland Law Reform Commission, *Consent To Health Care Of Young People*, Report 51 (1996) vol 2. Under cl 18(a) and (b), the Queensland Law Reform excluded from the definition of health care blood transfusions and non-touching health care. The Western Australian Law Reform Commission also considered that "medical treatment" should be given a broad meaning in the context of its discussion on young people's consent to medical treatment, although it did not put forward an actual definition of the term: see Western Australian Law Reform Commission, *Medical Treatment For Minors*, Project 77, Part 1, Discussion Paper (1988) [1.12].
 21. This term is defined in s 3 of the *Health and Disability Commissioner Act 1994* (NZ), and its definition applies to the Code as a piece of subordinate legislation: *Interpretation Act 1999* (NZ) s 34.
 22. See s 3(h) of the *Health and Disability Commissioner Act 1994* (NZ). The term "health practitioner" is defined according to s 2 of that Act and s 5(1) of the *Health Practitioners Competence Assurance Act 2003* (NZ).
 23. See *Health and Disability Commissioner Act 1994* (NZ) s 3(k). This subsection has been interpreted broadly to encompass providers who are not associated with health professions that have traditionally been regulated, and has been found to include a Shiatsu massage therapist, a beautician, and a social worker: see discussion in P D G Skegg and R Paterson (general eds), *Medical Law in New Zealand* (2006) [2.5.3].
 24. For a discussion of the distinction, see Brennan J in *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218, 269-274.

Adopting definitions from the *Health Care Complaints Act 1993*

3.19 The definitions of health practitioner, health service, and health registration Act in Recommendation 3 are taken largely from s 4 of the *Health Care Complaints Act 1993* (NSW). The *Health Care Complaints Act* provides a system for dealing with complaints against health care providers in New South Wales. We have chosen to follow its approach in defining these key terms for three reasons.

3.20 The *Health Care Complaints Act* seeks to find a balance between the more general and the more specific definition. It lists the types of health services that are to be included in its definition. It is an inclusive list. This means that it does not necessarily exclude another type of service that has not been listed. By specifying the types of services to be included within its scope, the legislation is made more readily understandable and more certain. By also allowing for services not specified to come within its scope, the legislation is not overly restrictive.

3.21 In the event of uncertainty in interpretation, there is an existing body of discussion and knowledge (if not case law)²⁵ that has grown up around the interpretation of these definitions used in the *Health Care Complaints Act*.

3.22 Adoption into the Commission's scheme of the definitions used in the *Health Care Complaints Act* ties in with the complaints system that we will be recommending for non-compliance with our recommended legislation. In Chapter 9, we discuss the ways in which our new scheme will deal with such non-compliance, a large part of which involves referral to the Health Care Complaints Commission.

3.23 There are a couple of important differences that need to be noted between the definition of a health practitioner and a health service in the *Health Care Complaints Act* and our recommended legislation. The definition of a health practitioner in the *Health Care Complaints Act* includes unregistered health practitioners. This would include those working in alternative health services such as traditional Chinese medicine, naturopathy, as well as psychotherapy. The definition of a health practitioner in our recommendation is confined to practitioners registered under a health registration Act (as defined) and does not include unregistered practitioners such as those working in these types of alternative health services.

3.24 Having accepted that people other than doctors and dentists (or those working under their supervision) may provide health services to young people, we initially took the view that any legislation that we recommend should cover all people providing a health service, whether or not they be registered with a professional body. On reflection, we think that this group, the unregistered health practitioners, should not be included within the legislative scheme that we are recommending. Our reason for taking this view is this. Our recommendations (and indeed, the current law) impose responsibilities on people who treat young people, to assess their competence in order to determine whether or not they can act on the wishes of a particular young person in respect of a particular treatment. With this responsibility comes a certain power: it is left largely to the practitioner to make that assessment of competence, in compliance with the law. Later in this report,²⁶ we

25. See Health Care Complaints Commission, *Consultation*.

26. See Chapter 5.

explain that our recommended legislation continues the approach of the current law in leaving this assessment of competence largely with the treating practitioner, because this is the only way of allowing for an assessment of each individual's capacities and level of maturity. In following this approach, we accept that we are bestowing on the treating practitioner a certain level of power (as well as a burden) with respect to the young patient.

3.25 Following on from this, we recommend in Chapter 9 that the legislation provide for a defence to health practitioners who make a reasonable but mistaken assessment about a young person's competence (or incompetence). This defence is intended to allow practitioners greater certainty, and therefore security, as to their responsibilities in seeing young patients and allow them to act without the constant anxiety of potentially facing legal action. The availability of such a defence does place not only responsibility, but also a certain level of trust, on the treating practitioner (subject to the important safeguard that he or she must be acting reasonably).

3.26 Practitioners who are registered with a professional body are subject to legislation that governs the exercise of their profession. The major function of a registration Act is to provide a vehicle for setting minimum standards for people practising the particular discipline and for maintaining those standards. Members of these professions are required to undertake a standard period of study and training. They remain answerable to their professional disciplinary body for as long as they practise their profession. These provide safeguards for ensuring that these health practitioners do not abuse the power with which they are endowed in assessing the competence of young people. Unregistered health practitioners, on the other hand, are not subject to any standardised training, they are largely unregulated,²⁷ and they are not subject to any disciplinary body. Since people of varying levels of experience and training can hold themselves out as alternative health practitioners, we think that it is too great a risk to give to unregistered health practitioners the responsibility of assessing a young person's competence to make decisions about his or her health care. In taking this view, we acknowledge that this leaves largely unregulated an area of health care that can affect young people, since our recommended legislation will not govern the conduct of unregistered health practitioners in treating young people. However, this is part of a larger issue relating to the regulation of unregistered health practitioners, which is beyond the ambit of this report.

DEFINING A "SERVICE"

3.27 The terms of the Commission's reference require a review of the law relating to consent to treatment. In adopting the definitions of the *Health Care Complaints Act*, the Commission has substituted the word, "service" for "treatment" in Recommendation 3. In keeping with the *Health Care Complaints Act*, the acts or conduct that are included within the notion of a "service" are not itemised, although the term is described according to a list of the types of services that are included within the meaning of a health service, such as medical, hospital or nursing services.

27. Part 2 Division 6A of the *Health Care Complaints Act 1993* (NSW) now makes provision for certain measures to be taken by the Health Care Complaints Commission in response to a complaint against an unregistered practitioner. See NSW Health Care Complaints Commission, *Annual Report 2006-2007*, 12-13.

3.28 Other legislation dealing with the provision of health care, and more particularly young people's consent to health care, has sought to detail more specifically the types of acts that come within the concept of "care", "service", or "treatment" (whichever be the chosen term). For instance, in New South Wales, the *Health Care Liability Act 2001*, which relates primarily to professional indemnity insurance, defines the term, "health care" as any care, treatment, advice, service, or goods provided in respect of a person's physical or mental health.²⁸ In South Australia, s 4 of the *Consent to Treatment and Palliative Care Act 1995* defines "medical treatment" as treatment or procedures, and expressly includes within that notion the prescription or supply of drugs. In its recommendations for legislation dealing with health care authorisation for young people, the Queensland Law Reform Commission formulated a definition of "health care" which consisted of care or treatment or a service or procedure, but explicitly excluded any non-touching care.²⁹

3.29 We think that it is better not to define the term, "health service" according to specific acts or procedures as legislation in other jurisdictions has sought to do. That approach could be too restrictive. We prefer to leave the concept of a service broadly defined. Reference to the types of services that are to be considered a health service (medical, nursing services, etc) makes it sufficiently clear what is meant by a health service without limiting the types of services that may be brought within the new legislative framework. For example, treatment that does not involve physical contact could come within this broad definition of a health service if it can be characterised as, for example, a medical service.

3.30 One point of departure from the definition of a health service in the *Health Care Complaints Act* is that our definition expressly links the meaning of a health service to services provided by a health practitioner (meaning a registered health practitioner). As a consequence of excluding unregistered health practitioners from our definition, we have omitted references in our definition of a health service to services carried out by those people listed in subsections (i) and (j) of the definition of a health service in s 4 of the *Health Care Complaints Act*. However, we make it clear that services that may be classified as alternative health care services will still come within the meaning of a health service for the purpose of our legislation if they are carried out by a health practitioner as defined. For example, a doctor who carries out acupuncture on a young person will still be brought within the scope of our recommended legislation.

3.31 There are several types of care that generate increasing controversy as they relate to young people and which have been brought to our attention in the process of this review as areas in particular need of reform. They are worth mentioning specifically here, because it is not necessarily immediately obvious whether they can be properly characterised as a health service in order to be brought within the scope of our recommended legislation.

28. See *Health Care Liability Act 2001* (NSW) s 4.

29. See *Health Care Authorisation for Young People Bill 1996* (DRAFT) cl 18, in Queensland Law Reform Commission, *Consent To Health Care Of Young People, Volume Two, The Commission's Legislative Scheme For Consent To Health Care Of Young People*, Report 51 (1996).

Predictive genetic testing

3.32 Predictive genetic testing tests individuals who are at risk of later onset of certain non-treatable genetic diseases. The testing reveals whether an individual carries the genetic mutation that will lead to onset of the disease. The testing, carried out by medical and other health practitioners, would normally be considered a health service under our definition, so as to require compliance with the rules set down for obtaining consent under our proposed scheme.

Palliative care

3.33 Similarly, we take the view that most aspects of palliative care could be characterised as a health service according to the recommended definition. Palliative care has been described as care which is aimed primarily at providing relief from pain and other distressing symptoms, and ensuring quality of life for people suffering from illnesses for which there is little or no prospect of a cure.³⁰ Palliative care will often involve the provision of medication and other measures to manage pain, and we can see no reason why this type of care should not normally be seen as a “health service” so as to bring it within the scope of the recommended legislative framework for consent.

End-of-life decisions

3.34 More problematic is care that essentially involves a failure to provide treatment as a means of ending life. Examples typically include failure to resuscitate a patient who suffers a cardiac arrest or withdrawal of life-sustaining treatment. There appears to be some disagreement in the case law about whether or not failure to act in these circumstances can properly be described as palliative care so as to amount to medical treatment or health care (whichever be the legislative term the subject of discussion). On the one hand, it has been argued that it is part of palliative care because it is aimed at symptom management, which is the central purpose of this type of care.³¹ On the other hand, it has been argued that the ordinary meanings of “medical treatment” and “palliative care” are not broad enough to include the withdrawal of life-sustaining treatment.³² We agree with this second view and find that the ordinary meanings of palliative care and health service are not sufficiently broad to include a failure to provide a service, and that, if we wanted to include failure to act within the definition of a health service in the recommended legislation, there would need to be express provision for this.³³ Ultimately, we have decided not to make a recommendation to this effect. The process for making end-of-life decisions for young people with incurable medical conditions seems to be an area of great uncertainty in the law, as well as one where it would be highly desirable to delineate the legal responsibilities and roles of those involved in the decision-making. However, these possible shortcomings in the law are not limited to end-of-life decisions affecting young people. For adults as well, the law relating to end-of-life decisions is

30. See World Health Organisation, 2005, www.who.int/cancer/palliative/definition/en; Palliative Care Australia, *Standards for Providing Quality Palliative Care for all Australians* (May 2005). See the discussion of the meaning of “palliative care” in *Re AG* [2007] NSWGT 1 (5 February 2007), [48]-[56]. See too *WK v Public Guardian (No 2)* [2006] NSWADT 121, [12]-[15].

31. *Re AG* [2007] NSWGT 1 (5 February 2007), [55].

32. *WK v Public Guardian (No 2)* [2006] NSWADT 121, [11].

33. As other legislation does, for example, *Guardianship and Administration Act 2000* (Qld) Sch 2 s 5(2).

largely unsettled and would benefit from review with a view to possible legislative reform.³⁴
An exercise of this kind is clearly outside the terms of our current reference.

34. Several Australian jurisdictions have introduced legislation to provide for and regulate the making of advance care directives which include procedures for making end-of-life decisions: see *Medical Treatment Act 1994* (ACT); *Natural Death Act 1988* (NT); *Powers of Attorney Act 1998* (Qld); *Consent to Medical Treatment and Palliative Care Act 1995* (SA); *Medical Treatment Act 1988* (Vic). See too *Directions for Medical Treatment Bill 2005* (Tas). NSW Health has issued a guideline on the use of Advance Care Directives and takes the view that advance care directives have legal standing and non-compliance with them may give rise to civil liability, although there is no reference to any legal principle to support this assertion: see NSW Health, *Guideline: Advance Care Directives (NSW) – Using* (GL2005_056, 22 March 2005). For a general discussion of the uncertain position at common law of the legal status of advance care directives, see L Willmott, B White, M Howard, “Refusing advance refusals: advance directives and life-sustaining medical treatment” (2006) 30 *Melbourne University Law Review* 7.

4. The current test for competency

- An overview
- The common law test: *Gillick* competency
- Section 49 of the *Minors (Property and Contracts) Act*
- Part 5 of the *Guardianship Act 1987* (NSW)
- Interaction of the common law and legislation
- The impact of the *parens patriae* jurisdiction
- The impact of child protection legislation
- Understanding and applying the current law

AN OVERVIEW

4.1 In Chapter 1, the Commission noted that the law historically assumed people below the age of majority to be incompetent to consent to or refuse health care because of their immaturity. Developments both at common law and by legislation have meant that now it is possible for young people to consent to or refuse health care if they satisfy certain criteria. This chapter provides an overview of these criteria, with the aim of determining whether or not they are appropriate indicators of legal competence.

4.2 There are three separate sets of rules that make up the current law for deciding whether or not a young person is competent. These derive from:

- the common law (or law developed by judges);
- section 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 17).

4.3 The operation of each of these three sets of rules is not clear, and the ways in which they interact with each other is uncertain. The Commission takes the view that s 49 of the *Minors (Property and Contracts) Act 1970* is now practically redundant, because it adds very little to the principles established by the common law,¹ and Part 5 of the *Guardianship Act* has a very limited application to people below the age of 18.² Instead, it is the common law that chiefly governs the assessment of young people's competence. This chapter concentrates on the developments of the common law in formulating and applying a test for determining young people's competence, and the impact of the legislative provisions on the common law test.

4.4 As part of this discussion, the Commission considers the ways in which the current law is perceived to be operating, particularly by the health practitioners who must apply it. The point of this is to gauge the utility of the current rules, that is, whether practitioners generally understand them and can readily apply them in practice.

4.5 It is also necessary to consider the effects of two additional legal principles on a young person's ability to make health care decisions. These principles derive from:

- the Supreme Court's *parens patriae* jurisdiction as well as the broad protective powers of the Family Court under the *Family Law Act 1975* (Cth), and
- the child protection provisions under the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

4.6 These legal principles do not relate directly to the assessment of a young person's competence to make health care decisions. Nevertheless, they impact on the extent to which young people, even those who have been deemed competent, may be left to make their own decisions about their health care without interference from the State.

1. See para 4.37-4.46.

2. See para 4.33-4.36.

THE COMMON LAW TEST: *GILLICK* COMPETENCY

4.7 The common law (which applies whenever there is no legislation governing a particular issue) has developed a test for determining a young person's competence to make health care decisions that is usually articulated as follows. Young people are capable of consenting to their own health care if and when they have sufficient understanding and intelligence to allow them to understand the care that is proposed. This test requires the treating health practitioner to consider the level of the individual young person's understanding in respect of the particular treatment or advice in question. It does not rely on a fixed age to determine competence: one person may be found competent where another person of the same age may be found incompetent. Nor does a finding of competence in one situation mean that a young person will then be automatically considered competent to make health care decisions generally, because the common law measures the level of understanding in respect of the specific treatment or procedure in question.

4.8 This test for competence was formulated in 1986 in the English case commonly known as *Gillick*.³ It has since been accepted as forming part of the common law in Australia. Before the decision in *Gillick*, the common law was uncertain. There had been little opportunity for the courts to consider the question of young people's legal competence and the scope of their parents' power to consent to health care. There appeared to be a gradually increasing inclination, at least by the English courts, towards recognising the validity of young people's choices regarding other aspects of their lives,⁴ but the question of their capacity to make choices about their health care had been largely left unanswered. In the absence of any definitive court decision on the matter, the prevailing view was arguably that people below the age of majority were reliant on their parent, or other legal guardian, to consent to health care on their behalf.⁵ In so far as it

3. *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

4. This inclination of the English courts was most apparent in cases dealing with young people who had left (or been taken away from) their father's custody. By the second half of the nineteenth century, the courts had established a principle by which a young person who had reached the "age of discretion" could refuse to return to his or her father's custody and the court would not compel his or her return: see *R v Howes* (1860) 121 ER 467, 468-469; *Thomasset v Thomasset* (1894) P 295, 298, 306; and see discussion by Lord Scarman in *Gillick v West Norfolk AHA* [1986] AC 112, 132. By 1984, although again in the context of a father's power forcibly to retain his child in his custody, the courts seemed willing to accept as a general proposition that a young person with sufficient intellectual and emotional capacity was capable of exercising choices, without regard to a judicially fixed age limit: see *R v D* [1984] AC 778, 804-805 (Lord Brandon). But at least McHugh J in *Marion* took the view that "[u]ntil recently, it was doubtful whether at common law a minor could validly consent to the carrying out of a medical procedure": *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218, 273.

5. See *Marion's case* (1991) 175 CLR 218, 237 and the discussion of the common law position pre-*Marion* in J Devereux, "The capacity of a child in Australia to consent to medical treatment – *Gillick* revisited?" (1991) 11 *Oxford Journal of Legal Studies* 283, 283-285.

expressly recognised a young person's⁶ capacity to give a personal consent to health care upon meeting certain criteria, the House of Lords transformed the common law.

The facts in *Gillick*

4.9 The main issue in *Gillick* was whether a young person could consent to contraceptive treatment, in particular advice and prescription for the oral contraceptive pill. The Department of Health and Social Security had issued a guidance which advised area health services that (among other things) doctors and those involved in the provision of family planning services could prescribe contraceptives to a girl below the age of 16 without the consent or knowledge of her parent if acting in good faith to protect the girl against the harmful effects of sex. Mrs Gillick, mother of five daughters, sought a declaration that the guidance was unlawful on the basis (partly) that a health practitioner could not give advice or treatment about contraception to a person below the age of 16 without his or her parent's consent because this would be inconsistent with parental rights. The majority of the House of Lords ultimately rejected her claim.⁷ In Lord Scarman's view, Mrs Gillick's claim must be refused because young people were these days maturing to such an extent that it was reasonable for the law to allow them some responsibility for their own decisions.⁸ On the other hand, Lord Fraser (also in the majority) rejected the mother's claim on the basis that the law had always recognised to some degree a young person's ability to authorise contact with his or her body, because to do otherwise would be impractical and absurd.⁹

Ambiguities in *Gillick*

4.10 There are several ambiguities in the *Gillick* case which have never been completely cleared up in subsequent cases and which therefore continue to plague the common law test for competence. The main areas of uncertainty are the following.

The level of understanding required

4.11 It is not clear from the *Gillick* case what level of understanding is expected of a young person in order to be legally competent. Lord Scarman in *Gillick* required that a young person understand *fully* what is proposed, which is a question of fact. In the case of consent to contraceptives, this would require an understanding not just of the nature of the advice, but also an understanding of the moral and family issues involved, such as an appreciation of the emotional impact of pregnancy and its termination.

6. In fact, the Court recognised the capacity of young people below the age of 16 to consent, rather than those below the age of 18 (being the age of majority). Legislation in the United Kingdom already recognised that young people aged 16 and above could consent to their own medical treatment in certain circumstances: see s 8 of the *Family Law Reform Act 1969* (UK).
7. The House of Lords reversed the decision of the Court of Appeal, which had held that the guidance was unlawful: *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 2 WLR 413 (CA).
8. See *Gillick* [1986] AC 112, 187-188 (Lord Scarman).
9. See *Gillick* [1986] AC 112, 169 (Lord Fraser).

4.12 On the other hand, Lord Fraser in *Gillick* set out a list of preconditions that must be satisfied before a girl below the age of 16 could give a personal consent to advice and prescription for the oral contraceptive pill. These required that: (1) the girl understand the advice, (2) the doctor could not persuade her to tell her parents or let the doctor tell them that she is seeking contraceptive advice, (3) she is likely to begin or continue to have sex with or without the advice or treatment, (4) unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer, and (5) her best interests require the doctor to give the advice or treatment without parental consent. It is not clear the extent to which these preconditions could or should be transferred to assess competence to consent to treatment not relating to contraception, or at least treatment not relating to sexual or reproductive health.¹⁰

4.13 In dissent in *Gillick*,¹¹ Lord Templeman was willing to recognise that a young person could lawfully consent to some forms of treatment, depending on the nature of the treatment and the age and understanding of the young person. However, a decision to engage in sex and practise contraception required not just an understanding of the facts of life but also of the emotional and other consequences to her family, to her male partner and to herself, and Lord Templeman took the view that no girl below the age of 16 could be sufficiently mature to understand all the issues involved to be capable of consenting to treatment for contraception.

4.14 While the judges in the *Gillick* case may have articulated it in different ways, it is clear that their vision of a common law test for competence demanded a level of understanding higher than that expected of an adult in order to be considered competent to consent. Whereas an adult is required, or rather presumed, to understand the general nature of the treatment proposed,¹² the *Gillick* test requires young people to have a much more detailed understanding of the treatment and its consequences, including the emotional and moral implications of the decision involved. It is difficult to know the extent to which the Court's emphasis on a higher level of understanding arose from the controversial and sensitive nature of the facts in the *Gillick* case, involving questions of teenage sex and pregnancy, and the extent to which these principles were intended to apply to other health care situations.

Residual rights of parents

4.15 Once a young person is determined competent to make a particular health care decision, it is not clear from the decision in *Gillick* if and to what extent a parent retains any right to be involved in that decision or to make that decision on behalf of his or her child. Lord Scarman seemed to suggest that parents' right to decide whether or not their child will have medical treatment will terminate once their child is deemed competent to decide for himself or herself. Lord Fraser, on the other hand, considered that parental

10. Recently, in the English case of *Axon*, Silber J noted that Lord Fraser's "guidelines" were of general application in assessing competence to consent to treatment for sexual matters: see *Axon v Secretary of State for Health and Family Planning Association* [2006] QB 539, 569-570.

11. Lord Brandon was the other dissenting judge, but he dissented on the ground that to provide contraceptive treatment would be to encourage and promote the commission of a criminal offence (since the criminal law did not recognise as legal the consent to sex of young girls below the age of 16).

12. See para 1.7.

rights clearly do exist, and do not wholly disappear until a young person reaches the age of majority, but yield to the young person's right to make his or her own decisions once he or she is capable of making up his or her own mind. This would suggest that parental rights to decide co-exist with a young person's right to decide, but dwindle as the young person's right strengthens with his or her growing maturity.

Adopting the *Gillick* test in Australia – *Marion's* case

4.16 In 1992, in a case known as *Marion*,¹³ the High Court of Australia approved the principles set out in *Gillick* as reflecting the common law in Australia. The majority of the Court articulated the *Gillick* test in terms of determining whether the young person has achieved a sufficient understanding and intelligence to allow him or her to understand fully what is proposed, reflecting Lord Scarman's formulation. The majority also noted that a parent's power to consent to medical treatment on behalf of his or her child terminates once the child's capacities and maturity develop to the point where he or she is legally competent.¹⁴

4.17 The facts of the case in *Marion* were very different from those in *Gillick*, involving a dispute over whether or not to authorise the sterilisation of a teenage girl with significant intellectual disabilities. It was undisputed that the young girl was not competent to consent to her own treatment (although the majority was clear that a young person with an intellectual disability was not to be automatically considered incompetent to make treatment decisions, but must be assessed in the same way as any other young person). The assessment of a young person's competence to make treatment decisions was therefore not the focus of the Court's decision, and the *Gillick* test was not discussed in great detail, nor its ambiguities dwelt on.

Developments of the common law test since *Gillick*

4.18 Australian courts have had very little occasion to develop the principles relating to young people's competence that were first articulated in *Gillick* and later adopted in *Marion*. The English courts have had greater opportunity to consider the application of the *Gillick* test. Until recently, however, most of the English cases have related to decisions about life-threatening illnesses where the young person has refused life-saving treatment and his or her mental capacity has been arguably affected by some form of mental disturbance, or influenced by religious beliefs passed on by his or her parents.¹⁵ The

13. *Marion's case* (1991) 175 CLR 218.

14. *Marion's case* at 237 (Mason CJ, Dawson, Toohey and Gaudron JJ) and at 311, 316 (McHugh J, agreeing on this point). See too Professor Parkinson's comments on this aspect of *Marion* in P Parkinson, "Children's rights and doctors' immunities" (1992) 6 *Australian Journal of Family Law* 101, 105. See Chapter 8.

15. See *In Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 (teenage girl refused to take anti-psychotic drugs); *Re W* [1992] 3 WLR 758 (young girl with anorexia); *In Re E* [1993] 1 FLR 386 (teenage boy refused life-saving blood transfusion because of religious objection). See also *Director General, New South Wales Department of Community Services v Y* [1999] NSWSC 644 (refusal of treatment for anorexia by 15-year-old girl and by her parents); *Re Heather* [2003]

courts have appeared much less willing than in *Gillick* to find the test for competence satisfied and, for this reason, some commentators have criticised these cases as representing a retreat from the advances made for young people in *Gillick*.¹⁶

4.19 But, in truth, the courts in these cases have been faced with different issues from those raised in *Gillick*. Whereas *Gillick* raised questions about recognising young people's sexual freedom and privacy, the cases that have followed it have brought into focus the difficulties in applying a test for competence which recognises young people's maturity but also protects them in the face of life-threatening situations. They have mostly involved consideration of a young person's right to refuse treatment and have generally resulted in the young person in question being found not competent to refuse, or even if competent, his or her decision subject to being overridden by the courts. Because of this, some have questioned whether the *Gillick* test in reality would ever apply to recognise a young person's right to refuse treatment if the young person's decision goes against the views of a parent or, more particularly, that of the court. Although the courts have noted that the *Gillick* test should apply equally to cases where a young person is refusing treatment as where a young person is seeking it out, ultimately they have also found that, whether "*Gillick* competent" or not, a court can override a young person's decision in order to avoid a risk that might have irreparable consequences or that is disproportionate to the benefits in taking such a risk.¹⁷ The first and paramount consideration will always be what best serves the well-being, welfare and interests of the young person.¹⁸

4.20 Two recent cases stand out as exceptions to the general nature of cases following *Gillick* to the extent that their facts relate to teenage sexual health and sexual identity, rather than life-threatening illnesses. The first case, *Re Alex*,¹⁹ was an Australian case, decided by the Family Court and involving an application by a thirteen-year-old girl wishing to begin the process of undergoing a sex change.²⁰ In deciding whether to grant the

NSWSC 532 (child and parents refused chemotherapy in preference for alternative therapy).

16. See, for example, J Potter, "Rewriting the competency rules for children: full recognition of the young person as rights-bearer" (2006) 14 *Journal of Law and Medicine* 64; A Morris, "*Gillick*, 20 years on: arrested development or growing pains?" (2005) 21 *Professional Negligence* 158.
17. See *Re W* [1992] 3 WLR 758.
18. *Re W* [1992] 3 WLR 758; *In Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11; *Re Heather* [2003] NSWSC 532.
19. *Re Alex* (2004) 31 Fam LR 503.
20. In an earlier case, *Re A* (1993) 16 Fam LR 715; [1993] FLC 92-402, the Family Court had been faced with the question of consenting to the removal and reconstruction of female genitalia to appear like male genitalia. In this case, however, the young girl had been born with congenital adrenal hyperplasia, which meant that she had an unusually high amount of male sex hormones. While in fact a female, the child had many male physical characteristics, and considered herself a boy. In *Re Alex*, there was no physical basis for the young girl's identification with the male sex. In *Re A*, the Court found that A understood the problem and, in general terms, the way in which it was proposed to resolve the problem, and had expressed a desire for that resolution, but it was not satisfied that she had sufficient capacity and maturity to appreciate fully all aspects of the matter to be able to assess objectively the various options available.

application, Chief Justice Nicholson considered the application of the principles in *Gillick*, and noted that the circumstances in which a young person can make a decision about medical treatment are far from precise, with a significant onus on the treating professional's assessment. Chief Justice Nicholson noted that it was "highly questionable" whether a thirteen year old could ever be regarded as having the capacity to decide for himself or herself on a course of treatment that would change his or her sex, even if he or she had a general understanding of what was proposed and its effect. While highlighting the ambiguities that remain in the common law test, his Honour made it clear that a higher level of understanding was expected of a competent young person than generally required of adults, at least in so far as applies to an understanding of the processes for a sex change.

4.21 The second case, *Axon*,²¹ was recently decided in the United Kingdom. Its facts more closely resemble the facts in *Gillick* than any of the previous cases since *Gillick*. *Axon* involved consideration of the lawfulness of a guidance to area health services regarding treatment and advice on contraception, termination of pregnancy, and sexual health for people aged below 16. A claim was brought by the mother of five children refuting the lawfulness of the guidance, and seeking a declaration that a medical practitioner must notify the parents of a young person seeking such treatment or advice, unless it would be in the young person's best interests not to do so. The Court was therefore required to consider the issue of confidentiality as linked with the question of a young person's right to consent in respect of matters relating to pregnancy and sexual health. Justice Silber confirmed the *Gillick* test as focusing on the sufficiency of the young person's understanding but emphasised that, in assessing competence, judges should reflect the extent to which there is now a keener appreciation of the autonomy of young people and a young person's consequential right to participate in decision-making processes that fundamentally affect him or her. His Lordship stated that in the case of articulate teenagers, we must accept that the right to freedom of expression and participation outweighs the paternalistic judgment of welfare. His Lordship made it clear that he viewed the judgments of the majority in *Gillick* as having a general application, rather than being confined to the specific nature of the treatment in question in that case. His Lordship noted that any right on the part of a parent to family life dwindles as his or her child gets older and is able to understand the consequences of different choices. In summary, Justice Silber held that there are five requirements to the provision of medical advice and treatment for sexual matters to young people without their parents' knowledge:

- The young person understands *all* aspects of the advice, that is, understands all relevant matters, which includes family and moral aspects as well as all possible adverse consequences that might follow on from the advice;
- The doctor cannot persuade the young person to tell a parent;
- At least in the case of treatment for contraception or sexually transmitted disease, the young person is likely to have sex even without the advice or treatment;
- Unless the young person receives the advice or treatment, his or her physical or mental health or both are likely to suffer;

21. *Axon v Secretary of State for Health and Family Planning Association* [2006] QB 539.

- The best interests of the young person require that he or she receive the advice or treatment on sexual matters without parental consent or notification.

Conclusions on the state of the common law

4.22 While the general test for assessing competence at common law seems now well established, there remain several uncertainties about the test which make it potentially difficult to know how to apply it in a variety of different health care situations. In particular, it is not clear just what is meant by the requirement that a young person understand “fully” the treatment proposed, and the extent to which the emphasis in *Gillick* on an understanding of the moral and emotional implications of a decision should be extended to situations not involving a teenager’s sexual health. The recent English case of *Axon* may indicate a greater readiness by the courts towards recognising young people’s independence and decision-making rights, although again, given the facts in *Axon*, it is difficult to know whether the courts will be now more willing to recognise a young person’s decision-making rights in a context outside that of sexual and reproductive health, especially in respect of life-saving treatment.

4.23 It is not necessarily clear whether, and to what degree, the common law permits a young person’s refusal to undergo treatment to be overridden by the court. Moreover, whatever recognition is given at common law to a young person’s refusal of treatment, it should be remembered that, in New South Wales, legislation allows medical practitioners and dentists to provide treatment to a person below the age of 18 without consent if the treatment is necessary, as a matter of urgency, to save the young person’s life or prevent serious damage to his or her health.²² This emergency provision will empower practitioners to override a young person’s refusal in some situations, such as refusal of a life-saving blood transfusion, although it will arguably not allow a practitioner to act in the face of such objection in cases where the need for treatment is less urgent, such as the force-feeding of an anorexic who is not yet at a critical stage, or where the health care in question is not an immediate life or death choice, such as treatment for mental illness (where the threat of suicide or self-harm is not evident) or for substance addiction.²³

4.24 There could also be said to be some uncertainty about the extent to which the common law is willing to recognise the residual rights of parents to consent to or refuse treatment on behalf of a young person who is *Gillick* competent. It is arguable that the Australian High Court in *Marion* has shown itself more inclined towards recognising greater control in the *Gillick*-competent young person than the House of Lords did in *Gillick*, but the Australian courts have not since had the opportunity to settle the question.

4.25 The ambiguities in the common law are heightened by the uncertain impact of the various legislative provisions in New South Wales. These are referred to below.

22. See *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 174. See Chapter 7.

23. It is true that, since *Re Elm* (2006) 69 NSWLR 145, the courts may be willing to interpret “urgency” more broadly than a single, life-threatening instance, although even in *Re Elm*, where the necessity for treatment continued over four weeks, there was an initial life-threatening condition which then required follow-up care over a period of time. See Chapter 7.

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

4.26 Section 49 of the *Minors (Property and Contracts) Act 1970* (NSW) 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:*
 - (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.*

History of section 49

4.27 Section 49 was enacted following a recommendation of this Commission in 1969 in its report, *Infancy in Relation to Contracts and Property*.²⁴ This report was concerned with the legal capacity of minors to enter into binding contracts and property transactions.²⁵ Included within its recommendations was a draft provision relating to minors' consent to medical and dental treatment. It was included on the basis that consent to treatment "may or may not be contractual in character" and was therefore at least an incidental matter to the Commission's terms of reference.²⁶ The recommended provision was considered to offer useful clarification of what was said to be an uncertain area of the law.²⁷ The Commission was clearly looking at the issue of young people's consent to treatment in the limited terms of contractual capacity and its implications for civil liability, rather than from a broader viewpoint of young people's health care rights and parental responsibilities. The origins of s 49 contrast strongly with those of the South Australian *Consent to Medical Treatment and Palliative Care Act 1995* (the only other piece of Australian legislation dealing directly with young people's general right to consent to treatment). The South Australian legislation derived from a much broader review focused on establishing a framework for health care decision-making.²⁸

4.28 Section 49 adopts exactly the terms of the Commission's recommended provision. The Commission did not give any reasons why it had chosen 14 and 16 as the ages between which either the consent of a young person or his or her parent could be relied on to avoid civil liability. It simply referred to the fact that it had made provision for an overlap of ages when either the consent of a parent or a young person could be relied on (that is, 14 and 15) and that it "could see no harm in that".²⁹

4.29 It is not clear what role the Commission envisaged (if it did at all) for parents of a young person aged 16 or above and no reason was given for choosing 16 as the cut-off age. In the United Kingdom two years previously, a parliamentary committee on the age of majority (known as the "Latey Committee") had recommended that legislation recognise

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24. NSW Law Reform Commission, *Infancy In Relation To Contracts And Property*, Report 6 (1969) [44], Appendix F (draft Minority Bill) s 48.
 25. See NSW Law Reform Commission, *Infancy In Relation To Contracts And Property*, Report 6 (1969) [1] for the terms of reference.
 26. NSW Law Reform Commission, *Infancy In Relation To Contracts And Property*, Report 6 (1969) 88.
 27. See NSW Law Reform Commission, *Infancy In Relation To Contracts And Property*, Report 6 (1969) 88 and NSW, Legislative Assembly, *Parliamentary Debates (Hansard)*, 19 August 1970, 5275.
 28. The 1995 Act originated from the *Consent to Medical and Dental Treatment Act 1985* (SA). The 1985 Act enacted recommendations of a working party on consent to treatment: see South Australia, Working Party on Consent to Treatment, *Report of the Working Party on Consent to Treatment* (December 1983). See also South Australia, Select Committee of the Legislative Council on the *Minors (Consent to Medical and Dental Treatment) Bill 1977-78*, *Report of the Select Committee of the Legislative Council on the Minors (Consent to Medical and Dental Treatment) Bill 1977-78* (1978).
 29. NSW Law Reform Commission, *Infancy In Relation To Contracts And Property*, Report 6 (1969), 88.

the validity of a young person's consent aged 16 or above.³⁰ Presumably, in nominating 16 as one of its cut-off ages in its recommended provision, the NSW Law Reform Commission was following on from the approach of the Latey Committee.³¹ The Latey Committee had chosen 16 as the appropriate age for recognising the validity of a young person's consent because, first, legislation in the United Kingdom at the time already provided that a person aged 16 or over could choose his or her own doctor and could make his or her own decisions about admission as a voluntary patient to a "mental hospital"; secondly, 16 was the age of consent to sex; and lastly, it was already widespread practice among health care services to accept the consent of a person aged 16 or above as sufficient to receive medical treatment.³²

4.30 There has been very little discussion of s 49 by the courts, and consequently there is very little case law to guide its interpretation. It is clear from the wording of the section that it is intended to apply to a limited set of circumstances where the medical or dental treatment in question has involved some form of physical contact that could potentially constitute an assault or battery. In these circumstances, the section operates to protect the practitioner from civil liability for assault or battery, but does nothing to provide an immunity from other forms of civil liability (such as false imprisonment³³ or negligence) or from criminal liability.

4.31 In the few cases that have considered its operation, the courts have insisted that s 49 does not create a general power of consent, but rather provides an immunity for doctors and dentists from civil liability in the situations referred to. It is not concerned with conferring rights but rather taking them away in so far as a consenting young person may lose any legal recourse against a doctor or dentist for assault or battery.³⁴

4.32 When reading s 49, it should be remembered that the section was enacted more than twenty years before the *Gillick* test was accepted as forming part of the common law of Australia in the case of *Marion*. The operation of s 49 needs to be viewed against the backdrop of the developments that have arisen in the common law since the introduction of the provision.

30. Great Britain, Committee on the Age of Majority ("the Latey Committee"), *Report Of The Committee On The Age Of Majority* (HMSO, London, Cmnd. 3342, 1967), [484].

31. The Law Reform Commission had said from the outset that it based much of its report on the work of the Latey Committee and agreed with its main recommendation of lowering the age of majority to 18: see NSW Law Reform Commission, *Infancy In Relation To Contracts And Property*, Report 6 (1969), [6].

32. Great Britain, Committee on the Age of Majority, *Report Of The Committee On The Age Of Majority* (Cmnd. 3342, 1967), [481].

33. See *Hart v Herron* (1984) Aust Torts Reports ¶80-201 (NSWSC, Fisher J and a jury) for an example of a successful claim of civil liability for false imprisonment involving the provision of medical treatment.

34. See *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311; *In Re Elizabeth* (1989) 13 Fam LR 47.

PART 5 OF THE *GUARDIANSHIP ACT 1987* (NSW)

4.33 Part 5 of the *Guardianship Act 1987* applies to people aged 16 and above who are “incapable of giving consent”³⁵ and sets up a statutory framework³⁶ to govern the decision-making process for their medical and dental treatment.³⁷ The legislation nominates people who are authorised to consent to medical or dental treatment on behalf of those not competent to consent for themselves. In the case of an incompetent 16- or 17-year-old, consent for “major” or “minor” treatment³⁸ may be given by a parent or person with parental responsibility³⁹ or by the Guardianship Tribunal, but consent for special treatment may only be given by the Guardianship Tribunal.⁴⁰

4.34 A person is incapable of giving consent if he or she:

- (a) *is incapable of understanding the general nature and effect of the proposed treatment, or*
- (b) *is incapable of indicating whether or not he or she consents or does not consent to the treatment being carried out.*⁴¹

4.35 The *Guardianship Act* is an Act “with respect to the guardianship of persons who have disabilities; and for other purposes.”⁴² Part 5 aims to ensure that people are not deprived of necessary medical or dental treatment merely because they lack capacity to consent, and that any such treatment is carried out for the purpose of promoting and maintaining their health and well-being.⁴³ Clearly, this legislation, including Part 5, was enacted with the intention of providing a framework for people with disabilities to protect them in their dealings with the world. It enables a person whose mental capacity is in some way impaired by reason of a disability to manage his or her life, as much as possible, as any other adult in terms of ordering finances and legal transactions, and

35. See *Guardianship Act 1987* (NSW) s 34(1)(b).

36. See *P v P* (1994) 181 CLR 583, 596 (Mason CJ, Deane, Toohey and Gaudron JJ): “the Part establishes a comprehensive scheme governing the administration of medical or dental treatment to incapable persons who are of or above the age of sixteen years”.

37. Medical or dental treatment is defined in s 33(1) of the *Guardianship Act 1987* (NSW).

38. Major treatment is any treatment prescribed by regulation: see *Guardianship Act 1987* (NSW) s 33(1); *Guardianship Regulation 2005* (NSW) cl 10. Minor treatment is treatment that is not major or special treatment, or treatment in the course of a clinical trial: s 33(1). See Chapter 8 for further discussion of special treatment.

39. Unlike the *Children and Young Persons (Care and Protection) Act 1998* (NSW), a “child” is defined in the *Guardianship Act 1987* (NSW) as a person below the age of 18: see s 3. Under the *Guardianship Act*, the person responsible for a child is the person with parental responsibility for the child: see s 33A(2).

40. See *Guardianship Act 1987* (NSW) s 36(1). A parent may consent to the continuation of special treatment if so authorised by the Tribunal: s 36(2).

41. See *Guardianship Act 1987* (NSW) s 33(2).

42. *Guardianship Act 1987* (NSW) Long Title.

43. See *Guardianship Act 1987* (NSW) s 32.

recognising an entitlement to appropriate health care. While the focus of the legislation is people with disabilities, the definition of a person incapable of giving consent to medical or dental treatment in Part 5 on its face includes not only 16- and 17-year-olds who are incapable of understanding because of a disability, but also those who are incapable of understanding because of immaturity. It seems a curiously expansive definition which, perhaps unintentionally, could expand the focus of the legislation beyond people with disabilities. The Commission was unsure why 16- and 17-year-olds (not yet legally adults) had been included within the scope of Part 5, with the legislation making no distinction between the decision-making process for this age group and the adults who come within its scope.

4.36 We consulted with the Guardianship Tribunal to find out its views on what we considered were ambiguities in the operation of Part 5.⁴⁴ The Tribunal agreed that, on its face, Part 5 does not necessarily exclude from its application a 16- or 17-year-old who is incapable of understanding a proposed treatment because of immaturity. However, it was not thought that any such case had ever come to the Tribunal's attention. Realistically, given the cognitive abilities of the average 16- or 17-year-old, any person of that age who was unable to understand a particular type of treatment so as to attract the operation of Part 5 would probably have impaired cognitive abilities by reason of some form of disability. As for the application of the Part to people who are not yet legally adults, while there is no conclusive evidence of the intentions of Parliament, it is possible that the inclusion of this age group in the Part was thought to be consistent with the general approach of the legislation, which is to treat people with disabilities as much as possible as any other person would be treated. It may be that Parliament took the view that 16- and 17-year-olds without disabilities would generally be capable of consenting to treatment and would therefore be treated as adults, not children, and for this reason it would be wrong to exclude 16- and 17-year-olds with disabilities from legislation aimed at ensuring that people with disabilities are treated as much as possible as any other person would be treated. If this was indeed a motivation of Parliament in including this age group within Part 5 of the *Guardianship Act*, it is one that is based on an incomplete picture of the current law: while in practice it may be that the average 16- or 17-year-old is treated much as an adult in terms of exercising choice over health care, in theory at least, the preceding discussion in this chapter shows that there is still a distinction made in law between an adult and a person of this age in their decision-making abilities.

INTERACTION OF THE COMMON LAW AND LEGISLATION

4.37 In Issues Paper 24, the Commission took the view that s 49 of the *Minors (Property and Contracts) Act 1970* now has a very limited operation, and that in most situations the determination of a young person's competence to consent to or refuse treatment is governed by the *Gillick* test at common law. We adhere to this conclusion, which was not refuted by submissions or in consultation.⁴⁵

4.38 The interaction of s 49 and the common law needs to be viewed subject to s 49(3)(a), which provides that s 49 does not affect the operation that a consent may

44. Guardianship Tribunal, *Consultation*.

45. NSW Law Reform Commission, *Minors' Consent to Medical Treatment*, Issues Paper 24 (2004), [2.18-2.24].

otherwise have. This subsection seems aimed at preserving the operation of the common law, to the extent to which the common law recognises a particular consent as legally effective in respect of a young person's medical or dental treatment. Following this reading of s 49(3), s 49(1) and 49(2) seem intended to operate only to the extent to which they provide additional recognition, beyond any recognition already provided by the common law, of a consent as legally effective. Since the decisions in *Gillick* and *Marion*, the common law is now prepared to recognise a young person's consent to treatment to an extent that surpasses the recognition provided for in s 49, and in this way s 49 is largely redundant.

4.39 In making this claim, we should note that s 49(2) provides for a young person aged 14 or above to consent to his or her own treatment "as if ... he or she were aged twenty-one years or upwards" (so as to provide an immunity from civil assault or battery). In our view, s 49(2) does not grant a presumption or conclusive finding of a fourteen-year-old's capacity to consent, irrespective of whether or not he or she is "*Gillick*-competent". It is implicit in s 49 that a consent will only be legally effective if it is a "true" consent, that is, one that is free from factors that would otherwise taint its validity at common law, factors such as fraud, misrepresentation, or mental incapacity. Section 49(2) is simply removing a young person's age as a barrier to giving an effective legal consent (once the young person has reached fourteen years and for the purposes of avoiding civil liability for assault or battery) but has not prevented the application of any other common law principle that may otherwise affect the validity of a consent. In doing so, the subsection is doing no more than what the common law subsequently did in *Gillick* and *Marion*.

4.40 With this in mind, we consider that the interaction of the legislation and the common law has the following effects on determining the competence of young people of various age groups.

Assessing the competence of young people to consent to or refuse health care other than medical or dental treatment

4.41 Section 49 of the *Minors (Property and Contracts) Act 1970* and Part 5 of the *Guardianship Act 1987* relate only to decisions about medical and/or dental treatment as defined in those Acts.⁴⁶ They do not attempt to regulate the decision-making process for other types of health care. While it is not clear,⁴⁷ it could be argued that the *Gillick* test at common law would govern the assessment of a young person's competence to consent to or refuse health care other than the types of care defined in these Acts, at least health care involving physical contact.⁴⁸

Assessing the competence of young people below 14 years of age

4.42 Section 49 does not refer to young people below the age of 14. For young people in this age group, the common law principles as set out in *Gillick* and approved in *Marion* apply to determining their competence to make health care decisions.

46. See *Minors (Property and Contracts) Act 1970* (NSW) s 49(4); *Guardianship Act 1987* (NSW) s 33.

47. The cases involving consideration of the *Gillick* test have all related to the provision of medical treatment.

48. See para 1.13-1.17 and Chapter 9 for the lines of liability for treatment involving and not involving physical contact.

Assessing the competence of young people aged 14 and over

4.43 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. While it is not clear, the Commission takes the view that this subsection does no more than confirm what is now the position at common law, that is, that a young person aged 14 or over is capable of consenting to treatment, provided he or she satisfies the criteria under the *Gillick* test. It does not allow medical practitioners to rely on the consent of a young person aged 14 or over if he or she is not competent to give consent according to the *Gillick* test.

Assessing the competence of young people below 16 years of age

4.44 Section 49(1) allows a parent or guardian to consent to the medical treatment of a young person aged below 16 as if the young person were 21 years of age and had authorised the giving of consent. This subsection adds nothing more to the position at common law for young people below 16 who are not competent to consent according to the *Gillick* test, and whose parents or legal guardian would normally be responsible for consenting to treatment on their behalf. For young people aged below 16 who are competent according to *Gillick*, then s 49(1) does seem to qualify the common law by making it clear that their parents can still consent to treatment on their behalf, for the purpose of that consent providing a defence to a civil claim for battery or assault.⁴⁹

Assessing the competence of young people aged 16 and over

4.45 Section 49(2) applies to young people aged 16 and over in the same way that it applies to young people aged 14 and over. In addition, Part 5 of the *Guardianship Act 1987* may apply to 16- and 17-year-olds who are considered incompetent according to its criteria for incompetence. The combination of the common law and Part 5 of the *Guardianship Act* will have the following effects for 16- and 17-year-olds:

- If the 16- or 17-year-old is found incapable of understanding the general nature and effect of the proposed treatment, and that treatment is considered to be medical or dental treatment as defined in the *Guardianship Act*,⁵⁰ then the decision-making framework set up under the *Guardianship Act* applies to obtain consent.

49. See para 4.15, 4.24 above regarding uncertainty at common law about the residual rights of parents.

50. *The Guardianship Act 1987* (NSW) s 33(1) defines medical or dental treatment for the purpose of Part 5 as:

- (a) 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, or
 - (b) dental treatment (including any dental procedure, operation or examination) normally carried out by or under the supervision of a dentist, or
 - (c) any other act declared by the regulations to be treatment for the purposes of this Part,
- (and, in the case of treatment in the course of a clinical trial, is taken to include the giving of placebos to some of the participants in the trial), but does not include:
- (d) any non-intrusive examination made for diagnostic purposes (including a visual examination of the mouth, throat, nasal cavity, eyes or ears), or
 - (e) first-aid medical or dental treatment, or

- If the 16- or 17-year-old *is* found capable of understanding the general nature and effect of the treatment, and can communicate consent or lack of consent to treatment, then Part 5 of the *Guardianship Act* does not apply to him or her and instead he or she is subject to the common law rules governing competence to consent. Similarly, if the 16- or 17-year-old is found incompetent as defined in Part 5 of the *Guardianship Act*, but the treatment in question does not come within the meaning of medical or dental treatment in that Act, or the 16- or 17-year-old is seeking to refuse⁵¹ the treatment rather than consent to it, then the common law applies.

4.46 Although unlikely in practice, in theory at least it is possible that a 16- or 17-year-old who meets the requirements for competence under Part 5 of the *Guardianship Act* will still be found incompetent under the common law *Gillick* test. The *Gillick* test arguably sets a higher standard for competence, requiring an understanding not just of the general nature and effect of the treatment, but that the young person understands *fully* all aspects and implications of the treatment.

THE IMPACT OF THE PARENS PATRIAE JURISDICTION

4.47 In Chapter 2,⁵² the Commission referred to a legal principle that requires the courts to act in a young person's best interests. This principle empowers the State's Supreme Court to intervene in decisions about a young person's health care if it takes the view that this is necessary to protect the young person's best interests. The Supreme Court exercises this power as part of what has historically been its "parens patriae" jurisdiction over children. Over several centuries, the common law developed the notion of a power, originally entrusted in the King, to protect those who were not able to take care of themselves.⁵³ The parens patriae jurisdiction is now vested in the Supreme Court, and allows it to make orders for the custody and care of children.⁵⁴ There is no limitation on this jurisdiction: the Court can make any order which it regards necessary to promote the best interests of the child. For example, it can make orders for the sterilisation of a child,

(f) the administration of a pharmaceutical drug for the purpose, and in accordance with the dosage level, recommended in the manufacturer's instructions (being a drug for which a prescription is not required and which is normally self-administered), or

(g) any other kind of treatment that is declared by the regulations not to be treatment for the purposes of this Part.

51. The Part says nothing about the capacity to refuse treatment (although it does require that certain medical treatment for which no consent is necessary in some situations not be provided if the patient objects to it: s 37).

52. See para 2.52-2.64.

53. See *Wellesley v Duke of Beaufort* (1827) 2 Russ. 1, 20; *Fountain v Alexander* (1982) 150 CLR 633; *R v Gyngall* [1893] 2 QB 232, 241; *In re McGrath (Infants)* [1893] 1 Ch 143, 147-148. See discussion in *Marion*, 258 (Mason CJ, Dawson, Toohey, and Gaudron JJ), 280 (Brennan J).

54. The jurisdiction was vested in the Supreme Court by the *Supreme Court Act 1970* (NSW). See *Director General, New South Wales Department of Community Services v Y* [1999] NSWSC 644, [87-88]; *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311.

or to override parents' decisions about their children's medical treatment.⁵⁵ Although it can be displaced by legislation, it seems that the Supreme Court's *parens patriae* jurisdiction over young people survives, despite legislation which directly provides for the Family Court and the Children's Court also to have jurisdiction relating to young people's welfare.⁵⁶

4.48 It seems that the Supreme Court's *parens patriae* jurisdiction may be used not only to override a parent's decision about his or her child's health care, but can also be invoked to override a young person's health care decision after that young person is competent according to the *Gillick* test. For example, the Court can order that a teenage girl be detained in hospital against her and her parents' wishes for the treatment of an eating disorder.⁵⁷ It can require a young person to submit to chemotherapy,⁵⁸ or to take anti-psychotic drugs which she is refusing to take.⁵⁹ While it has been emphasised that the Court should exercise its jurisdiction to override a young person's decision sparingly and with extreme caution, all the same it may do so where it considers this to be necessary for the young person's best interests, including his or her long term health and survival. Reasonable force may be used to carry out the Court's orders.⁶⁰

4.49 The exercise of the *parens patriae* jurisdiction to override a competent young person's health care decision has not gone uncriticised. Indeed, in Canada, there has been some doubt expressed as to whether the common law there allows the exercise of the *parens patriae* power to override a "mature minor's" decision, since the courts cannot have power to protect a person "who is no longer in need of protection".⁶¹ Like adults (assuming they are not incompetent), it has been argued that mature young people should have their decisions respected, without intervention by the courts.⁶² This argument is based on a particular view of the "mature minor", which is one that equates the status of

55. See *Marion* (1991) 175 CLR 218; *Director General, New South Wales Department of Community Services v Y* [1999] NSWSC 644, [86-95]; *Re Paul* [2008] NSWSC 960.

56. See *P v P* (1994) 181 CLR 583. See NSWLRC, *Minors' consent to medical treatment*, Issues paper 24 (2004), [4.28]-[4.33].

57. See *Director General, New South Wales Department of Community Services v Y* ("DOCS v Y") [1999] NSWSC 644, [98]-[103]. See also, in the United Kingdom, *Re W* [1992] 3 WLR 758, cited with approval by Austin J in *DOCS v Y* at [101]. In *DOCS v Y*, Justice Austin did not expressly state whether or not he considered the young woman to be competent, but did make it clear that a finding of competence would not limit his power to order her hospitalisation. In *Re W*, the judge at first instance did find that the young anorexic woman had sufficient understanding to make an informed decision, but that he had the power to order her treatment without her consent. This decision was upheld by the Court of Appeal. See too *Re R* [1991] 3 WLR 592.

58. *Re Heather* [2003] NSWSC 532.

59. *Re R* [1991] 3 WLR 592.

60. See *Re C* [1997] 2 FLR 180, cited with approval by Austin J in *DOCS v Y* [1999] NSWSC 644, [102].

61. See *CU v. McGonigle* (2003) ABCA 66, [33] (Russell J).

62. See L Ferguson, "The end of an age: beyond age restrictions for minors' medical treatment decisions" *Paper prepared for the Law Commission of Canada* (October 24, 2004), 20.

the mature minor with that of an adult. From this viewpoint, there is no sound reason for extending the courts' protective jurisdiction to competent young people.

4.50 But there is another view of the mature minor that does not consider him or her in the same light as a competent adult. Adults are assumed to be generally competent to consent, that is, to consent to all types of health care (although that assumption is rebuttable). Young people, on the other hand, may be found competent in respect of one particular type of treatment, if they pass the *Gillick* test, but may not be competent in respect of another type of treatment. Their competence, once established, does not operate as a general and automatic entitlement, but must be proved on a case-by-case basis. Competence for them is therefore not a black and white matter, but rather a continuum of maturity which may be found sufficient in some cases but not in others. On this basis, it could be argued that their legal status is something different from that of adults. For reasons of public policy, based on the arguments which we put forward in paragraphs 2.72-2.74, we consider it appropriate for the law to continue to view the competence of young people as something apart from that of adults, and continue to play a protective role towards them. The *parens patriae* jurisdiction provides a necessary safety net to protect young people from the long-term consequences of decisions which they may regret at an age of greater maturity once they have passed through the developmental stages to which we referred in Chapter 2.

4.51 In addition to the State Supreme Court's *parens patriae* jurisdiction, federal legislation empowers the Family Court to intervene in matters relating to young people, including their health care. These powers are very broad, and are similar to the State's *parens patriae* powers, to act to ensure the best interests of a child.⁶³

THE IMPACT OF CHILD PROTECTION LEGISLATION

4.52 As with the *parens patriae* jurisdiction, the operation of the State's child protection legislation has a potential impact on the ability of young people to make their own health care decisions. Among other things, the *Children and Young Persons (Care and Protection) Act 1998* (NSW) makes provision for the State's intervention in the care of children and young people whom it believes are in need of care and protection. On its face, the Act would seem to authorise the State to intervene to protect a young person from the consequences of a decision he or she has made, even if that young person is considered *Gillick* competent. For example, the Act allows the Director General of the Department of Community Services to take whatever action is necessary to safeguard or promote a child or young person's safety, welfare, and well-being if the Director General believes, on reasonable grounds, that the child or young person is in need of care and protection.⁶⁴

63. See NSWLRC, *Minors' consent to medical treatment*, Issues paper 24 (2004), [4.24]-[4.25]

64. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 34.

UNDERSTANDING AND APPLYING THE CURRENT LAW

4.53 In light of the uncertainties that are apparent in the current law, how are health practitioners applying it to assess young people's competence in real life situations? While there may be theoretical problems, are practitioners generally confident of having a good understanding of the law, and is it working reasonably well in practice, or is there a real need for change?

Perceptions of the current law in government directives and professional resources

4.54 There are a number of government directives and professional resources that aim either to direct or assist health practitioners in New South Wales in (among other things) determining questions of consent to health care for young people. To an extent, these texts inform practitioners' perceptions and application of the current law.

4.55 A directive of the New South Wales Department of Health to those working in the public health system sets out the Department's policies on issues of patient consent to treatment. In the case of non-urgent treatment, the directive stipulates that:

It is NSW Health policy that if the patient is under the age of 14 years, the consent of the parent or guardian is necessary.

A child aged 14 years and above may consent to their own treatment provided they adequately understand and appreciate the nature and consequences of the operation, procedure or treatment. However, where the child is 14 or 15 years of age, it is prudent for practitioners or hospitals to also obtain the consent of the parent or guardian, unless the patient objects.

Generally, the age at which a young person is sufficiently mature to consent independently to medical treatment depends not only on their age but also on the seriousness of the treatment in question relative to their levels of maturity. The health practitioner must decide on a case-by-case basis where the young person has sufficient understanding and intelligence to enable him or her to fully understand what is proposed.⁶⁵

4.56 Inconsistently with the common law position,⁶⁶ the Health Department's directive fixes 14 as a cut-off age below which a young person cannot give a personal consent to treatment. The directive does emphasise the importance of making an individual assessment of the level of each patient's understanding. It does not suggest any criteria by which to judge the patient's maturity. It also encourages practitioners to seek parents' consent for treatment for 14- and 15-year-olds, although does not go so far as requiring them to do so over the objection of the young patient.

65. NSW Health, *Consent To Medical Treatment – Patient Information* (Policy Directive, PD2005_406, 2005), 25.2.

66. See para 4.7-4.25.

4.57 In a resource for health workers on the ethical and legal responsibilities of working with young people, the NSW Association for Adolescent Health describes the law in New South Wales as allowing young people aged below 18 to give “informed consent” to most types of medical treatment if they have sufficient emotional maturity and intellectual capacity. It notes that s 49 of the *Minors (Property and Contracts) Act 1970* (NSW) allows a medical or dental practitioner to treat a young person without being liable for assault if the young person is aged 14 or over and has consented to the treatment, or if the young person is aged below 16 and a parent or guardian has consented on behalf of the young person.⁶⁷

4.58 A resource for general practitioners articulates the law as recognising young people aged 14-16 as capable of giving informed consent to medical or dental treatment, as well as allowing for the possibility that people below the age of 14 may be capable of giving informed consent, although the general practitioner must consider the nature of the treatment and the ability of the young person to understand the treatment. General practitioners must form their own opinion about a patient’s intelligence and understanding, involving consideration of the young patient’s age, level of independence, level of schooling, maturity, and ability to express his or her wishes.⁶⁸

4.59 Although not dealing directly with treatment and the provision of health care, it is interesting to compare these texts with the position taken in the guidelines for research involving young people in the National Statement on Ethical Conduct in Human Research.⁶⁹ These guidelines require that consent to a research project involving a young person’s participation be obtained from the young person, if he or she has capacity to make that decision, and also one parent (or legal guardian) unless the severity of risk involved requires consent from two parents. There is provision for a mature young person to give consent without requiring consent also from a parent, but only in situations of low risk, and where either the young person is estranged from his or her parent, or it is contrary to his or her best interests to involve the parents.

Empirical studies on the provision of health care to young people

4.60 There has been limited empirical research in Australia on the provision of adolescent health care.⁷⁰ Several studies have focused specifically on practitioners’

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- 67. NSW Association for Adolescent Health, *Working With Young People: Ethical And Legal Responsibilities For Health Workers – A Resource For Health Workers In NSW* (February 2005), 12.
 - 68. M Kang and P Chown, *GP Resource Kit: Enhancing The Skills Of General Practitioners In Caring For Young People From Culturally Diverse Backgrounds – A Collaboration Between NSW Transcultural Mental Health Centre And NSW Centre For The Advancement Of Adolescent Health* (May 2004), 49.
 - 69. See Australia National Health and Medical Research Council, *National Statement on Ethical Conduct in Human Research* (2007), [4.2.7].
 - 70. For example, F Veit, L Sanci, D Young, G Bowes, “Adolescent health care: perspectives of Victorian general practitioners” (1995) 163 *Medical Journal of Australia* 16; T Bartholomew, L Sanci, F Veit, *Towards A Practical Set Of Guidelines For Clarifying Informed Consent Criteria And Confidentiality Obligations With Young Patients* (Cth Department of Health and Aged Care – General Practice

current understanding and application of the law for determining young people's competence. These have been carried out in Victoria, where the common law applies without the need to consider the impact of legislation on the assessment of competence, as happens in New South Wales. Although too few to form any definite conclusions, these studies suggested that a large proportion of the sample groups of Victorian GPs felt unsure and inadequately informed about the legal rules for assessing young people's competence, and that there was a divergence of opinion about factors relevant to determining competence. For example, in the most recent study, GPs were asked to respond to questions about the competence of a hypothetical 14-year-old girl seeking a prescription for the oral contraceptive pill. A greater proportion of respondents found the girl competent, citing good insight and understanding of the consequences, risks, and issues as a primary reason for this assessment (that is, making use of the factors set down in the *Gillick* test), and also took her age into account. Of those who did not find her competent, some cited her age in combination with other factors, and others cited her age alone, as the reasons for finding her incompetent.⁷¹

The Commission's consultations with practitioners

4.61 The Commission sought the views of health practitioners involved in various aspects of caring for young people's health, to get a sense (among other things) of their perceptions of what the current law is, and how well it is working. For the most part, the groups with whom we were able to consult worked as multi-disciplinary teams, usually headed by medical practitioners.⁷² These teams were all devoted to the provision of youth

Evaluation Program, 1999-2001); 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; T Bartholomew and T Carvalho, "General practitioners' competence and confidentiality determinations with a minor who requests the oral contraceptive pill" (2005) 13 *Journal of Law and Medicine* 191; NSW Centre for the Advancement of Adolescent Health, The Children's Hospital at Westmead, *Access To Health Care Among NSW Adolescents: Phase 1: Final Report* (May 2002), *Phase 2* (2005). An empirical study is currently being conducted in Victoria concerning clinicians' assessment of young people's competence to make medical treatment decisions: see Dr R Duncan, NHMRC Research Fellow, *Project: Medical Maturity: An Assessment Of Clinicians Methods For Judging Competence In Young People* (ongoing, 2007-2011).

71. The study relied on voluntary responses to a questionnaire mailed out to 1,000 general practitioners in Victoria. Of these 1,000, 305 responded. 41% of these 305 general practitioners reported feeling unsure about the law, 28% were inadequately informed, and 4% were not at all informed: T Bartholomew and T Carvalho, "General practitioners' competence and confidentiality determinations" (2005) 13 *Journal of Law and Medicine* 191, 195.

72. See Dr S Towns, Department of Adolescent Medicine, Children's Hospital at Westmead, *Consultation*; Dr M Kang, Department of General Practice, University of Sydney, *Consultation*; Department of Psychological Medicine, Children's Hospital at Westmead, *Consultation*; Dr S Trethewie, Sydney Children's Hospital at Randwick, *Consultation*, Department of Pain and Palliative Care, Children's Hospital at Westmead, *Consultation*; Australian Medical Association, *Consultation*.

health services, with specialised experience in working with young people. They could therefore be expected to have a more detailed knowledge of the legal requirements for treating young people than the more general population of health practitioners and to this extent their views may perhaps not be completely representative.

4.62 These consultations did provide the Commission with invaluable insight into the realities of applying the current law to resolve issues about competence and consent in a wide variety of real life situations. It was apparent that the “cut-off” ages in s 49 of the *Minors (Property and Contracts) Act 1970* were the source of some confusion, with some practitioners taking the view that the provision set down an absolute age of consent (whether that be 14 or 16), although they also had a sound understanding of the *Gillick* test and the need to apply it to assessing competence. There appeared to be general agreement with the approach taken in the *Gillick* test, both because it allows consideration of the individual patient’s level of maturity, and because it forces the practitioner to take time in engaging the young person to assess his or her competence. It was thought that the requirement in the *Gillick* test that the young person understand “fully” was quite meaningless, and it was difficult to know how much a person would need to understand in practical terms in order to meet that criterion. It did, however, encourage practitioners to take time in communicating information to the young person, in an effort to ensure that he or she had a “full understanding”.⁷³ In contrast, it was submitted on behalf of dentists practising in New South Wales that many members of that profession would be unaware of the specific test set down in *Gillick*, although in practice they would follow its approach, generally without controversy (and keeping in mind that for most dentists, working in private practice and requiring fees for service, consent issues are less likely to arise than in the provision of medical treatment, because dentists are less likely to see young people who are unaccompanied by their parents).⁷⁴

4.63 There was also some variety in the views expressed by practitioners about the age when most young people should generally be expected to be competent to make health care decisions. Perhaps the differences in views can be partly attributed to the different areas of health care in which these practitioners worked. One practitioner from the Department of Adolescent Medicine in the Children’s Hospital at Westmead took the view that, if the Commission were contemplating a cut-off age for recognising an absolute age of consent, this should be no younger than 16, and that even for 16- and 17-year-olds, it was important to retain the safety net provided by the child protection legislation to protect young people from harmful decisions. By contrast, in the Department of Psychological Medicine in the Children’s Hospital at Westmead (which deals with young people with psychological and psychiatric disturbances), practitioners nominated the ages between 12 and 14 as a “grey area” when it can be difficult to assess competence. They considered that many young people aged 14 and 15 were competent to make their own health care decisions, although they also referred to the child protection legislation which is still available as a last resort. Practitioners from this Department referred to occasional disagreements between parents and young people over treatment decisions, particularly in their area of mental health where parents may sometimes be reluctant to accept that their child is in need of and is seeking treatment. Some practitioners from this Department

73. Dr S Towns, Department of Adolescent Medicine, Children’s Hospital at Westmead, *Consultation*; Dr M Kang, Department of General Practice, University of Sydney, *Consultation*.

74. See Australian Dental Association (NSW Branch), *Submission*, 1.

took the firm view that legislation was needed to give voice to young people in the decision-making process and ensure their participation in that process.

4.64 By contrast, practitioners from palliative care referred to the cautious approach generally taken by the hospitals in deferring to parents' wishes in decisions about their child's palliative care, although it was also said that a practitioner would not usually treat an adolescent who was refusing treatment. Difficulties can arise in some situations, such as where parents do not want their children to know that they are dying and request that practitioners not tell their child. Even for older teenagers, the parents' wishes may be respected, and the young person will not be involved in the decision-making if the parents do not wish them to know of the nature of their illness. This can cause problems for practitioners, especially if the young person asks them directly whether they are going to die, or if the parents make decisions about their child's care which the practitioner does not necessarily agree with (for example, if they choose an aggressive treatment which the practitioner considers will have little benefit when weighed up against the pain it will cause, or when the parents insist that the young person be resuscitated when the practitioner believes that this is not medically the best decision). Practitioners stressed the special sensitivities of working in this area, and that while they may help, clearer legal rules will not avoid altogether the dilemmas practitioners have to face in helping parents come to terms with the fact that their child is terminally ill.

4.65 The area of predictive genetic testing is another area where there appears to be strong disagreement about whether or not young people should be able to make decisions on their own.⁷⁵ Because of the potentially damaging emotional and psychological effects on a person who tests positive to one of a number of adult-onset diseases, some practitioners take the view that young people should never be allowed to submit to predictive genetic testing.⁷⁶ Others consider that, as with any other medical decision, a young person should be able to consent to testing if he or she is mature enough to understand its implications, although it is also said that many practitioners consider 16 to be the minimum age at which a young person could demonstrate the requisite degree of maturity for such a serious decision.⁷⁷

4.66 All these groups in consultation emphasised that it was best practice, and achieved the best outcomes for the young patient, if both the young person and his or her parents

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75. See Interview with J Blackwell, Policy Project Officer, Genetic Services, NSW Department of Health (Telephone interview, 7 November 2006). See, too, the differing views expressed in R Duncan, *Holding Your Breath: predictive genetic testing in young people* (Doctoral thesis, Departments of Paediatrics and Public Health, The University of Melbourne, July 2005) and F H Richards, "Maturity of judgement in decision making for predictive testing for nontreatable adult-onset neurogenetic conditions: a case against predictive testing of minors" (2006) 70 *Clinical Genetics* 396.
76. See Human Genetics Society of Australasia, *Pre-Symptomatic And Predictive Testing In Children And Young People* (Position statement 2008 PS02, February 2008).
77. Interview with J Blackwell, Policy Project Officer, Genetic Services, NSW Department of Health (Telephone interview, 7 November 2006).

were able to be involved in health care decisions, and could reach agreement on what was the best course of action for the young person.

4.67 In addition to these consultations with more specialised groups, we sought to hear from the population of General Practitioners about some of their experiences in treating young people. We were particularly interested in consulting with GPs since it is this group of health practitioners from whom it seems young people are most likely to seek help about their health concerns.⁷⁸ While we were limited in the extent to which we could consult with the GP population, we were able to gain snapshots of some of their experiences in treating young people.⁷⁹

4.68 In the context of General Practice, the process of assessing the competence of a young patient was described as an interactive one, requiring the GP to engage the young person's trust in order to encourage them to communicate their real concerns and the real reasons for them seeking help (which they may be reluctant to reveal) and then to determine the level of their understanding about the issues surrounding their concerns. There can be many constraints on this interaction between the GP and the young patient, such as time and a lack of training⁸⁰ and experience on the part of the GP in communicating with adolescents. A number of GPs appear to hold the view that young people below the age of 14 cannot consent to their own treatment, that the age between 14 and 15 is a grey area for assessing competence, and that young people aged 16 and above are able to consent. To a large extent, this view is probably based on the position taken by the Health Department in its directive.⁸¹

4.69 When asked what were the principal factors that they relied on to assess a young patient's competence, several factors were consistently put forward by the GPs with whom we consulted. These included the age of the young person, his or her level of education, intelligence and ability to retell or summarise in his or her own words the treatment intended. Other matters which appeared to weigh in some GPs' assessment of competence included whether or not the young person presented alone to the clinic, the young person's living status (whether he or she was living alone), the young person's

78. See M Booth, D Bernard, S Quine, M Kang, T Usherwood, G Alperstein, L Beasley, D Bennett, *Access To Health Care Among NSW Adolescents: Phase 1* (Final Report, Centre for the Advancement of Adolescent Health, May 2002), 7.

79. We consulted with Dr Melissa Kang from the Department of General Practice, University of Sydney, and we also conducted a survey of general practitioners who attended a postgraduate seminar, Paediatric Postgraduate Weekend for General Practitioners, Children's Hospital at Westmead, 5 August 2007. We received 25 written responses to this survey ("Survey of General Practitioners").

80. See Survey of General Practitioners: most respondents considered that they had received average to a little training, only two stating that they had received a lot of training, and one saying that they had received none at all.

81. See NSW Health, *Consent To Medical Treatment – Patient Information* (Policy Directive, PD2005_406, 2005), 25.2, discussed above at para 4.55-4.56. Sixteen of the twenty-five respondents to the survey said that they applied the Directive of NSW Health when treating young people: Survey of General Practitioners. See, too, the submission from the Australian Dental Association, which cited the directive of NSW Health as imposing cut-off ages for consent for those practising in the public sector: see Australian Dental Association (NSW Branch), *Submission*, 2.

general body language, and the GP's prior knowledge of the young person through treating his or her family over a long period of time. While a couple of those involved in General Practice thought that the current law for determining young people's competence was working relatively well, several others expressed a preference for clearer guidance and thought that it was an area that was often misunderstood (both by practitioners and parents).

5. Refining the competency test

- The need for reform
- Building on the common law
- Formulating a legislative test
- The Commission's formulation
- Consequential legislative amendments

THE NEED FOR REFORM

5.1 This chapter sets out the Commission's recommendations for reform. The central recommendation is for the enactment of a legislative formulation for assessing a young person's competence to consent to or refuse health care. This test for competence builds on the general approach of the common law under *Gillick*. It takes account of initiatives in other jurisdictions to devise legislative formulations for assessing competency. A number of consequential recommendations flow on from this central recommendation. They relate to changes to existing legislation in New South Wales, namely:

- repeal of s 49 of the *Minors (Property and Contracts) Act 1970* (NSW), and
- amendment to Part 5 of the *Guardianship Act 1987* (NSW).

BUILDING ON THE COMMON LAW

The *Gillick* test

5.2 In so far as the *Gillick* test at common law assesses competence according to an individualised notion of maturity, we favour it as the appropriate approach in determining legal capacity. It is the approach most consistent with the psychological and empirical evidence that demonstrates that the development of the brain and social maturity are ongoing processes which vary not only from person to person but also with respect to different types of decisions.¹ The approach of the common law seems generally to have the support of practitioners who must apply it.² It was also generally supported by submissions,³ although there was a divergence in views about whether or not it should be combined with a legislatively fixed cut-off age for consent to be recognised at a particular age or with respect to particular types of treatment.⁴ The *Gillick* test is also generally favoured in other common law jurisdictions.⁵

1. See para 2.20-2.36.

2. See para 461-69.

3. Doctors Reform Society, *Submission*, 2; S Siedlecky, *Submission*, 3; G Tomossy, *Submission*, 2; National Children's and Youth Law Centre, *Submission*, 7; Shopfront Youth Legal Centre, *Submission*, 4; Students of the Faculty of Nursing, Midwifery and Health, UTS, *Submission*, 2; Youth Action and Policy Association NSW, *Submission*, 1; Youth Justice Coalition, *Submission*, 3; Commission for Children and Young People, *Submission*, 7-8; NSW Council for Intellectual Disability, *Submission*, 1. On behalf of the Australian Dental Association, it was submitted that most dentists would apply the *Gillick* test when treating unaccompanied minors, although they may not generally know that this was the legal terminology for what they simply consider to be a common sense approach: see Australian Dental Association (NSW Branch), *Submission*, 1, 3.

4. For views put forward in submissions in relation to particular types of health care, see para 6.64-6.86.

5. See para 5.6-5.33 below.

To legislate or leave to the common law?

5.3 While it seems fairly clear and uncontroversial that the common law approach is essentially the preferred approach in assessing a young person's competence, the next step to reform is less obvious. Should the common law be left alone, without any attempt at encapsulating it in legislative form, so that it can be allowed to develop with the support of an existing (if somewhat small) body of case law? Repeal of s 49 of the *Minors (Property and Contracts) Act* would leave the common law free to develop on its own, unencumbered by the confusion that now arises from the interaction between the two.⁶ Or is it preferable to recommend a legislative formulation that is based on the *Gillick* test but perhaps modifies and builds on it?

5.4 Ultimately, we take the view that an attempt at a legislative formulation based on the *Gillick* test should be made. We recognise the concerns about trying to encapsulate in legislation the common law approach, namely a loss of flexibility and uncertainties in legislative interpretation, but nevertheless we consider that this is the preferable option. We have four reasons for reaching this conclusion.

- First, the ambiguities in the common law are important enough to warrant closer attention and to be clarified in legislation.
- Secondly, these ambiguities do not generally reflect simple technical uncertainties in the operation of the law, but relate to more substantive questions about the decision-making processes for young people's health care. Attempts at clarification should not be left to the necessarily ad hoc developments of the common law but should be based on considered policies that have properly weighed up matters relating to, for example, the appropriate level of understanding to be expected of a competent young person and the proper role of parents in making decisions concerning mature young people. While the common law has the advantage of flexibility, the controversial nature of much of this area of the law is such that it will benefit from a properly thought-out approach to setting down criteria for competence.
- Thirdly, the confused state of the current law in New South Wales is perhaps unique, due largely to the uncertainties arising from the interaction between the common law and statute law, in particular s 49 of the *Minors (Property and Contracts) Act*. In our view, repealing s 49 will not be enough. Legislation is needed to provide some certainty about what exactly the law is. There is an advantage for health practitioners in having a clear statement of the law that they can find in an easily accessible place.
- Fourthly, while there is always the risk of uncertainty in legislative interpretation, we are not recommending an entirely new and unfamiliar test. Much of the existing case law surrounding the *Gillick* test will be transferable to the interpretation of the new legislation. In this case, the advantage of clarification and greater certainty through legislation outweighs the risks of ambiguity in interpretation.

5.5 For these reasons, we recommend a legislative formulation of the test for determining competence that is based on the common law approach. At the same time, as we made clear in Chapter 1,⁷ we are not seeking to codify this area of the law. The common law will continue to play a part in the rules governing decision-making for young people's health care, as we have no intention for legislation to cover the field. For

6. See Recommendation 8 below.

7. See para 1.25.

example, the law governing the best interests of the child, the inherent *parens patriae* jurisdiction of the Supreme Court, will continue to play an important part in the law governing the circumstances in which a young person's decision about his or her health care will be recognised as legally effective.

FORMULATING A LEGISLATIVE TEST

Previous Australian initiatives

5.6 The suggestion for legislative reform of the law on young people's competence is not new. For decades, both within Australia and internationally, legislators, law reformers and academic commentators have struggled to find the perfect legislative expression of their views about the appropriate role of young people in decisions about their own health care. Various tests for assessing a young person's competence have been proposed, and some implemented in legislation. We have considered whether these can provide guidance in formulating a statutory provision for assessing competence for young people in New South Wales.

5.7 Apart from New South Wales' limited statutory provisions, South Australia is the only Australian jurisdiction with legislation that governs the general assessment of young people's competence to consent to medical treatment.⁸ The *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides a statutory framework for dealing with the rights of adults and young people in South Australia to make decisions about their medical treatment or palliative care, and includes provisions regulating the assessment of young people's competence to consent to treatment.⁹

5.8 While few Australian Parliaments have enacted legislation to regulate young people's consent to medical treatment (or health care), there has been a steady push throughout Australia for greater legislative regulation of this area within the last 30 years. In 1980, the Standing Committee of Commonwealth and State Attorneys-General referred to the Western Australian Law Reform Commission an inquiry into the law relating to the provision of medical treatment to minors, with a view to recommending uniform legislation

8. Most Australian jurisdictions have legislation regulating young people's right to consent in specific situations, such as consent to organ and tissue donation and blood donation and transfusion (*Transplantation and Anatomy Act 1978* (ACT) Part 2 Div 2.3, Div 2.5; *Transplantation and Anatomy Act 1979* (Qld) Part 2 Div 2A, s 18, 20; *Transplantation and Anatomy Act 1983* (SA) s 12-13, 19; *Human Tissue Act 1985* (Tas) s 12, 19, 21; *Human Tissue Act 1982* (Vic) Part 2 Div 3, s 22, 24; *Human Tissue and Transplant Act 1982* (WA) s 12-13, 19, 21; *Human Tissue Act 1983* (NSW) s 10, 11, 11A, 20, 20A; or termination of pregnancy (*Criminal Code 1983* (NT) s 174(4)(b)). See para 1.32-1.42.
9. The Act recognizes the competence of people aged 16 or above to "make decisions" about their treatment as validly and effectively as an adult, which presumably includes the competence to refuse treatment: see *Consent to Medical Treatment and Palliative Care 1995* (SA) s 6. However, the test to assess the competence of a child (that is, a person below 16) refers only to the competence to consent to treatment: see *Consent to Medical Treatment and Palliative Care 1995* (SA) s 12.

for enactment throughout Australia.¹⁰ That reference was withdrawn in 1984 because of insufficient resources. The Western Australian Law Reform Commission proceeded on a more limited inquiry into the law in Western Australia, and proposed a statutory scheme for determining young people's right to consent to medical treatment in that State. In the meantime, a review of South Australian law surrounding young people's consent to medical and dental treatment had begun in 1978,¹¹ been revived in a different form in 1983,¹² and in 1985 culminated in legislation.¹³ More recently, the Queensland Law Reform Commission conducted a review of the law on young people's competence to consent to health care, which resulted in recommendations for a wide-ranging statutory regime to clarify and build upon the existing law.¹⁴

5.9 There are several common threads that run through the findings of these reviews, and several notable points of divergence.

Fixing a cut-off age for consent at 16

5.10 In South Australia and Western Australia, it was recommended that legislation fix at 16 the age of consent to medical treatment, that is, young people aged 16 and over could make decisions about their medical treatment to the same extent as if of full age. A young person of this age would then only be considered incompetent for the same reasons that an adult might, for example, by reason of some incapacity of mind, rather than immaturity because of age. That recommendation is now law in South Australia

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10. See South Australia, Working Party on Consent to Treatment, *Report of the Working Party on Consent to Treatment* (December 1983), 22; Western Australian Law Reform Commission, *Medical Treatment for Minors*, Project 77, Part 1, Discussion Paper (June 1988), [1.2]. The original terms of reference from the Standing Committee of Commonwealth and State Attorneys-General are reproduced as Appendix 1 to the Discussion Paper of the Western Australian Law Reform Commission.
 11. A private member's bill had been introduced in the South Australian Parliament, and was then referred to a Select Committee of the Legislative Council for comment. The Select Committee published a report in July 1978: see South Australia, Select Committee of the Legislative Council on the *Minors (Consent to Medical and Dental Treatment) Bill 1977-78*, *Report of the Select Committee of the Legislative Council on the Minors (Consent to Medical and Dental Treatment) Bill 1977-78* (1978).
 12. South Australia, Working Party on Consent to Treatment, *Report of the Working Party on Consent to Treatment* (December 1983).
 13. *Consent to Medical and Dental Treatment Act 1985* (SA), repealed by the *Consent to Medical Treatment and Palliative Care Act 1995* (SA), following a report of a Select Committee of the House of Assembly into the law and practice relating to death and dying: see South Australia, Parliament, House of Assembly, Select Committee on the Law and Practice Relating to Death and Dying, *Final Report Of The Select Committee On The Law And Practice Relating To Death And Dying* (1992).
 14. See Queensland, Law Reform Commission, *Consent to Health Care of Young People*, Report 51 (1996). To date, the recommendations of the QLRC have not been implemented.

under s 6 of the *Consent to Medical Treatment and Palliative Care Act 1995*.¹⁵ The reasons for fixing 16 as the cut-off age for consent were, first, that 16 is already recognised as the age when a person assumes a certain measure of responsibility in some areas, such as consenting to sex or driving a car, and it is reasonable to assume that this is an acceptable age for the law to recognise maturity in decision-making;¹⁶ secondly, a young person would generally be able to assess information and make a decision on that information (although there was no scientific or empirical evidence provided to support this assertion);¹⁷ thirdly, 16 has been fixed in legislation in several jurisdictions overseas as the age of consent to medical treatment and there is little controversy about the ability of young people of this age to make their own medical decisions.¹⁸

5.11 On the other hand, the Queensland Law Reform Commission did not recommend a cut-off age for consent at 16.¹⁹ It applied the same test for competency to 16- and 17-year-olds that it did to younger ages (a test more stringent than that applied to adults). It did, however, make a distinction in the consequences of finding a 16- or 17-year-old competent: once found competent, this age group would legally be able to consent to and refuse medical treatment in the same way as adults, regardless of whether or not that decision served their best interests, and irrespective of their parents' view. The reasons put forward by the Queensland Law Reform Commission appear to be based mainly on a desire for simplicity. It expressed concern that it would be too complicated and unworkable to apply two different rules for competency to those below 16 and those aged 16 and 17.²⁰ It is arguable, however, that the Queensland Law Reform Commission's recommended

15. The proposal of the Western Australian Law Reform Commission was phrased similarly, although it was expressed in terms limited to consent, and not refusal. It proposed that legislation should "enable children of 16 or over to give a valid and sufficient consent to medical treatment to the same extent as if they were of full age": Discussion Paper (June 1988), [5.12]. The Western Australian Law Reform Commission did not specifically discuss its proposal in relation to a 16-year-old's right to refuse medical treatment. However, it seemed to imply that the right to consent would include a right to refuse when it noted that its proposal would remove any parental right "to override the consent to medical treatment, or refusal of consent to medical treatment, of a child of 16 or over": [5.12].

16. South Australia, Select Committee of the Legislative Council on the *Minors (Consent to Medical and Dental Treatment) Bill 1977-78*, Report (July 1978), [4]; South Australia, Working Party on Consent to Treatment, *Report of the Working Party on Consent to Treatment* (December 1983), 23.

17. South Australia, Working Party on Consent to Treatment, *Report of the Working Party on Consent to Treatment* (December 1983), 23.

18. Western Australian Law Reform Commission, *Medical Treatment for Minors*, Discussion Paper, Project 77, Part I (June 1988), [5.11].

19. For the recommendations and discussion of the Queensland Law Reform Commission relating to the 16 and 17-year age group, see Queensland Law Reform Commission, *Consent to Health Care of Young People*, Report 51 (1996) vol 2, Ch 12.

20. See in particular Queensland Law Reform Commission, *Consent to Health Care of Young People*, Report 51 (1996) vol 2, 269-270. The Commission also noted that its competency test for 16 and 17-year-olds would provide extra protection for young people of this age in relation to refusal of health care.

provisions are unnecessarily complicated in distinguishing between the consequences of a finding of competency.

Formulating the test for competence

5.12 Whether it was applied to those aged below 16, or to all young people below the age of 18, the general test for assessing competence put forward in Western Australia, South Australia and Queensland consistently contained elements of the common law test in *Gillick*. The proposed tests focused on the individual's level of maturity, requiring consideration of whether the young person was capable of understanding the nature and consequences of the proposed treatment,²¹ or, phrased differently, if he or she were of sufficient intelligence and understanding to comprehend the nature and implications, including the consequences, of the proposed treatment.²² The Queensland Law Reform Commission framed its test for competence according to whether a young person understands the nature and consequences of the health care, and communicated his or her decision in some way.²³ It emphasised its modification of the common law test from capability to understand to actual understanding, although it is questionable whether a health practitioner would be able to discern and apply any practical distinction in the tests.²⁴

5.13 While the basic formulation of the test for competency in the three States was essentially the same (with some variation in Queensland), there was a fair amount of divergence in the details of each formulation, in particular in relation to safeguards which it was considered should be included to protect both the interests of the doctor, or other health care provider, and young people. There were also important differences of opinions about the role parents should play in treatment decisions for competent young people.

5.14 The Western Australian Law Reform Commission recommended that legislation presume that young people aged 13 to 15 were competent to consent, with that presumption being rebuttable upon sufficient evidence. Young people below the age of 13 were potentially mature but their competence must be established to the satisfaction of the doctor. It was considered that the presumption for the older age group would provide doctors with clearer guidance.²⁵ The Western Australian Law Reform Commission took the view that once a young person was deemed competent to consent to or refuse

21. South Australia, Working Party on Consent to Treatment, *Report of the Working Party on Consent to Treatment* (December 1983), 26. Section 12 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) now provides to this effect, though with an important qualification relating to best interests: see below para 5.15.

22. Western Australian Law Reform Commission, *Medical Treatment for Minors*, Discussion Paper, Project 77, Part 1 (June 1988), [5.15].

23. See Queensland Law Reform Commission, *Consent to Health Care of Young People*, Report 51 (1996) vol 2, 199-201.

24. Similarly, it is questionable whether the second element of the Queensland Law Reform Commission's test, requiring the young person to communicate his or her decision, would add anything to the common law test in practice, since in order for a doctor to determine a young patient's understanding the young patient must presumably be able to communicate with the doctor in some way.

25. Western Australian Law Reform Commission, *Medical Treatment for Minors*, Discussion Paper, Project 77, Part 1 (June 1988), [5.17].

treatment, whether it be because the young person was aged 16 or over, or because a younger person was determined to be competent, a parent could not override that decision, except where the young person's consent could not be given for reasons other than because of his or her age, such as unsoundness of mind or unconsciousness.²⁶ As well, the Western Australian Law Reform Commission recommended the formulation of guidelines by which doctors and hospitals should regulate their conduct for obtaining consent and communicating certain information to a "mature minor", or, in other cases, to the young person's guardian:

a sufficiently accurate and detailed description of the treatment to identify that to which the child has consented;

a description of the inherent risks (and their severity) which could result from the treatment together with an assessment of the likelihood of those risks being realised;

an indication of alternative treatment;

an indication of the likely course of the patient's condition or disease in the event (1) of the proposed treatment, (2) the alternative treatments, or (3) no treatment, being carried out;

a description of any benefits about the proposed procedure; and

*that the child is free to withhold or withdraw consent at any time.*²⁷

5.15 The South Australian legislation²⁸ provides for young people aged 16 and 17 to make decisions about medical treatment as validly and effectively as an adult, with no express qualification to that right, and no reference to any concurrent rights of a parent. It is open to question whether the courts would nevertheless infer an overriding requirement that the decision is in the young person's best interests.²⁹ Certainly, for young people

26. Western Australian Law Reform Commission, *Medical Treatment for Minors*, Discussion Paper, Project 77, Part 1 (June 1988), [5.12], [5.15].

27. Western Australian Law Reform Commission, *Medical Treatment for Minors*, Discussion Paper, Project 77, Part 1 (June 1988), [8.7]-[8.8]. It was considered that it would be appropriate to adopt the same guidelines for the treatment of adult patients.

28. Originally, the *Consent to Medical and Dental Treatment Act 1985* (SA), subsequently repealed and replaced by the *Consent to Medical and Palliative Care Act 1995* (SA). Section 12 of the 1995 Act deals with the competence of children to consent to medical treatment.

29. In the United Kingdom, the courts have interpreted a similar provision as allowing them an overriding right to intervene and act contrary to a 16 or 17-year-old's decision where the young person's best interests so required: *In re W (a minor) (medical treatment: court's jurisdiction)* [1993] Fam 64. In the absence of case law, it is arguable that the same principle applies to the operation of the South Australian legislation, which is limited by the *parens patriae* jurisdiction of the Supreme Court to protect a young person's best interests: see D Worswick, *The Law Governing Children Consenting To Medical Treatment In Australia* (Thesis

aged below 16, the South Australian legislation expressly requires that competent young people in this age group may only consent to treatment personally if that treatment is in their best interests and the treating doctor's determination of competence is supported by the written opinion of another medical practitioner who examines the young person.³⁰ Western Australia and Queensland considered the benefits of including in their recommended statutory schemes this requirement for a second opinion, as a safeguard for the young person against a wrong assessment. Both States ultimately rejected a requirement to this effect, on the basis that it would be impractical and could become merely a rubber stamp.³¹ That view has also been expressed to the Commission by health care practitioners in consultation.³²

5.16 The Queensland Law Reform Commission agreed with the approach taken in the South Australian legislation that a competent young person below the age of 16 should only be able to give a legally valid consent to medical treatment if that treatment is also in his or her best interests.³³ Its greatest point of divergence from the conclusions of the other Australian reviews was to fix a lower age limit, 12, below which no young person would be legally capable of consenting to, or refusing medical treatment. This recommendation reflected the position taken by the Queensland Law Reform Commission that parents should generally be involved in all significant decisions affecting the health of their children below the age of 12.³⁴ However, as exceptions to this general rule, it recommended that competent (as defined according to its *Gillick*-style test) young people below 12 be able to consent to certain types of treatment, such as contraceptive and sexual health care.

Providing a defence for practitioners

5.17 Both the Western Australian and the Queensland Law Reform Commissions recommended the provision of a statutory defence for practitioners to a claim for civil or criminal liability where the action was based on a lack of a young person's capacity to consent (but not where it was based, for example, on the doctor's negligence). Under the

submitted in fulfillment of the requirements for the research degree of Master of Laws, Flinders University of South Australia, 2001), 115.

30. *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 12.
31. Western Australian Law Reform Commission, *Medical Treatment for Minors*, Discussion Paper, Project 77, Part 1 (June 1988), [5.24]; Queensland Law Reform Commission, *Consent to Health Care of Young People*, Report 51 (1996) 257-258. See too the Scottish Law Commission, which also decided against such a requirement: *Report on the Legal Capacity and Responsibility of Minors and Pupils* (Scot Law Com No 110, 1987), [3.75-3.77].
32. See Dr S Towns, Department of Adolescent Medicine, Children's Hospital at Westmead, *Consultation*; Dr M Kang, Department of General Practice, University of Sydney, *Consultation*; Department of Psychological Medicine, Children's Hospital at Westmead, *Consultation*.
33. Queensland Law Reform Commission, *Consent to Health Care of Young People*, Report 51 (1996) vol 2, 256-257. By contrast, as noted in para 5.11, competent young people aged 16 and 17 would be able to consent to (and refuse) medical treatment that was not in their best interests under the statutory scheme recommended by the Queensland Law Reform Commission.
34. Queensland Law Reform Commission, *Consent to Health Care of Young People*, Report 51 (1996) vol 2, 235.

Western Australian recommended provision, this defence would be available if the practitioner reasonably believed that the young person was mature, or if the treatment was necessary to deal with a serious threat to the life or health of the young person. The Western Australian Law Reform Commission took the view that this defence would encourage practitioners to act upon the directions of young people whom they might previously be reluctant to treat without parental consent, even if they considered them to be competent. It also considered that the provision of this defence removed the need for any special rules for particularly sensitive types of treatment, such as treatment relating to sexual health, termination of pregnancy, contraception, and other adolescent health issues, where questions of determining a young person's competence to consent must be balanced with the public interest in encouraging them to seek help and treatment. The defence would allow doctors to treat a young patient even if he or she was not considered competent to consent, if this was the only way that he or she would seek treatment.³⁵

5.18 The Queensland Law Reform Commission recommended a defence, or defences, from liability for health care providers who acted under the mistaken but honest and reasonable belief as to the young person's competence. This defence would protect the health care provider from criminal and civil liability for assault or battery under the general law, as well as from civil liability under the new cause of action which it recommended in its legislative scheme for unauthorised health care.³⁶

5.19 These defences are discussed more fully in Chapters 9.

Overseas jurisdictions

5.20 Many common law countries overseas have sought to achieve the ideal statutory framework for determining the roles of young people, parents, and the State in making decisions about a young person's health care. A snapshot of some of the more interesting innovations is given below.

Canada

5.21 In Canada, several provinces have legislation dealing with a young person's competence to make health care decisions.

5.22 In British Columbia, s 17(2) of the *Infants Act 1996* provides:

Subject to subsection (3), an infant may consent to health care whether or not that health care would, in the absence of consent, constitute a trespass to the infant's person, and if an infant provides that consent, the consent is effective and it is not necessary to obtain a consent to the health care from the infant's parent or guardian.

35. Western Australian Law Reform Commission, *Medical Treatment for Minors*, Discussion Paper, Project 77, Part 1 (June 1988), [6.1]-[6.22]. This approach was not intended to apply to sterilisation and other methods of long-term pregnancy prevention, for which it was considered court authorisation should be required: [6.23]-[6.30].

36. Queensland Law Reform Commission, *Consent to Health Care of Young People*, Report 51 (1996) vol 2, 214-215, Ch 17.

5.23 And s 17(3) provides:

A request for or consent, agreement or acquiescent to health care by an infant does not constitute consent to the health care for the purposes of subsection (2) unless the health care provider providing the health care

(a) has explained to the infant and has been satisfied that the infant understands the nature and consequences and the reasonably foreseeable benefits and risks of the health care, and

(b) has made reasonable efforts to determine and has concluded that the health care is in the infant's best interests.

5.24 This provision has undergone substantial changes since it was originally introduced in 1973.³⁷ In its present form, it has been described in one case as amounting essentially to a codification³⁸ of the common law rules, providing certainty with regard to those to whom they apply.³⁹ (It should be pointed out that this case concerned a constitutional challenge to the then new provision on the basis that it infringed the rights of children and parents to liberty and security of person. By finding that the provision essentially reflected the common law test, against which there was no complaint, the court upheld the constitutional validity of the provision.) At the same time, the central test for competence in s 17(3)(a) has been described as conceiving of maturity in terms largely of intelligence and comprehension, rather than with any wider focus on questions of emotional, ethical and religious maturity.⁴⁰ And in one case, the court interpreted the requirement for the practitioner to make reasonable efforts to determine that the care is in

37. Section 16 of the *Infants Act 1973* applied only to young people aged 16 and over (therefore leaving the common law to govern the position of young people below the age of 16) and allowed a medical practitioner to provide treatment without facing liability for trespass based upon the young person's consent, but only if a reasonable effort had been made first to obtain the consent of a parent or guardian, or to obtain a written opinion from a second practitioner. This section was replaced in 1992 by the *Miscellaneous Statutes Amendment Act 1992* which came into force on 1 January 1993. The amending Act replaced s 16 with the provision as it currently appears. The section was renumbered as s 17 in the 1996 Statute Revision.

38. While the word "codification" was used, it is clear from subsequent cases that this was not meant to imply that the provision replaced entirely the application of the common law in this area. It has since been held (in one case, by the same judge, Huddart JA, who decided *Ney v Canada (Attorney General)* (1993) 102 DLR (4th) 136) that the provision under the *Infants Act* was not inconsistent with the common law, and did not exclude the operation of the court's *parens patriae* jurisdiction at common law: see *Van Mol v Ashmore* (1999) 168 DLR (4th) 637; *B v British Columbia (Director of Child, Family and Community Service)* [2005] BCSC 573.

39. See *Ney v Canada (Attorney General)* (1993) 102 DLR (4th) 136.

40. Manitoba, Law Reform Commission, *Minors' Consent To Health Care*, Report 91 (1995) 17.

the young person's best interests as likely to require consultation with the young person's parents.⁴¹

5.25 At the time of its introduction, one commentator described the test under the *Infants Act* as changing the common law in a number of significant ways.⁴² These included the following:

- It was argued that, although the common law accepted the possibility of a young person below the age of 16 being competent, it was more likely to view a person of this age as not capable of consenting and would apply special ethical considerations that went beyond mere cognitive ability to that assessment. These considerations related to the guidelines set out by Lord Fraser in the *Gillick* case.⁴³ It was argued that these same considerations did not form part of the statutory provision under the *Infants Act*, therefore increasing the possibility for a young person to be competent to consent under the statutory test.
- It was argued that the common law gave greater control and input by parents into the decision-making process for their children than the test set up by the statutory provision.⁴⁴
- It was noted that the legislative provision extended the requirement for consent beyond consent to health care involving physical contact (although there is no discussion of the legal repercussions for treatment not involving such contact for which there is no valid consent).

5.26 In Ontario, the *Health Care Consent Act 1996* provides a statutory scheme to regulate health care decision-making which applies both to adults and minors. Section 4(2) of the Act creates a general presumption that a person is capable of making decisions about treatment (among other things), and there is no age restriction on that presumption. The presumption can be rebutted: capability, or capacity, is tested under s 4(1) according to whether or not:

... the person is able to understand the information that is relevant to making a decision about the treatment ...and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

5.27 The courts have had several opportunities to consider the meaning of this formulation.⁴⁵ It has been said that the use of the term, "appreciate", requires an ability to

41. See *Ney v Canada (Attorney General)* (1993) 102 DLR (4th) 136.

42. See J Broom, "The recent amendment to the *Infants Act*: a look at some of the legal issues" (1993) 51 *The Advocate* 391.

43. See para 4.12.

44. The basis for arguing that there was greater scope for parental input at common law was again Lord Fraser's guidelines in *Gillick*. It should be noted that following publication of Broom's article, the decision in *Ney v Canada (Attorney General)* (1993) 102 DLR (4th) 136 was handed down, which held that the requirement in (then) s 16(3) of the *Infants Act* for the practitioner to make reasonable efforts to determine that the health care was in the young person's best interests would generally require consultation with parents.

45. However, the cases have involved the treatment of adults with alleged mental illnesses rather than young people whose capacity is under challenge because of

evaluate, not just understand, information.⁴⁶ The Canadian Supreme Court agreed⁴⁷ that this test for capacity is not limited to a lack of a rational ability to understand, but extends to a lack of ability to “appreciate” or judge. Appreciation imposes a more stringent standard than a test based on understanding, since it includes both a cognitive and an affective component. The first component of the test requires the intellectual ability to process the information as it applies to the treatment in question, including its potential benefits and drawbacks, while the second component requires an ability to weigh up or evaluate the foreseeable consequences of accepting or refusing the treatment. The Supreme Court has also emphasised the distinction between ability to understand and appreciate and actual understanding and appreciation. A person may lack actual understanding but this may not undermine his or her ability to understand if, for example, the failure actually to understand is due to the practitioner failing to provide that person with the information that is relevant to acquiring such an understanding.

5.28 Similarly, the *Consent to Treatment and Health Care Directives Act 1988* of Prince Edward Island provides for a general presumption of capacity to consent to or refuse treatment,⁴⁸ where capacity is assessed by the health practitioner according to the patient’s ability to understand the information that is relevant to making a decision concerning the treatment; understand the information that applies to his or her particular situation, understand his or her right to make a decision; and appreciate the reasonably foreseeable consequences of a decision or lack of a decision.⁴⁹

5.29 New Brunswick has legislation similar to that of British Columbia in so far as it requires the health practitioner to assess the young person’s understanding and whether the health care serves his or her best interests. The *Medical Consent of Minors Act 1976* grants young people aged 16 and above the right to consent to medical treatment “as if they had attained the age of majority”.⁵⁰ The consent of a young person below that age may be as effective as if that person had attained the age of majority if a specified health practitioner considers that the young person is capable of understanding the nature and consequences of the medical treatment, and the medical treatment is in the best interests of the young person and his or her continuing health and well-being.⁵¹

5.30 In Quebec, the *Civil Code* makes a distinction between treatment that is “required by the state of health” of the minor⁵² and treatment that is not required by the state of health of the minor.⁵³ For treatment that is required by the minor’s state of health, consent

their age: for example, see *Starson v Swayze* [2003] 1 SCR 722; *Fleming v Reid* (1991) 82 DLR (4th) 298; *Sevels v Fleming* (2007) CanLII 18577 (OnSC).

46. See *Neto v Klukach* [2004] OJ No. 394 (Day J, Ontario Superior Court of Justice).

47. See *Starson v Swayze* [2003] 1 S.C.R. 722. The differences between the majority and dissenting judges lay not in their interpretation of the statutory test but in its application to the facts.

48. *Consent to Treatment and Health Care Directives Act 1988* RSPEI 1988, c.C-17.2 (Prince Edward Island) s 3.

49. *Consent to Treatment and Health Care Directives Act 1988* RSPEI 1988, c.C-17.2 s 7(1).

50. See *Medical Consent of Minors Act*, SNB 1976, c.M-6.1 (New Brunswick), s 2.

51. See *Medical Consent of Minors Act*, SNB 1976, c.M-6.1 (New Brunswick), s 3(1).

52. *Civil Code*, RSQ 1992, c.C-1991 (Quebec) art 14, 16.

53. *Civil Code*, RSQ 1992, c.C-1991 (Quebec) art 17, 18.

of a parent or guardian is required for a person below the age of 14, and young people aged 14 and above may give their own consent or refusal but their refusal may be overridden by court authorisation. For treatment that is not required by the minor's state of health, people below the age of 14 cannot give their own consent, and people aged 14 and above may consent themselves unless the care entails a serious risk to the young person's health and may cause grave and permanent effects.

United Kingdom

5.31 In the United Kingdom, s 8 of the *Family Law Reform Act 1969* (UK) provides, among other things, that a person who has attained the age of 16 is able to give as effective a consent as if he or she were of full age to any surgical, medical or dental treatment which, in the absence of such consent, would constitute a trespass. That provision originally arose from recommendations of a Parliamentary report in 1967, which noted that all the professional bodies with which it consulted had considered that patients aged between 16 and 18 should be able to give an effective consent to treatment.⁵⁴ It has been held that s 8 does not confer on young people aged 16 and 17 an absolute right to make decisions about their medical care, but simply enables them to give consent for the purpose of protecting a medical practitioner from any liability for trespass. The courts may nevertheless override the decision of a 16 or 17-year-old if his or her best interests require such intervention.⁵⁵

5.32 In 1995, the Law Commission of England and Wales published a report on mental incapacity in adults, in which it considered various formulations of the test for determining competence to consent to medical treatment where there is a question of mental incapacity. It recommended that the test be formulated in terms of deeming an adult patient not competent if his or her disability is such that he or she is unable to make a decision based on the information relevant to the decision in question. While this test was confined to adults, there is no reason why it could not be as equally applicable a test for patients below the age of 18.

New Zealand

5.33 In New Zealand, the *Care of Children Act 2004* (NZ), in particular s 36, provides a framework for the making of medical decisions concerning young people. This section replaced s 25 of the *Guardianship Act 1968* (NZ), with only slight modification. Section 36(1)(b) expressly provides that the consent or refusal of a young person aged 16 and over to medical, surgical or dental treatment or procedure, including a blood transfusion, has effect as if that young person were of full age, where the treatment or procedure is to be carried out on the young person for the young person's benefit.⁵⁶ The subsection does not address the question of whether parents, guardians, or courts, retain a co-existing right to make decisions for those aged 16 and over. It also does not deal expressly with the rights of those aged below 16 to consent to and refuse medical

54. See Great Britain, Committee on the Age of Majority, *Report of the Committee on the Age of Majority* (Cmnd. 3342, 1967).

55. See *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64.

56. It has been argued that this inserts a best interests qualification to the right to consent: see M McDowell, "Medical treatment and children: assessing the scope of a child's capacity to consent or refuse to consent in New Zealand" (1997) 5 *Journal of Law and Medicine* 81, 91.

treatment, and on its face it would seem that in New Zealand a young person below the age of 16 must generally rely on his or her parents to make medical decisions on his or her behalf.⁵⁷ It has been argued⁵⁸ that, by expressly preserving⁵⁹ (among other things) a rule of law by which no consent or no express consent is necessary, the common law relating to the ability of a mature minor to consent to medical treatment is adopted into New Zealand law. It should also be noted that, under s 36(2), young people who are married, in a civil union, or living with another person as a de facto partner, can consent to and refuse medical treatment for themselves, or for any other person (presumably their child) as fully as if they were of full age. Section 38 of the Act allows a young woman of any age to consent to or refuse an abortion. New Zealand has also adopted a Code of Health and Disability Services Consumers Rights,⁶⁰ which places various obligations on health and disability support service providers and provides for consumer rights, including the right to make an informed choice and give informed consent if competent, with a presumption in favour of competence.⁶¹

THE COMMISSION'S FORMULATION

RECOMMENDATION 4

The legislation should provide that:

- a competent young person may accept or refuse health care and it is not necessary to obtain an acceptance or refusal of the health care from the young person's parent or other legal guardian;
- a young person is competent to accept or refuse health care if, in the opinion of the health practitioner offering the health care, the young person understands the information that is relevant to making a decision about the health care, and appreciates the reasonably foreseeable consequences of that decision.

RECOMMENDATION 5

The legislation should provide that a health practitioner must not rely on the acceptance or refusal of health care of a parent or guardian on a young person's behalf if that acceptance or refusal conflicts with the young person's decision where the young person is competent to make a decision about his or her health care according to Recommendation 4.

57. See Tompkins J in *Auckland Healthcare Services Ltd v Liu* (unreported, High Court, Auckland, 11 July 1996, M812/96) at 7.

58. See M McDowell, "Medical treatment and children: assessing the scope of a child's capacity to consent or refuse to consent in New Zealand" (1997) 5 *Journal of Law and Medicine* 81, 92.

59. See *Care of Children Act 2004* (NZ) s 36(5)(a).

60. See *Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996* (NZ).

61. See Right 7.

RECOMMENDATION 6

The legislation should provide that:

- a young person who is aged 16 or over is presumed to be competent to make a decision about his or her health care according to Recommendation 4,
- that presumption can be rebutted if, in the opinion of the health practitioner, the young person does not understand the information that is relevant to making a decision about the health care and does not appreciate the reasonably foreseeable consequences of the decision.

RECOMMENDATION 7

Nothing in Recommendations 4-6 prevents a parent from giving consent to health care on behalf of or in relation to a young person who is not competent to give consent or to decide to accept or refuse health care for reasons other than immaturity, such as unconsciousness or cognitive impairment.

Some preliminary matters

5.34 There are a number of preliminary matters worth noting about the basic test for competence that we are putting forward. First, it continues to put the onus on the treating practitioner to assess the young person's competence. This is the only practical way of applying a test that relies on consideration of each individual's qualities. The practitioners with whom we consulted largely appeared to accept their role in the assessment process as appropriate, although we note the practical constraints that can be placed on them in carrying out that role, specifically time constraints and financial concerns, as well as sometimes a lack of specific training in treating and communicating with young people. On the other hand, as was put to us in consultation,⁶² a test which requires assessment of an individual's understanding at least forces a practitioner to some extent to spend some time engaging with young patients in order to extract from them their level of maturity. By encapsulating the test for competence in a statutory provision, practitioners are less likely to be confused by apparent cut-off ages of 14 and 16 (as seems to happen in some cases now)⁶³ and it will be clearer to them that they are required to spend some time assessing the patient. Also, we are recommending a more certain and accessible complaints mechanism for responding to situations where the assessment exercise may not have been properly carried out.⁶⁴

5.35 A second preliminary point about our recommended test is that it makes no distinction between consent and refusal, that is, the same test is applied to determine legal competence to consent to care as to refuse care. We see no reason in principle why

62. See Dr S Towns, Department of Adolescent Medicine, Children's Hospital at Westmead, *Consultation*; Dr M Kang, Department of General Practice, University of Sydney, *Consultation*.

63. By reason of s 49 of the *Minors (Property and Contracts) Act 1970* (NSW), which will be repealed: see Recommendation 8.

64. See Chapter 9.

competence should be measured differently depending on whether a young person seeks to consent or refuse.

5.36 Thirdly, as with the *Gillick* test, our formulation involves an assessment of competence in relation to each particular type of treatment that is proposed. It will therefore still be possible for the same young person to be competent to make a decision about one type of health care, but not another. This approach has been criticised partly on the basis that it imposes a risk-related standard of competence, that is, the greater the likelihood of harm from a particular treatment, the greater the level of competency that should be expected.⁶⁵ However, we have no concerns about this. We concede that our test requires a greater understanding than is expected of adults, and that it involves consideration of the consequences of a decision (which would include an appreciation of the risks). It is reasonable to expect that some forms of treatment, particularly those addressing more serious health concerns, may require an understanding of more complex considerations, and so a young person may not be competent to decide about it even though they are competent to decide other matters. We note that this approach was favoured by practitioners in consultation.⁶⁶

5.37 A last preliminary matter relates to consideration of the young person's best interests. Unlike some provisions in other jurisdictions, our formulation does not include a requirement for the practitioner to be satisfied that the decision is in the young person's best interests as part of the exercise of determining competence. We do not consider that it is the practitioner's role to decide what is in the patient's best interests (beyond any ethical duty to do no harm), and it may have the perhaps unintended effect, as it seems to have had in British Columbia, of providing scope for the practitioner to ignore applicable consideration of confidentiality and consult with parents and guardians in order to determine the young person's best interests. Once the young person is determined to be competent, according to the required level of understanding and appreciation, that should be the end of the practitioner's involvement in questioning the young person's decision. This is different from the overarching power of the State's Supreme Court to intervene in the young person's decision in the exercise of its *parens patriae* jurisdiction which derives from the common law. This jurisdiction will not be ousted by the new legislation, and will act as a safety net for people below the age of 18. There will of course also be the power of the federal courts to exercise their welfare jurisdiction over children arising from the *Family Law Act* (Cth).

Points of divergence from the common law

5.38 Moving on to the substance of the formulation, there are a number of points of divergence in the wording of the Commission's test from the traditional formulation of the *Gillick* test at common law.

65. See J Potter, "Rewriting the competency rules for children: full recognition of the young person as rights-bearer" (2006) 14 *Journal of Law and Medicine* 64.

66. See Dr S Towns, Department of Adolescent Medicine, Children's Hospital at Westmead, *Consultation*; Dr M Kang, Department of General Practice, University of Sydney, *Consultation*.

The level of understanding expected

5.39 First, the Commission's formulation does away with the requirement to understand "fully". Instead, our test adopts the wording of the provision in Ontario, under the *Health Care Consent Act 1996*, which requires an understanding of the information relevant to the care and an appreciation of the reasonably foreseeable consequences of the decision.⁶⁷ This wording is more precise than the requirement for a "full" understanding under the *Gillick* test, and it can be hoped that greater precision will bring greater certainty and meaning to its application. The focus of this new formulation is on the information that is relevant to the health care in question. Like the provision in the *Infants Act* of British Columbia, which in this respect is similar to the provision of Ontario, the range of matters of which the young person is expected to have an understanding is more limited than the potentially endless range of ethical, emotional, and moral matters which he or she may be expected to understand at common law. The recommended formulation concentrates on the intellectual ability to process and comprehend the information that relate to the care.

5.40 At the same time, as the Canadian courts have made clear, the requirement not just to understand but also to appreciate imposes a more stringent standard of competence than one based solely on intellectual comprehension. It involves an ability to weigh up and evaluate information and consider the various consequences of the decision. That appreciation may be diminished by, for example, a delusional belief arising from a mental illness,⁶⁸ or an inability to consider long-term consequences of a decision because of immaturity.

5.41 By requiring a greater level of understanding for young people than the basic test of intellectual comprehension that is generally expected of adults, it is clear that, like the common law, our formulation applies a more stringent standard of competence on young people than on adults. We believe that this is appropriate for the reasons which we discussed in Chapter 2. We have, however, tried to make the formulation more precise than the vague requirement for a "full" understanding at common law, and keep it grounded with a focus on the processing of information that relates to the health care in question.

Actual understanding, not ability to understand

5.42 While the common law test is generally framed in terms of the young person's understanding, there has been some dispute in other jurisdictions as to whether it is preferable to require proof of actual understanding or ability to understand. A requirement that a young person is able to understand means that he or she will not be incompetent simply because the practitioner failed to provide the relevant information. On the other hand, a test that requires actual understanding reinforces to the practitioner the need to make sure he or she is communicating clearly to be certain that the young person does in fact understand. While any practical difference in the wording is likely to be minimal, we consider it preferable that the test require actual understanding.

Presumption of competence at 16

5.43 Unlike the common law, the recommended legislation presumes that young people aged 16 and over are competent to consent to or refuse health care. That presumption is

67. See para 5.26-5.27.

68. See *Starson v Swayze* [2003] 1 SCR 722.

rebuttable where, in the practitioner's view, the young person in question does not satisfy the test for competence under Recommendation 4. The choice of 16 as an age for a presumption of competence follows the general trend elsewhere of identifying 16 as the age when young people are generally capable of consenting. It accords with much of what appears to be the current practice of those working in the area of adolescent health.⁶⁹ It is also supported by much of the psychological evidence on young people's development that indicates that at least their cognitive skills are usually fully developed by this age, and it is consistent with other aspects of the law in recognising young people's decision-making abilities at this age. However, there is also enough psychological evidence to suggest that not all 16-year-olds will be mature enough to exercise a mature choice with respect to all sorts of treatment, and that is why we have recommended a presumption rather than a blanket age of consent.

No overriding power of parents for competent young people

5.44 The new legislation will make it clear that a parent or guardian has no power to override a decision made by a young person once that young person is competent. This clarifies the position at common law, and certainly modifies the position in New South Wales, where the interaction of the common law with s 49 of the *Minors (Property and Contracts) Act 1970* apparently means that a parent or guardian may currently be able to override the decision of a competent young person. The effect of the new legislation on parental powers in respect of competent young people will have implications on patient confidentiality, something which will be discussed as part of the Commission's reference on privacy.⁷⁰

5.45 It should be noted here that while a parent may not have any power to override the decision of his or her child once competent, the courts will retain the power which they have at common law to intervene in decisions affecting young people which are not thought to be in their best interests. Concerned parents can apply for the courts' intervention even though they themselves will not be able to act unilaterally.

5.46 Lastly, Recommendation 7 should be noted. It is intended to apply to situations where a young person is not competent to consent to health care for reasons other than his or her age, for example, a young person who is in a coma and who requires non-urgent treatment. Recommendation 7 makes it clear that a health practitioner can rely on the consent of the young person's parent in this situation.

Application of the formulation to some typically controversial cases

5.47 The preceding chapters have highlighted some of the more typically controversial cases involving decisions about young people's health care. It is helpful to test the practicality of our recommended formulation by applying it to some such cases. In many of these situations, the finding of competence or incompetence would likely be the same whether the common law *Gillick* test was applied or the Commission's new test, since our test is based on the common law. It is our view, however, that our test will tend to make the determination of competence more precise and therefore more easily and more consistently carried out.

69. See Chapter 4 at para 4.53-4.69.

70. See para 1.54-1.64.

Contraceptive treatment

5.48 Under the Commission's test, the health practitioner would not need to concern himself or herself with the young woman's moral character to the same extent as appears to be expected in, for example, the guidelines put down by Lord Fraser in *Gillick*. The focus of the recommended test would be on the young woman's intellectual ability to comprehend the care in question (including her ability to comply with a specific treatment regime, such as taking the Pill daily at a set time). She would need to show an appreciation of the reasonably foreseeable consequences of the decision, which in this case would be to prevent of an unwanted pregnancy. There would be less focus on the young woman's insight into the moral repercussions of her decision to be sexually active.

Treatment for a terminal illness

5.49 In situations involving a young person who is terminally ill, the potential for controversy seems most likely to arise where the young person and his or her family are faced with the choice between following a more aggressive form of treatment and palliative care. Under our test, in order to make that decision himself or herself, the young person would have to understand the care that is proposed and the consequences of it, such as the chances of success of aggressive treatment, its side-effects, the likely consequences of accepting palliative care and the implications of this on the family. Given that young people in these situations are often said to have a special maturity, borne from their experiences with hospitals and facing life/death situations, there is a distinct possibility that a terminally ill young person, at least a teenager, would be found to appreciate the reasonably foreseeable consequences of his or her decision. A young person aged 16 or over would be presumed competent to make that decision. It seems likely that our test would put a greater duty on practitioners to inform the young person of the options for care, including (where relevant) the likelihood of death. This does not appear to happen consistently now, even for older adolescents, if their families do not want them to be told. While this response is completely understandable, it benefits the mature young person, and ultimately his or her family, to be involved in a decision so important to the quality of his or her life.

CONSEQUENTIAL LEGISLATIVE AMENDMENTS

Section 49 of the *Minors (Property and Contracts) Act 1970* (NSW)

RECOMMENDATION 8

Section 49 of the *Minors (Property and Contracts) Act 1970* (NSW) should be repealed.

5.50 We discussed the origins of s 49 at paragraph 4.27-4.32. We noted that, while it may have served a purpose when it was originally enacted, that purpose is no longer relevant because of the developments that have arisen at common law since that time. Instead, the section now really achieves very little, and confuses practitioners with the appearance of imposing cut-off ages for consent. Submissions that addressed this issue

generally agreed that the current law is in need of clarification.⁷¹ We recommend that s 49 of the *Minors (Property and Contracts) Act 1970* be repealed.

Part 5 of the *Guardianship Act 1987* (NSW)

Recommendation 9

The definition of incapacity in s 33(2) in Part 5 of the *Guardianship Act 1987* (NSW) should be amended to exclude from its operation any person who cannot consent solely by reason of his or her immaturity.

Recommendation 10

The legislative scheme that is recommended in Recommendation 1 should make it clear that it does not apply to people who are incapable of consenting for reasons that bring them within the scope of Part 5 of the *Guardianship Act 1987* (NSW) following amendment according to Recommendation 9.

5.51 We referred in Chapter 4 to the uncertainties in the application of Part 5 to young people aged 16 and 17. We agree with the Guardianship Tribunal that in practice the existence of a separate regime for this small age group is unlikely to be problematic. However, the threshold definition of incapacity under Part 5 does not necessarily restrict the application of the Part to people with disabilities, but may apply generally to 16- and 17-year-olds. That age group is therefore potentially subjected to two different tests for competence and two different schemes once competence has been determined. The interaction of the general law and the guardianship legislation may be further complicated upon the implementation of our Recommendation 6, which recommends a general legislative presumption of competence for young people aged 16 and above. Faced with these two schemes, a practitioner may be understandably at a loss to know which law to apply first when treating a 16- or 17-year-old patient.

5.52 It is outside the terms of this reference to review the State's guardianship legislation, even as it applies to a specific group of young people. Apart from our discussion with the Guardianship Tribunal, the Commission has not consulted on the operation of the *Guardianship Act*, and it would be foolish to make specific recommendations for legislative reform without a full discussion on the ramifications of such reform with those with expertise and experience in this area. At the same time, we take the view that the law has been unnecessarily complicated as a perhaps unintended result of the way in which Part 5 of the *Guardianship Act* is drafted, and this is something that should be rectified. For this reason, we make two general recommendations in relation to Part 5 in so far as it relates to our legislative reforms. These recommendations make it clear that the protections afforded by the *Guardianship Act* are intended to apply only to young people (as well as adults) who are incompetent to make a decision by reason of a disability rather than solely by immaturity.

71. Doctors Reform Society, *Submission*, 2; S Siedlecky, *Submission*, 2; Commission for Children and Young People, *Submission*, 2.

6. Young people who lack capacity

- Introduction
- Parents as decision makers
- Substitute decision makers other than parents
- Necessary treatment

INTRODUCTION

6.1 Except in cases of emergency,¹ a health practitioner who treats a patient without consent exposes himself or herself to criminal or civil liability.² Where a patient is incompetent to give consent, a practitioner must obtain consent from a person authorised to make decisions on behalf of the patient. In the case of young people, that person is most commonly the parent. However, there are cases where, because of family circumstances, or the delicate nature of certain health concerns affecting young people, a parent is not available, not willing or, perhaps, incompetent to give consent to treatment. In these circumstances, it may be unclear to health practitioners who can provide a valid consent in place of the parent, thus jeopardising the young person's access to timely and appropriate health care. The Commission believes that in cases such as these, the health needs of the young person should primarily be the concern of other people with an interest in his or her health and well-being. A clear statutory hierarchy of such people will give health practitioners confidence to treat young people without fear of liability.

6.2 There may be situations where there is no person directly involved in the care of a young person who lacks capacity to consent or such young person feels that they cannot approach a parent about a sensitive health problem affecting them, preferring not to seek treatment rather than running the risk of their parents being informed. In these cases, the Commission considers that it is important, at least for certain health practitioners, to administer treatment to a young person without a valid consent in circumstances where it is necessary and in the interests of the young person's health and well-being that treatment be given without delay, even though the circumstances may not constitute an emergency. In reaching our recommendations, we are guided by the principle that the law should not impede a young person's access to prompt and appropriate health care.

PARENTS AS DECISION MAKERS

Who is a parent?

6.3 The parents of a young person are usually the most appropriate persons to give consent to medical treatment for that young person where the young person is not competent to consent to their own health care. The major piece of legislation that deals with parents' rights and responsibilities is the *Family Law Act 1975* (Cth). A parent of a child or young person is a person having parental responsibility for the child or young person. In relation to a child who has been adopted, parent includes the adopted parent of the child.³

6.4 Defining a parent is a far more complicated exercise today in light of the great diversity of family structures that exist, and the diverse family arrangements within these family types. Increased numbers of blended and step-parent families, gay and lesbian families, and children born using assisted reproductive technologies, challenge traditional

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1. See Chapter 7.
 2. See Chapter 4.
 3. *Family Law Act 1975* (Cth) s 4.

family stereotypes in which a child is raised by two biological and heterosexual parents. In some families today, there may be several adults in a young person's life who exercise a parental role in a social or functional sense. In Aboriginal and Torres Strait Islander families, for example, it is common for children to be raised by kin. In some families, the biological parents of a young person may not be his or her social or functional parents, or even his or her legal parents. This poses great difficulties for the health practitioner in terms of identifying the person authorised to give consent to treatment for the incompetent young person.

6.5 The *Minors (Property and Contracts) Act 1970* (NSW) does not define parent or guardian. It is arguable that it has the same meaning as that provided under the more recent *Children and Young Persons (Care and Protection) Act 1998* (NSW), which defines parent as one having parental responsibility for the child, consistently with the *Family Law Act 1975*.⁴ For clarity and consistency, the Commission has recommended that legislation resulting from this Report should define parent as one having parental responsibility in the same terms as the *Children and Young Persons (Care and Protection) Act 1998*.⁵

Parental responsibility under the *Family Law Act*

6.6 Since June 1996,⁶ each parent has joint parental responsibility for children under 18 years unless a court order provides otherwise.⁷ Parental responsibility is defined as "all the duties, powers, responsibilities and authority, which, *by law*, parents have in relation to children".⁸ They have responsibility for a whole range of matters affecting children including, for example, education, choice of religion, maintenance and financial support, and making decisions regarding medical treatment.

6.7 Parental responsibility is not affected by the nature of the relationship between the parents. It continues, for example, even if the parents separate or remarry, and is not affected by whether the child lives with the parent or not.⁹

6.8 Parental responsibility can be varied or displaced by:

- an order of any court,¹⁰ including a parenting order under the *Family Law Act 1975* or an order of the Children's Court or the Guardianship Tribunal; or by
- a parenting plan entered into voluntarily by both parents under the *Family Law Act 1975*.¹¹

4. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 3.

5. See Recommendation 3.

6. *Family Law Reform Act 1995* (Cth) replaced the old concepts of custody and guardianship with "parental responsibility".

7. *Family Law Act 1975* (Cth) s 61B, s 61C(1).

8. *Family Law Act 1975* (Cth) s 61B.

9. *Family Law Act 1975* (Cth) s 61C(2). See also *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218.

10. *Family Law Act 1975* (Cth) s 61C(3).

11. *Family Law Act 1975* (Cth) s 63C.

Parenting orders

6.9 Any person with an interest in the care, welfare or development of a child can apply to the Family Court for a parenting order conferring parental responsibility on that person.¹² Parenting orders¹³ may deal with who a child is to live with, contact, child maintenance and any aspect of the care, welfare or development of the child.¹⁴ This includes giving consent to medical treatment.

6.10 Parenting orders need not be made in favour of a parent. They can be made in favour of a person *other than a parent of the child*, including a grandparent or other relative of the child¹⁵ or indeed, on “some other person”.¹⁶ In 2003, there were 22,500 grandparent families¹⁷ raising 31,100 children aged under 17 years, representing 1% of all families with children.¹⁸

6.11 When deciding whether to issue a parenting order in favour of a person, the court must consider the child’s best interests as its paramount consideration.¹⁹ It must also apply a presumption that it is in the best interests of the child for both parents to have equal shared parental responsibility for the child, unless there is evidence of family violence or abuse.²⁰ Where parental responsibility is to be shared by two or more persons, the order may set out how those persons consult with each other about decisions to be taken.²¹ Once a court has made a parenting order allocating shared parental responsibility to two or more persons, the major decisions for the long-term care and welfare of a child

12. *Family Law Act 1975* (Cth) s 65C.

13. *Family Law Act 1975* (Cth) s 61D.

14. *Family Law Act 1975* (Cth) s 64B.

15. *Family Law Act 1975* (Cth) s 64B(2).

16. *Family Law Act 1975* (Cth) s 64C.

17. Grandparent families are those in which grandparents are raising their grandchildren, either as a result of formal arrangements or informal arrangements. Grandparents usually take on the role of primary carers of their grandchildren when the parents are no longer able to fulfil their parental responsibilities often because of substance abuse, the death of one or both parents, mental or physical illness, or because the child requires a more protective environment: Australian Institute of Health and Welfare, *Australia’s Welfare 2007* (Cat. no. AUS 93, Canberra), 23.

18. Australian Bureau of Statistics, *Family Characteristics, Australia, June 2003* (Cat. no. 4442.0, Canberra), 40.

19. *Family Law Act 1975* (Cth) s 65AA and s 60CA. Section 60CC sets out two primary considerations the court is to take into account, namely, the desirability of the child having a meaningful relationship with both parents, and the need to protect the child from harm as a result of abuse, neglect or family violence. The court is also directed to take into account a number of additional considerations including, but not limited to, the views of the child, the nature of the relationship between the child and the parents or another person and the capacity of the parent or another person to provide for the needs of the child. Sections 60CB to 60CG of the *Family Law Act 1975* (Cth) relate to how the Court is to determine the best interests of the child.

20. *Family Law Act 1975* (Cth) s 61DA. The presumption is rebuttable by evidence that equal shared parental responsibility would not be in the best interests of the child: s 61DA(4).

21. *Family Law Act 1975* (Cth) s 64B (2)(d).

must be made jointly unless a court otherwise provides.²² Major long-term issues are defined in s 4(1) of the FLA and include, but are not limited to, matters relating to the child's health.²³

Should either parent be able to give consent to medical treatment?

6.12 In its Issues Paper on *Minors' Consent to Medical Treatment*, ("IP 24"), the Commission asked whether a health practitioner should be able to rely on the consent of just one parent.²⁴ The wording of s 49 of the *Minors (Contracts and Property) Act 1970* (NSW) makes it clear that the consent of only *one* parent or guardian is sufficient in situations to which that legislation applies. This is the law more generally. Speaking about the law of consent at common law, Lord Donaldson said:

[C]onsent by itself creates no obligation to treat. It is merely a key which unlocks the door. ... [I]n the ordinary family unit where a young child is the patient there will be two keyholders, namely the parents, with a several as well as a joint right to turn the key and unlock the door. If the parents disagree, one consenting and the other refusing, the doctor will be presented with a professional and ethical, but not with a legal, problem because, if he has the consent of one authorised person, treatment will not without more constitute a trespass or a criminal assault.²⁵

6.13 In practice, doctors usually act on the consent of one parent. When there is apparently no dispute they may assume that the other's consent is implied. This is quite appropriate as each of a child's parents has automatic parental responsibility for that child under the *Family Law Act 1975* which they can exercise either independently or jointly.

6.14 However, recent amendments to the *Family Law Act 1975* provide that where there is an order for equal shared parental responsibility, parents have a duty to co-operate and come to joint decisions regarding major health issues affecting their child, unless the Court provides otherwise.²⁶ The effect of the amendments, as Professor Richard Chisholm points out, is:

... that each parent has parental responsibility (not that they share it), and [they must] cooperate (on major matters) only when the court makes an order for equal shared parental responsibility.²⁷

22. *Family Law Act 1975* (Cth) s 65DAC.

23. Other matters include, but are not limited to, a child's education, religious and cultural upbringing, name and living arrangements.

24. NSW Law Reform Commission, *Minors' Consent to Medical Treatment*, Issues Paper 24 (2004) ("IP 24"), [4.2]-[4.3] and Issue 4.2.

25. *In Re R (A Minor) (Wardship: Consent to Treatment)* [1992] 1 FLR 190, 196 (Lord Donaldson of Lynton MR).

26. *Goode v Goode* [2006] FamCA 1346, [39] (Bryant CJ, Finn and Boland JJ).

27. R Chisholm, "Making it Work: the Family Law Amendment (Shared Parental Responsibility) Act 2006" (2007) 21 *Australian Journal of Family Law* 143, 161.

6.15 In a family breakdown situation, therefore, health practitioners must take care to obtain consent according to the terms of any parenting order. In practical terms, it is difficult for a practitioner to establish whether two or more persons sharing parental responsibility do so pursuant to an order of a court, and, if so, whether the consent of one of them is a decision to which they both agreed.²⁸ In recognition of this, the *Family Law Act 1975* explicitly provides that a third party is not required to establish that a decision that has been communicated to them by one of the parents is a decision that has been made jointly.²⁹ This provision is intended to allow a person such as a doctor, dentist, school principal etc, to act on a decision communicated to them by one of the parents. If it is a decision that ought to have been made jointly, it is not for the third party to check that this has occurred. Recourse can be had under the *Family Law Act 1975* for breaches of parenting orders.³⁰ Submissions that addressed this issue agreed that the current law is appropriate: to require health practitioners to obtain the consent of both parents would be unwieldy.³¹

6.16 The Health Care Complaints Commission receives a small number of complaints from estranged parents complaining that medical treatment was administered to their child without their consent, in contravention of parenting orders. These complaints are generally resolved quickly at the conciliation stage. Although the doctor is legally entitled to rely on the consent of one of the parents, they are generally happy to agree to refrain from further treatment unless both parents give their consent.³²

When there is a dispute between the parents

6.17 Where the doctor becomes aware of a dispute between the parents about the provision of medical treatment, ethical issues arise. Illustrative of this scenario are recent English immunisation cases. In two separate but very similar cases, the (estranged) fathers of two young girls sought court orders for their children to be immunised as was appropriate for their age against the wishes of their mothers, both of whom had the primary care of the children.³³ Relying on expert evidence, the trial judge decided that the benefits of immunisation outweighed the concerns, and that it was therefore in the best interests of the children that they be immunised.³⁴ Affirming this decision, the English Court of Appeal added that immunisation fell within a “small group of important decisions” which should only be made if there was agreement between all those with parental responsibility for the child.³⁵ Another “important and irreversible” decision, which the

28. See, for example, Australian Dental Association (NSW Branch), *Submission*, 1.

29. *Family Law Act 1975* (Cth) s 65DAC(4).

30. *Family Law Act 1975* (Cth) Division 13A of Part VII deals with contraventions of parenting orders.

31. Dr S Siedlecky, *Submission*, 9; National Children’s and Youth Law Centre, *Submission*, 13.

32. Health Care Complaints Commission, *Consultation*.

33. *Re C (A Child) (Immunisation: Parental Rights)* [2003] EWCA Civ 1148 (Thorpe and Sedley LJ, Evans J).

34. *Re C & F (Children)* 2003 EWHC1376 (Fam) (Sumner J).

35. *Re C (A Child) (Immunisation: Parental Rights)* [2003] EWCA Civ 1148, [17].

English courts have held should not be taken except with the consent of both parents, is non-therapeutic circumcision.³⁶

6.18 Where doctors are aware of a dispute between the parents, they are effectively put on notice that there may be consent issues. This is particularly so where one of the parties threatens to bring, or commences, an action in a court. What the English cases show is that a court, exercising its *parens patriae* jurisdiction, can require that for certain treatments or medical procedures, it is in the child's best interests for *both* parties to consent. Although the issue has not been tested in NSW, a prudent doctor would be unlikely to continue to treat a child or young person when he or she became aware that the medical treatment was against the wishes of one of the parents.

6.19 The *Minors (Property and Contracts) Act 1970* (NSW) makes no reference to a situation where the parents are in dispute about their child's medical treatment, and how that dispute should be resolved. Currently, where parents cannot agree on medical treatment for their child, there is provision for the final decision to be made by a court. The Family Court, for example, has a wide jurisdiction to make orders for the welfare of a child of a marriage, including orders concerning the child's medical care.³⁷ The Supreme Court, too, has a limited jurisdiction over the medical treatment of children.³⁸ Anyone with an interest in the health and welfare of the young person could begin proceedings in either jurisdiction.

6.20 There is also provision under the *Children and Young Persons (Care and Protection) Act* for a parent, young person or any other person to ask the Director General of the Department of Community Services for assistance if there is a serious or persistent conflict between the parents and the young person of such a nature that it compromises the young person's safety, welfare or well-being.³⁹ Once such a request is received, the Director General may provide advice and assistance to the parties concerned to help resolve their conflict without recourse to legal proceedings, or to enable the parties to have access to appropriate services.⁴⁰ Furthermore, any person who suspects that a young person is at risk of harm may make an anonymous report to the Director General.⁴¹ Section 23 defines risk of harm to include the circumstance where the parents or caregivers have not arranged, or are unable or unwilling to arrange, for the young person to receive medical care.

36. *Re S (Children) (Specific Issue: Circumcision)* [2005] 1 FLR 236. See also *Re J (A Minor) (Prohibited Steps Order: Circumcision)* [2000] 1 FLR 571.

37. *Family Law Act 1975* (Cth) s 67ZC; *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218 affirmed in *P v P* (1994) 181 CLR 583 at 598. See also para 4.51.

38. See para 4.47.

39. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 113(1).

40. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 113(2).

41. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 24, s 26.

Young people who are parents

6.21 In NSW, 3386 children were born to teenage mothers in 2003.⁴² The issue that arises is whether these young parents should be able to consent automatically to the medical treatment of their children regardless of their competency to give consent.

6.22 Parenthood does not, by itself, make a person under 18 years competent to make decisions about his or her own medical care or that of his or her own children.⁴³ Even in the case of marriage of a person under 18 years of age, any emancipatory effect can only be conferred by statute.⁴⁴

6.23 Little guidance is provided in the general law on parental responsibility for the health care of children, which does not distinguish parents who are under 18 from those who are 18 or older. This uncertainty can create a dilemma for the health practitioner who must decide whether to treat the child assuming competence on the part of the young parent, or only give treatment where the young parent is assessed as competent to give consent. The dilemma will be most evident where the child's parents are both under 18 and not *Gillick* competent; and where the parents, regardless of age, have a mental illness or intellectual disability that impairs their ability to understand.

6.24 Neither situation has been the subject of case law. In practice, most practitioners are unlikely to question the competence of a young parent who presents his or her child for treatment.⁴⁵ One submission suggested that parents who are under 18 should be able to consent to or refuse treatment for their children, provided they are competent to do so. Where the parent(s) are not competent to give consent, the requisite consent should be obtained from another person or a tribunal.⁴⁶

6.25 Law reform agencies that have considered this question, and US States that have enacted legislation, have adopted one of two broad approaches:

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- 42. New South Wales Department of Health, Centre for Epidemiology and Research. "New South Wales Mothers and Babies 2003" (2004) 15 (s-5) *NSW Public Health Bulletin*. This was a decrease from 4099 births in 1999.
 - 43. See, for example, the advice of the Medical Practitioners Board of Victoria that "an unmarried young person who is a parent should be assessed for competency like any other young person": Medical Practitioners Board of Victoria, *Consent for Treatment and Confidentiality in Young People* (2004), 7.
 - 44. See, for example, *Married Persons (Equality of Status) Act 1996* (NSW) s 4(2). Compare *Human Tissue Act 1983* (NSW) s 4: "child means a person who has not attained the age of 18 years and who is not married".
 - 45. Dr S Towns, Department of Adolescent Medicine, and Dr M Kang, Department of General Practice, Children's Hospital at Westmead, *Consultation*. See also Queensland Law Reform Commission, *Consent to Health Care of Young People*, Report 51 (1996) vol 2, 327.
 - 46. Doctors Reform Society, *Submission*, 5; Shopfront Youth Legal Centre, *Submission*, 11.

- allow a young person who is capable of consenting to his or her own health care to consent to that of his or her child;⁴⁷ or
- confer a statutory right on the young person on the basis of parenthood to consent to the health care of his or her own child and/or his or her own healthcare.⁴⁸

6.26 Legislation in New Zealand has adopted the latter approach. Section 36(2) of the *Care of Children Act 2004* (NZ), provides that a child (meaning a person who is under 18 years of age)⁴⁹ who is married, in a civil union, or living with another person as a de facto partner, can consent to and refuse medical treatment for themselves, or for any other person (which obviously includes their child) as fully as if they were of full age.⁵⁰

6.27 As the question of competence to consent to medical treatment has to be judged in relation to the particular treatment proposed,⁵¹ the Commission does not understand how the law can properly be drawn in propositions that appeal to the supposed “general” competency or inability of a child’s parents to consent to medical treatment. To do so deflects attention away from the real question, which is whether the young person understands the treatment proposed. Once this is appreciated, we do not understand how a young person who is not competent to consent to that particular medical treatment, can possibly be “deemed” to be able to do so simply because that treatment is to administered to a third person, in this case their children. The protection of both parties and of the health care providers necessitates the negation of this option. Our view is, therefore, that young people should only be capable of consenting to medical treatment of their children if they are competent to consent to that particular treatment. This restates, for this context, and out of abundance of caution, the general competency rule in Recommendation 4.

6.28 In making this recommendation, we stress the following:

- A young person’s competence to consent to the particular treatment in this respect involves an understanding of what that treatment means for their child, not whether they would be capable of consenting to that treatment if it were performed on themselves. If it were otherwise, a mother would, by definition, be incapable of

47. See, for example, Law Reform Commission of Saskatchewan, *Proposals for a Consent of Minors to Health Care Act*, Report (1980), 13; Queensland Law Reform Commission, *Consent to Health Care of Young People*, Report 51 (1996) vol 2, 328.

48. See, for example, *Florida Statutes 2005* §743.065(2) (“unwed minor mother” can consent to healthcare of her child); *Alaska Statutes* Title 25 Ch 20 §25 (a minor who is a parent can consent to healthcare for self and for child); *Montana Code Annotated 2005* §41-1-402 (a minor who is a parent can consent to healthcare for self and for child); University of Alberta, Institute of Law Research and Reform, *Consent of Minors to Health Care*, Report 19 (1975), 22-23 (a minor who is a mother should be able to consent to healthcare for self and for child).

49. See *Care of Children Act 2004* (NZ) s 8.

50. Section 36(1)(b) expressly provides that the consent or refusal of a young person aged 16 and over has effect as if that young person were of full age, to medical, surgical or dental treatment or procedure, including a blood transfusion, to be carried out on the young person for the young person’s benefit.

51. See para 4.7-4.25.

consenting to treatment on her male child where the treatment relates to a condition that only affects males.

- Where the young parent is not competent to give consent to medical treatment for their child, the consent must be obtained from a substitute decision maker. The substitute decision maker is the person who performs that role for the young person's child (not the young person). Where that is not determined by a court order or parenting plan,⁵² it will have to be determined in accordance with Recommendation 12.

52. See para 6.6–6.11.

RECOMMENDATION 11

The legislation should provide that a young person is competent to accept or refuse health care for his or her children if, in the opinion of the health practitioner offering the care, the young person understands the information relevant to making a decision about the health care, and appreciates the reasonably foreseeable consequences of that decision.

SUBSTITUTE DECISION MAKERS OTHER THAN PARENTS

6.29 In the vast majority of cases, treating health practitioners will be able to obtain a valid consent from a young person's parent quickly and easily so that the young person receives appropriate medical care without delay. However, there are situations where parental consent is not easily obtained, thus potentially jeopardising the health outcomes for the young person as treatment is delayed, or, worse, denied because of health practitioners' fear of liability.

6.30 There are a number of situations in which legislation recognises the need for the easy identification and availability of decision-makers other than the young person's parents to consent generally to the medical and dental treatment of young persons. These include:

- Young persons between the ages of 16 and 18 who, by reason of their need for a guardian, are subject to a guardianship order under the *Guardianship Act 1987* (NSW).⁵³ Depending on the terms of the order, the guardian may consent to the carrying out of medical or dental treatment on the young person.⁵⁴
- Young people in out-of-home care under the *Children and Young Persons (Care and Protection) Act 1998* (NSW).⁵⁵ Out-of-home care is residential care and control of a young person at a place other than his or her usual home by a person other than his or her parents, for a specified period of time.⁵⁶ An authorised carer has the authority to consent to: medical or dental treatment, not involving surgery, for the young person in their care; medical or dental treatment involving surgery that a medical practitioner or dentist certifies in writing needs to be carried out as a matter of urgency in the best interests of the young person; non-urgent medical or dental treatment involving surgery if the authorised carer has a delegation of that authority in accordance with the Act.⁵⁷ The carer's consent to medical treatment for a child aged under 16 years is as effective as consent given by a parent or guardian.⁵⁸

53. A guardianship order may only be made under the legislation in respect of a person who is over 16 years of age: *Guardianship Act 1987* (NSW) s 15(1)(a).

54. *Guardianship Act 1987* (NSW) Pt 5, esp s 33A.

55. At 30 June 2006, there were 6.2 children and young people per every 1000 aged 0–17 years in some form of out-of-home care in NSW, compared to 3.4 per 1000 young people aged 0–17 years in 1997. In the same period, there was a much higher incidence of Indigenous children and young people in out-of-home care (44.7 per every 1000): Australian Institute of Health and Welfare, *Child Protection in Australia 2005–2006*, Child Welfare Series Cat no 40 (2007), 55–56.

56. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 135.

57. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 157.

58. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 177(2).

6.31 Legislative regimes such as these do not exhaust the situations in which there is a need for a person, other than the young person's parent, to consent to medical treatment for a young person who lacks capacity to consent to proposed health care. Apart from the circumstance discussed above where the young person's parents are themselves not competent to consent to the treatment,⁵⁹ two important situations in which that need arises is where the young person is homeless or in a detention centre.

Homeless youth

6.32 Substitute decision makers are clearly needed where the young person has little or no contact with their parents or where the parents are unwilling or too disinterested in their care to give consent, and where no alternative legal guardian has been appointed for the young person. According to the 2001 Census, of the 100,000 people across Australia who are homeless, nearly half are under 24 years, and a quarter are teenagers aged between 12 and 18 years.⁶⁰ In NSW, 10 in every 1000 young people are homeless.⁶¹ Most homeless young people live in youth refuges or with family or friends or in squats, moving frequently between locations.

6.33 Homeless young people present significant health problems: they are at increased risk of malnutrition, contracting sexually transmitted diseases, including potentially fatal ones like HIV/AIDS, and experiencing psychotic episodes.⁶² A number of homeless young people have experienced physical and or sexual abuse, or witnessed domestic violence, and, as a result, are emotionally disturbed.⁶³ They are more likely than young people in the general population to engage in risk behaviours. Recent research with homeless youth in Melbourne reveals that almost 80% have drug and alcohol problems and over half use hard drugs; 41% had attempted suicide at some point in their lives; one-third had been pregnant during their lifetime; almost one fifth identified as non-heterosexual; over half had unprotected sex and 5% were engaged in sex work.⁶⁴

59. See para 6.21-6.28.

60. C Chamberlain and D MacKenzie, *Australian Census Analytic Program: Counting the Homeless 2001*, Australian Bureau of Statistics, Cat no 2050.0 (2003). See also National Youth Commission, *Australia's Homeless Youth: A Report of the National Youth Commission Inquiry into Youth Homelessness* (2008) ("National Youth Commission Report") which finds that the number of homeless youth has doubled since the first inquiry into youth homelessness in 1989 by Brian Burdekin. Recent 2006 Census figures (Australian Bureau of Statistics Report forthcoming) show that the number of homeless teenagers has dropped from 26,100 in 2001 to just under 21,000, in part due to early intervention programs introduced since the Burdekin Inquiry: National Youth Commission Report, 63.

61. C Chamberlain and D MacKenzie, *Australian Census Analytic Program: Counting the Homeless 2001*, Australian Bureau of Statistics, Cat no 2050.0 (2003).

62. National Youth Commission Report, Ch 17 explores the link between homelessness and health issues. See also Ch 10 on mental health issues affecting homeless youth.

63. National Youth Commission Report, [17.34]-[17.38].

64. N Milburn, M J Rotheram-Borus, E Rice, S Mallett and D Rosenthal, "Cross-national variations in behavioural profiles among homeless youth" (2006) 37

6.34 Despite their need for services including mental health and general health services, homeless young people experience difficulties accessing mainstream services for a number of reasons, including because of issues of consent.⁶⁵ They are also typically mistrustful of anyone in authority so are unlikely to seek treatment from general practitioners. If they do present at a clinic or outpatient service of a hospital, there are concerns that homeless young people will not adhere to a course of treatment or present for follow-ups. As one submission observed:

*[Homeless young people] may not have their own Medicare card, and cannot afford fees, so that primarily they will seek treatment in hospital outpatient departments and clinics. Homeless young people often have a complex mix of medical and social problems, such as drug taking, inadequate support, inability to afford medication or a proper diet and do not reliably follow medical instructions. They are often discharged from hospital without adequate follow-up.*⁶⁶

Young people in detention

6.35 Young people, ranging in age from 10 to 21, may be detained in one of nine Detention Centres in NSW, administered by the Department of Juvenile Justice under the *Children (Detention Centres) Act 1987* (NSW). Some young people aged over 16 years may be committed to a Correctional Centre,⁶⁷ such as Kariong Juvenile Correction Centre, which is run by the Department of Corrective Services.

6.36 The Department of Juvenile Justice reports that, on average, there are 331 young people in detention each day. Of these, about half are serving custodial sentences, while the other half are on remand, awaiting the completion of court proceedings. Half of these detainees are from an Aboriginal or Torres Strait Islander background.⁶⁸

6.37 Rising numbers of young people in detention centres are presenting with increasingly complex health problems, including chronic illnesses.⁶⁹ A 2006 study of

American Journal of Community Psychology 63, 67 cited in Mission Australia, *Homeless Young Australians: Issues and Responses Snapshot 2007*. See also National Youth Commission Report.

65. National Youth Commission Report, [17.14]. See also N Milburn, M J Rotheram-Borus, E Rice, S Mallett and D Rosenthal, "Cross-national variations in behavioural profiles among homeless youth" (2006) 37 *American Journal of Community Psychology* 63, 66; M Kang, D Bernard, M Booth, S Quine, G Alperstein, T Usherwood and D Bennett, "Access to primary health care for Australian young people: service provider perspectives" (2003) 53 *British Journal of General Practice* 947.

66. Dr S Siedlecky, *Submission*, 16.

67. See, for example, *Children (Detention Centres) Act 1987* (NSW) s 28B.

68. NSW, Department of Juvenile Justice, *Annual Report 2007*, 45.

69. NSW, Department of Juvenile Justice, *2003 NSW Young People in Custody Health Survey: Key Findings Report* (NSW Department of Juvenile Justice, 2003); Robyn Rosina, NSW Justice Health, Paper presented at Public Forum on Minors' Consent to Medical Treatment, Parliament House, Sydney, 20 November 2006.

young people serving community orders shows that significant numbers have low intelligence and/or learning problems.⁷⁰ There are also large numbers of young people with brain injuries. Typically they have poor concentration and large numbers are at risk of suffering from anxiety or depressive disorders.⁷¹ They are treated by a diverse range of clinicians in detention centres including medical practitioners, nurses, dentists, sexual health experts and psychologists, co-ordinated by the NSW Justice Health Service.⁷²

6.38 Almost 90% of young people in detention in NSW were not living with their family prior to their detention. They were either estranged from their parents or were orphaned.⁷³ Obviously, there is at least a potential need for substitute decision makers to consent to medical treatment for such young people if they lack capacity to do so. The *Children (Detention Centres) Act 1987* (NSW) does make provision for the medical treatment of young people in Detention Centres, but not in Correctional Centres. It requires the Director General of the Department of Juvenile Justice to ensure that adequate arrangements exist to maintain the physical, psychological and emotional well-being of detainees,⁷⁴ and requires that each detainee be supplied with such medical attendance, treatment and medicine as is necessary to promote his or her health and well-being, and that of other detainees or any other person.⁷⁵

6.39 The legislation does not, however, alter, or elaborate on, the general rules relating to consent to medical treatment, save that it authorises a doctor to administer medical treatment on a detainee without his or her consent "if the Chief Executive Officer, Justice Health is of the opinion, having taken into account the cultural background and religious views of the detainee, that it is necessary to do so in order to save the detainee's life or to prevent serious damage to the detainee's health".⁷⁶ Medical treatment in these circumstances is taken to have been carried out with the detainee's consent.⁷⁷ These provisions mirror those that apply to the adult prison population in the *Crimes (Administration of Sentences) Act 1999* (NSW).⁷⁸ The legislation also dispenses with the need for consent in its requirement that a detainee must, on admission to a detention

70. D T Kenny, P Nelson, T Butler, C Lennings, M Allerton and U Champion, *NSW Young People on Community Orders Health Survey 2003-2006: Key Findings Report* (University of Sydney, 2006), 20-23.

71. D T Kenny, P Nelson, T Butler, C Lennings, M Allerton and U Champion, *NSW Young People on Community Orders Health Survey 2003-2006: Key Findings Report* (University of Sydney, 2006), 27.

72. Health services to detainees are provided by the NSW Justice Health Service through clinics at each juvenile detention centre. Justice Health is a statutory health corporation under the *Health Services Act 1997* (NSW).

73. NSW, Department of Juvenile Justice, *2003 NSW Young People in Custody Health Survey: Key Findings Report* (NSW Department of Juvenile Justice, 2003), 13; see also D T Kenny, P Nelson, T Butler, C Lennings, M Allerton and U Champion, *NSW Young People on Community Orders Health Survey 2003-2006: Key Findings Report* (University of Sydney, 2006), 11.

74. *Children (Detention Centres) Act 1987* (NSW) s 14(a).

75. *Children (Detention Centres) Act 1987* (NSW) s 27(1). See also *Crimes (Detention Centres) Regulation 2005* (NSW) reg 8(1), (3) and (4).

76. *Children (Detention Centres) Act 1987* (NSW) s 27(2).

77. *Children (Detention Centres) Act 1987* (NSW) s 27(3).

78. *Crimes (Administration of Sentences) Act 1999* (NSW) s 73.

facility, undergo a medical examination to assess his or health, and determine what treatment, if any, is required.⁷⁹

Existing models for substitute decision-makers

6.40 There are several statutory examples of hierarchies of substitute decision makers that are potentially of use in identifying who should be able to give a valid consent to the medical treatment of a young person who cannot consent to their own health care.

“Person responsible” under the Guardianship Act 1987 (NSW)

6.41 Part 5 of the *Guardianship Act 1987* (NSW) sets out a hierarchy of “persons responsible” who can give consent to the medical and dental treatment of another person where that person lacks capacity to give consent themselves. The twin purposes of Part 5 are to ensure that:

- people are not deprived of medical or dental treatment merely because they lack the capacity to give consent to that treatment; and
- any medical or dental treatment that is carried out is for the person’s health and well-being.⁸⁰

6.42 In relation to a young person (which in this context means a person between the ages of 16 and 18 years of age since a guardianship order cannot be made in respect of a person under the age of 16),⁸¹ the “person responsible” is the person with parental responsibility for the child.⁸² However, if the young person is in the care of the Minister or the Director General, under the *Children and Young Persons (Care and Protection) Act 1998* (NSW), the person responsible is the Minister or Director General as the case may be.⁸³

6.43 In relation to a person other than a young person or a person in the care of the Director General, the *Guardianship Act* sets out a hierarchy of persons from whom the “person responsible” is to be ascertained.⁸⁴ That hierarchy is, in descending order:

- (a) *the person’s guardian, if any, but only if the order or instrument appointing the guardian provides for the guardian to exercise the function of giving consent to the carrying out of medical or dental treatment on the person,*
- (b) *the spouse of the person, if any, if:*
 - (i) *the relationship between the person and the spouse is close and continuing,*
and

79. *Children (Detention Centres) Regulation 2005* reg 8(2).

80. *Guardianship Act 1987* (NSW) s 32.

81. See *Guardianship Act 1987* (NSW) s 3 (“child”), 15(1)(a).

82. “Parental responsibility” has the meaning given under *Children and Young Persons (Care and Protection Act) 1998* (NSW).

83. *Guardianship Act 1987* (NSW) s 33A(2) and (3).

84. *Guardianship Act 1987* (NSW) s 33A(4).

- (ii) *the spouse is not a person under guardianship,*
- (c) *a person who has the care of the person,*
- (d) *a close friend or relative of the person.*

6.44 A person having the “care” of another is one who provides, or arranges another to provide, domestic services and support for that person on a regular basis, for no payment.⁸⁵ Someone may still have the care of another person even if that person has subsequently moved to an institution such as a hospital or nursing home.⁸⁶

6.45 A close friend or relative is defined as a person who maintains both a close personal relationship with the other person through frequent personal contact, and a personal interest in the other person’s welfare. A person is not to be regarded as being a close friend or relative if he or she is being paid for any services that he or she performs for the other person in relation to the person’s care or has a financial interest in those services.⁸⁷

6.46 If the person responsible declines to exercise any of the functions, or if a medical practitioner or other qualified person certifies that the person is not capable of exercising the functions, the person next in the hierarchy becomes the person responsible.⁸⁸ The person responsible can consent to minor⁸⁹ or major⁹⁰ treatment. But if the treatment is “special”, consent must be sought from the Guardianship Tribunal.⁹¹

6.47 The *Guardianship Act* further recognises that there may be some instances where there is no person responsible or the person responsible cannot be located, or is unable or unwilling to make a decision. In these situations, and if the treatment is minor, the *Guardianship Act* permits a medical practitioner to treat the person *without consent* so long as the treatment is necessary and appropriate and the person does not object.⁹² If the person objects or the treatment is major, consent must be sought from the Guardianship Tribunal.⁹³

Primary carer model under the Mental Health Act 2007

6.48 One of the objects of the new *Mental Health Act 2007* (NSW), after providing for the appropriate care, treatment and control of people with mental illness, is “to facilitate

85. *Guardianship Act 1987* (NSW) s 3D.

86. *Guardianship Act 1987* (NSW) s 3D(2).

87. *Guardianship Act 1987* (NSW) s 3E.

88. *Guardianship Act 1987* (NSW) s 33A(5).

89. Minor treatment is defined as “treatment that is not special treatment, major treatment or treatment in the course of a clinical trial” *Guardianship Act 1987* (NSW) s 33. See further para 6.97.

90. Major treatment is defined as treatment, other than special medical treatment or treatment associated with clinical trials that is declared to be major treatment in the Regulations: *Guardianship Act 1987* (NSW) s 33. See para 6.97.

91. *Guardianship Act 1987* (NSW) Pt 5 Div 4. For special medical treatment, see Chapter 8.

92. *Guardianship Act 1987* (NSW) s 37.

93. *Guardianship Act 1987* (NSW) Pt 5 Div 4.

the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.”⁹⁴

6.49 Among other things, this Act requires a mental health facility to notify the primary carer of a person that he or she has been detained under the Act, except in certain circumstances.⁹⁵ It also requires notice or information to be shared with the primary carer of a person if any one of a series of events occurs, including for example, where it is proposed to transfer the patient to another facility or where it is proposed to apply to the Tribunal for electroconvulsive therapy. The Act also allows a person to be detained in a mental health institution at the request of a “primary carer” or relative or friend of the person.⁹⁶

6.50 A primary carer of the patient is defined as:

- (a) the guardian of the patient, or*
- (b) the parent of a patient who is a child⁹⁷ (subject to any nomination by a patient referred to in paragraph (c)), or*
- (c) if the patient is over the age of 14 years and is not a person under guardianship, the person nominated by the patient as the primary carer under this Part under a nomination that is in force, or*
- (d) if the patient is not a patient referred to in paragraph (a) or (b) or there is no nomination in force as referred to in paragraph (c):*
 - (i) the spouse of the patient, if any, if the relationship between the patient and the spouse is close and continuing, or*
 - (ii) any person who is primarily responsible for providing support or care to the patient (other than wholly or substantially on a commercial basis), or*
 - (iii) a close friend or relative of the patient.*

6.51 A close friend is defined as a friend or relative of the patient who maintains both a close personal relationship with the patient through frequent personal contact and a personal interest in the patient’s welfare and who does not provide support to the patient wholly or substantially on a commercial basis.⁹⁸ Under this Act, a person can nominate another person to be their primary carer, and may also nominate a person to be excluded

94. *Mental Health Act 2007* (NSW) s 3.

95. *Mental Health Act 2007* (NSW) s 75.

96. *Mental Health Act 2007* (NSW) s 26.

97. “Child” is not defined for the purposes of the Act generally or in Chapter 4 of the Act which deals with “Care and Treatment”. However, it seems to be used to refer to persons under 16 years of age: consider *Mental Health Act 2007* (NSW) s 6 (dealing with voluntary admission of children).

98. *Mental Health Act 2007* (NSW) s 71(2).

from receiving information or notice (about them).⁹⁹ However, a young person aged between 14 and 18 years may not exclude their parent from such information or notice.¹⁰⁰

New Zealand

6.52 The *Care of Children Act 2004* (NZ) provides a relatively simple hierarchy of decision makers where consent to health care procedures by another person is necessary or sufficient. It provides that consent may be given by;

- a guardian,¹⁰¹ or, where there is no guardian, or where they cannot be found or are not capable of giving consent,
- a person who has been acting in the place of a parent, or where there is no such person,
- a District Court judge or the chief executive of the Department (responsible for administering the *Children, Young Persons, and Their Families Act 1989*).¹⁰²

Submissions

6.53 In IP 24, the Commission asked whether a caregiver or a relative *other than* a young person's parents should have authority to consent to or refuse medical treatment for the young person.¹⁰³ Submissions received in response to this issue argued that the primary decision maker should be the child or young person's parent, or the caregiver who has been given parental responsibility either under the *Family Law Act 1975* (Cth) or the *Children and Young Persons (Care and Protection) Act 1998* (NSW).¹⁰⁴ Submissions agreed that, where the parents are absent or themselves incompetent to make decisions for their child, authority should be given to a carer or relative to provide the necessary consent.¹⁰⁵

6.54 The Shopfront Youth Legal Centre submitted that there is a place for the involvement of other family members or caregivers, especially where a child lives with extended family members or in alternative accommodation such as a youth refuge, but where no order has been made re-allocating parental responsibility. It submitted that the provisions of the *Guardianship Act 1987* (NSW) should be extended to children aged under 16 years, in cases of minor medical treatment. For more serious forms of treatment, but not special treatment,¹⁰⁶ the Shopfront Youth Legal Centre argued that the

99. *Mental Health Act 2007* (NSW) s 72(1) and (2).

100. *Mental Health Act 2007* (NSW) s 72(3).

101. Guardian is defined as having "all duties, powers, rights, and responsibilities that a parent of the child has in relation to the upbringing of the child". *Care of Children Act 2004* (NZ) s 15.

102. *Care of Children Act 2004* (NZ) s 36(3).

103. NSW Law Reform Commission, *Minors' Consent to Medical Treatment*, Issues Paper 24 (2004), Issue 4.3.

104. National Children's and Youth Law Centre, *Submission*, 14.

105. Dr S Siedlecky, *Submission*, 10.

106. See chapter 8.

Guardianship Tribunal be given power to appoint a relative or carer as a guardian for the purpose of making decisions about the child's treatment.¹⁰⁷

The Commission's view

6.55 In the vast majority of cases, parents will make health care decisions for young people who lack capacity. Throughout this report, the Commission has acknowledged the primary and significant role of parents in the health care of their children. However, a considerable number of young people do not live in traditional nuclear family settings. Some live in boarding houses, refuges or with friends or relatives. These young people, incompetent to consent to their own health care, are vulnerable members of our community because the absence of a legal guardian potentially impedes their access to timely and appropriate health care.

6.56 The plight of homeless youth highlights, in the starkest manner, the need to put in place an alternative and acceptable system to ensure the delivery of appropriate health care to all young people, regardless of their particular living arrangements. Young people from Aboriginal and Torres Strait Islander communities provide another example. They are often cared for by members of their extended family and kinship groups. Decisions about their care, including medical treatment, are, accordingly, often made by their extended family or kin. These cultural traditions and practices are increasingly being recognised in other areas of the law, including adoption laws,¹⁰⁸ laws relating to care,¹⁰⁹ mental health¹¹⁰ and family law. Submissions that addressed this issue supported the view that the law should expressly recognise these traditional relationships.¹¹¹ It was suggested that one means of achieving this was to expand the definition of "person responsible" for the child or young person.

6.57 In the Commission's view, there is clearly a need for the law to make provision for persons other than a parent or court-appointed guardian to consent to the medical treatment of young people who lack capacity themselves to consent to such treatment. This will give health practitioners a level of certainty and confidence to treat the young person without risk of legal action against them, and thus ensure that the young person receives appropriate health care. In our view, the best way to achieve this is to provide a statutory hierarchy of persons responsible for making decisions for incompetent young people.

6.58 We have adopted as our template the hierarchy set out in the guardianship legislation, which is substantially mirrored in the other legislative provisions mentioned above, and which was supported in submissions.¹¹² A more precisely defined hierarchy is preferable to the potentially ambiguous notion of "in loco parentis", which is retained in the

107. Shopfront Youth Legal Centre, *Submission*, 7.

108. *Adoption Act 2000* (NSW) s 32, 33.

109. *Children and Young Persons (Care and Protection) Act 1998* (NSW) Part 2.

110. *Mental Health Act 2007* (NSW) s 68(g).

111. NSW Commission For Children and Young People, *Submission*, [10.4]; Shopfront Legal Centre, *Submission*, 7.

112. Shopfront Youth Legal Centre, *Submission*, 7; Dr S Siedlecky, *Submission*, 10; National Children's and Youth Law Centre, *Submission*, 14.

New Zealand legislation and in South Australia.¹¹³ A health practitioner may be reluctant to treat a young person if he or she is not certain that the decision maker actually stands in place of a parent. A list gives certainty, even where it contains categories (such as “carer” and “close friend or relative”) that are inherently and potentially contestable. Our consultations with the Guardianship Tribunal revealed that the statutory hierarchy of “persons responsible” works well in practice. While issues of interpretation do arise, such as whether a person is “caring for” a person under guardianship, the Tribunal is well equipped to resolve such issues. It looks at the nature of the relationship and not just the fact of the relationship. The Tribunal advised that medical practitioners appear to understand and cope well with the statutory hierarchy of persons responsible.¹¹⁴

6.59 We would, however, make an addition to the hierarchy as it appears in the *Guardianship Act*. It is important that the hierarchy cannot be exhausted. The *parens patriae* jurisdiction of the Supreme Court ensures that this will be the case. However, we are of the view that it is more appropriate that the relatively informal processes of the Guardianship Tribunal, which has experience in approving specified health care both for young people generally¹¹⁵ and for young people with disabilities,¹¹⁶ should be available as, effectively, the last rung in the hierarchy.

6.60 Unlike the position under the *Guardianship Act*, we do not, however, need to restrict the ability of substitute decision makers to consent only to particular types of treatment on behalf of young persons. For present purposes, the distinction that the *Guardianship Act* draws between “major” and “minor” treatment is irrelevant. In any event, under the *Guardianship Act* a substitute decision maker can consent to both major and minor treatment.¹¹⁷ This leaves “special treatment”. We deal with this in Chapter 8, where we point out that such treatment is regulated by the common law in respect of all young people, and should otherwise only be available, with the consent of the Guardianship Tribunal.¹¹⁸

6.61 The *Guardianship Act* identifies as one of its underlying principles the duty of everyone exercising functions under the Act in respect of people with disabilities to recognise the “importance of preserving the family relationships and the cultural and linguistic environments of such persons”.¹¹⁹ We have recommended that in the interpretation and application of the legislation proposed in this Report, “account shall be taken of the culture, disability, language, religion and sexuality of the young person, and, if relevant, those with parental responsibility for the young person”.¹²⁰ While this may make it strictly unnecessary to do so, we believe that it is important to identify specifically in this context the importance of culture, language, ethnicity and religion as factors integral to the decision making process. To do so accords with the increasing recognition of these

113. *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 4 (“parent” includes a person *in loco parentis*).

114. NSW Guardianship Tribunal, *Consultation*.

115. See *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175.

116. *Guardianship Act 1987* (NSW) Pt 5 Div 4.

117. *Guardianship Act 1987* (NSW) s 36(1)(a).

118. See Recommendation 16.

119. *Guardianship Act 1987* (NSW) s 4.

120. Recommendation 2.

factors in various areas of the law¹²¹ and with some of the submissions that we received.¹²²

Recommendation 12

The legislation should provide a hierarchy of “persons responsible” who are authorised to make decisions concerning the health care of a young person where that young person is not competent to accept or refuse health care and no person having parental responsibility for the young person is available or competent to exercise that parental responsibility.

The list should be expressed in descending order, commencing with:

- a guardian of the young person appointed under law;
- a spouse of the young person;
- a person who has the care of the young person;
- a close friend or relative of the young person;

or where none of the above exist, or are available to make a decision as a person responsible,

- the Guardianship Tribunal.

The legislation should define a person who has the care of a young person as a person who provides, without payment, domestic services and support for the young person on a regular basis or who arranges for the young person to be provided with such services and support.

The legislation should define close friend or relative of the young person as a person who has a close personal relationship with the young person through frequent personal contact, and has a personal interest in the young person’s welfare.

In ascertaining the “person responsible” for the young person, the legislation should recognise the importance of:

- the cultural traditions of young Aboriginal and Torres Strait Islander people; and
- the cultural, linguistic and religious background of young people.

NECESSARY TREATMENT

6.62 The law allows medical practitioners to treat a young person without consent in emergency situations, that is, in situations where the medical treatment is considered necessary in order to save the person’s life or prevent serious injury to the person’s health.¹²³ But there may be other situations, which fall short of an emergency, where a young person nevertheless needs medical treatment without delay, for example for drug or alcohol abuse or health risks incurred as a result of sexual behaviour. Under our recommended legislative model, a doctor cannot legally treat the young person in these situations without obtaining consent from the young person or his or her parent (or other person responsible). For many young people who lack capacity, and who are either estranged from their parents or, because of the nature of the treatment, do not want their

121. For example, *Children (Detention Centres) Act 1987* (NSW) s 27(2), inserted by *Children (Detention Centres) Amendment Act 2006* (NSW). This provision mirrors those that apply to the adult prison population in the *Crimes (Administration of Sentences) Act 1999* (NSW) s 73, inserted by *Crimes (Administration of Sentences) Amendment Act 2000* (NSW) Sch 1[12].

122. Dr S Siedlecky, *Submission*, 16; Doctors Reform Society, *Submission*, 5.

123. See para 7.1-7.3.

parents to be involved, access to appropriate and timely health care services is made difficult.

6.63 In IP 24, the Commission asked whether there are certain types of conditions in respect of which a health practitioner should be permitted to treat a young person who lacks capacity without a valid consent.¹²⁴ The following conditions and treatments were specifically singled out because they are serious health concerns affecting young people today. The specific areas for treatment are:

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

Contraceptive advice and prescription

6.64 Recent research shows that more and more teenagers are sexually active, and at a younger age.¹²⁵ The third national survey of Year 10 and 12 students by the Australian Research Centre in Sex, Health & Society found that adolescents are likely to have multiple partners.¹²⁶ It also concluded that unwanted sex remains a worrying issue with about one-quarter of students (mostly 15 year old girls) reporting that they had unwanted sex because they were drunk or felt pressured.¹²⁷ The study showed that the use of condoms and other forms of contraception remained steady, although 10% indicated they had used no contraceptives at their last sexual encounter.¹²⁸

6.65 Important sources of information for teenagers about sex and contraception are school-based sex education programs, the internet and talking to parents, friends and siblings.¹²⁹ A large proportion of students, however, indicated they were far less confident

124. IP 24, [3.44].

125. See P Aguis, S Dyson, A Mitchell, M Pitts and A Smith, *Secondary Students and Sexual Health 2002: Results of the 3rd National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health*, Australian Research Centre in Sex, Health & Society, La Trobe University, Melbourne (2003) ("Secondary Students and Sexual Health Survey 2002"), 58-60. For the first time, the survey included students in Catholic and Independent schools as well as Government schools, so was more truly national. Previous surveys were held in 1992 and 1997. See also Joan Sauers, *Sex Lives of Australian Teenagers* (Sydney, 2007), 465 which surveyed 300 boys and girls aged 13 – 19 over a period of 4 months, and found that most teenagers were found to be having some kind of sexual experience.

126. Secondary Students and Sexual Health Survey 2002, 34 - 35.

127. Secondary Students and Sexual Health Survey 2002, 59.

128. Secondary Students and Sexual Health Survey 2002, 52.

129. Secondary Students and Sexual Health Survey 2002, 86 - 88.

to discuss such issues with their parents.¹³⁰ In another study in Victoria, adolescents regarded medical practitioners to be an important source of information about sexuality and contraception.¹³¹ Yet many of the doctors in that survey reported feeling uncomfortable giving contraceptive advice to teenagers, particularly to those aged under 16 years because they were unsure of the young person's rights, their own obligations and their own personal feelings about contraceptive care for younger adolescents.¹³²

6.66 While there are a number of contraceptive methods available to prevent unwanted pregnancies, including the oral contraceptive pill, hormone injections and other barrier methods, the only one that offers protection against sexually transmitted diseases is the condom. Condoms are widely available over the counter at pharmacies, supermarkets, service stations and in some public toilets. They can also be obtained free from some family planning clinics. No age restrictions apply to their purchase and there is no need to see a general practitioner. Condom use is strongly encouraged to prevent the spread of sexually transmitted diseases. Despite this, 30% of sexually active high school students in Australia do not use condoms consistently.¹³³

6.67 The oral contraceptive pill, on the other hand, is available only on prescription from a doctor. It has few substantiated negative side effects and, if used properly, is an effective means of avoiding pregnancy. Whilst health experts advocate the use of both the oral contraceptive pill and condoms to prevent the spread of sexually transmitted diseases and unwanted pregnancies,¹³⁴ about one-third of sexually active high school students in Australia reported using only condoms.¹³⁵ Some submissions have argued that newer long-lasting forms of contraception, such as Depo-Provera (an injectable hormone) and Implanon (a rod implant inserted under the skin), should also be available to young girls, regardless of age.¹³⁶ As they are long-lasting, they may be useful where the young person has difficulty keeping to the dose routine of the oral contraceptive pill. However, their suitability is questioned by some experts because of evidence that they cause a loss of bone mineral density in adolescents at a crucial growing stage.¹³⁷ Both forms have

130. Secondary Students and Sexual Health Survey 2002, 59, 61.

131. T P Bartholomew and T Carvalho, "General practitioners competence and confidentiality determinations with a minor who requests the oral contraceptive pill" (2005) 13 *Journal of Law and Medicine* 191, 193. See too, M Kang, D Bernard, M Booth, S Quine, G Alperstein, T Usherwood and D Bennett, "Access to primary health care for Australian young people: service provider perspectives (2003) 53 *British Journal of General Practice* 947, 951; and Secondary Students and Sexual Health Survey 2002, 82.

132. T P Bartholomew and T Carvalho, "General practitioners competence and confidentiality determinations with a minor who requests the oral contraceptive pill" (2005) 13 *Journal of Law and Medicine* 191. See further para 4.60.

133. Secondary Students and Sexual Health Survey 2002, 44.

134. J Lindsay, A Smith and D Rosenthal, "Conflicting advice? Australian Adolescents' Use of Condoms or the Pill" (1999) 31 *Family Planning Perspective* 190.

135. Secondary Students and Sexual Health Survey 2002, 51-52.

136. Dr S Siedlecky, *Submission*, 7; Doctors Reform Society, *Submission*, 3.

137. See, for example, R Klein, *Implanon: Just Slip it in?* (Online Opinion, posted 6 May 2008) at <http://www.onlineopinion.com.au/view.asp?article=7331&page=0> (at 8 May 2008).

been subject to negative media attention, which, coupled with their prohibitive cost, has affected their uptake.

6.68 Emergency contraception (often referred to erroneously as the “morning after pill”) is available from a general practitioner, a family planning clinic or youth health service. It is a fallback option where a young person has unprotected sex. Since January 2006, emergency contraception is also available without prescription at pharmacies. Before it was available over the counter, teenagers were the most frequent users of emergency contraception at Australian family planning clinics.¹³⁸ In order to be effective, it needs to be taken within 72 hours of unprotected sex. Like condoms, there is no age limit at which a person can purchase the emergency pill. However, the pharmacist will ask the woman about her menstrual cycle and the method of contraception used in order to assess whether she may already be pregnant. Information about possible side effects and follow-up procedures should also be given. The discussion is confidential. Anecdotal evidence suggests that some pharmacists will not sell the emergency contraceptive pill to young girls.

6.69 Without access to contraceptive advice and prescription, teenagers are at great risk of unwanted pregnancies and being infected with a sexually transmitted disease including Hepatitis B, chlamydia and HIV.¹³⁹ Research shows that providing information to young people about sex and contraception does not itself encourage sexual activity; it assists them to practise safe sex.

Sexually transmissible diseases (STDs)

6.70 The risk of contracting a sexually transmitted disease is more acute for young people than for adults as young people tend to have multiple partners, and may lack the confidence to insist on safe sex.¹⁴⁰ Many infections are asymptomatic, and therefore go undiagnosed and untreated with potentially deleterious effects on the health of the young person. Although education campaigns have increased young people's awareness of STDs,¹⁴¹ the incidence of infection, particularly of chlamydia, has grown more than threefold in the last decade.¹⁴²

6.71 The incidence and control of sexually transmitted diseases is a significant concern and priority for public health. This is evident in public health laws which require health practitioners and laboratories to notify health authorities immediately of certain STDs.¹⁴³ A person who knows that they have a sexually transmitted disease and who has

138. SR Skinner and M Hickey, “Current priorities for adolescent sexual and reproductive health in Australia” (2003) 179 *Medical Journal of Australia* 158, 158.

139. Secondary Students and Sexual Health Survey 2002, 1. Six per cent of girls surveyed had had sex that resulted in pregnancy. See further para 6.70-6.72 and para 6.79-6.80.

140. See para 6.64.

141. Secondary Students and Sexual Health Survey 2002, 15 – 22

142. Australian Department of Health and Ageing, *National sexually transmissible infections strategy, 2005 – 2008*, (2005), 7 - 8. See also Australian Research Centre in Sex, Health & Society, *Annual Report* (2006) at 15.

143. *Public Health Act 1991* (NSW) Division 3 s 14 to 16.

unprotected sex with another person commits an offence, unless they have told the other person and he or she has voluntarily accepted the risk.¹⁴⁴

6.72 Because of the risk to their own health and of others, young people need to be assessed properly for their risk of infection, and treated as a matter of urgency where they have a sexually transmitted disease. Confidentiality is vital in order to secure the confidence and co-operation of young people so that they are honest about any risky behaviour and thus permit a proper appraisal of their risk of infection. The majority of submissions on this issue argued that requiring parental consent deters many young people from seeking treatment for sexually transmitted diseases.¹⁴⁵

Drug and substance abuse

6.73 Drug and alcohol use among young people aged between 10 and 17 years is also a significant problem. Alcohol and cannabis, which are categorised as 'soft' drugs, are the most commonly used in this age group. A 2005 survey of secondary school students found that about 86% of students had tried alcohol by the time they were 14 and 70% had consumed alcohol in the month prior to the survey by the age of 17.¹⁴⁶ Eighteen per cent of students were found to have used cannabis during their lifetime.¹⁴⁷ The increased incidence of binge drinking among young people is of topical concern.¹⁴⁸ Many people who start off using alcohol and cannabis end up using 'hard' drugs like amphetamines, ecstasy and heroin.¹⁴⁹

6.74 There are recognised links between drug use and involvement in the criminal justice system and homelessness.¹⁵⁰ Among the high risk factors leading juveniles to

144. *Public Health Act 1991* (NSW) s 13.

145. Commission for Children and Young People, *Submission*, [5.2]; National Children's and Youth Law Centre, *Submission*, 12-13; and Doctors Reform Society, *Submission*, 2 and 6.

146. V White and J Hayman, *Australian Secondary Students' Use of Alcohol in 2005* (Cancer Council of Victoria, June 2006) based on data collected from the 2005 *Australian Secondary Students' Alcohol and Drug Survey* ("ASSADS") of 21,805 high school students from 375 schools across Australia aged between 12-17. See also, J Payne and J Prichard, *Alcohol, Drugs and Crime: A Study of Juveniles in Detention 2005*, Australian Institute of Criminology, Research and Public Policy Series no 67 (2005), 14-16; and Secondary Students and Sexual Health Survey, 77.

147. V White and J Hayman, *Australian Secondary Students' Use of Over-the Counter and Illicit Substances in 2005*, Cancer Council of Victoria (2006).

148. See for example, N Wallace, 'Illicit drug use, drinking starting at 12', *The Sydney Morning Herald*, 18 December 2007.

149. J Payne and J Prichard, *Alcohol, Drugs and Crime: A Study of Juveniles in Detention 2005*, Australian Institute of Criminology, Research and Public Policy Series no 67 (2005), 14-16.

150. J Payne and J Prichard, *Alcohol, Drugs and Crime: A Study of Juveniles in Detention 2005*, Australian Institute of Criminology, Research and Public Policy Series no 67 (2005), 30; S Mallett, J Edwards, D Keys, P Myers, D Rosenthal, *Disrupting Stereotypes: Young people, drug use & homelessness* (2003).

alcohol and drug abuse and criminal activity are family instability and lack of parental supervision or parental support of drug use.¹⁵¹ Notably, most juveniles in the criminal justice system who seek treatment only do so because they are compelled to by a court order or encouraged to during a period of detention.¹⁵²

Mental health

6.75 Mental illness and behavioural disorders are the main health issues affecting young people in Australia. Research shows that up to 20% of young people suffer from a mental disorder.¹⁵³ Although adolescents with mental health problems transcend the various socio-economic, gender and cultural divides, young people from low-income, blended or sole-parent families are more likely to be affected.¹⁵⁴

6.76 Among the main causes of mental illness in young people are cultural pressures, difficulty in achieving a sense of belonging and identity, and isolation.¹⁵⁵ Same-sex attracted young people, who face issues such as discrimination, bullying, homophobia, victimisation and violence, may be up to six times more likely to attempt suicide compared with the general population.¹⁵⁶ Young homeless people are also greatly affected by mental health problems. Family breakdown, which is one of the major causes of homelessness among young people, is often accompanied by trauma, grief and a disturbed emotional state.¹⁵⁷

6.77 Young people who suffer mental health disorders are more likely to engage in high risk behaviour including drug use, drinking, smoking and suicide ideation.¹⁵⁸ Untreated,

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- 151. J Payne and J Prichard, *Alcohol, Drugs and Crime: A Study of Juveniles in Detention 2005*, Australian Institute of Criminology, Research and Public Policy Series no 67 (2005), 13.
 - 152. J Payne and J Prichard, *Alcohol, Drugs and Crime: A Study of Juveniles in Detention 2005*, Australian Institute of Criminology, Research and Public Policy Series no 67 (2005), 36.
 - 153. MG Sawyer (et al), *Child and Adolescent Component of the National Survey of Mental Health and Wellbeing* (Commonwealth Department of Health and Aged Care, 2000), 10-12 and 35.
 - 154. MG Sawyer (et al), *Child and Adolescent Component of the National Survey of Mental Health and Wellbeing* (Commonwealth Department of Health and Aged Care, 2000), 10-12.
 - 155. NSW Centre for the Advancement of Adolescent Health, *Online GP Resource Kit, Section 1 Understanding Adolescents and their Health Needs* at p12 available at <http://www.caah.chw.edu.au/resources/gp-section1.pdf> (at 19 May 2008).
 - 156. S Dyson, A Mitchell, A Smith, G Dowsett, M Pitts, L Hillier, *Don't Ask, Don't Tell* (2003), 11.
 - 157. See para 6.33.
 - 158. MG Sawyer (et al), *Child and Adolescent Component of the National Survey of Mental Health and Wellbeing* (Commonwealth Department of Health and Aged Care, 2000), 38-40.

depression and other serious mental health disorders are a significant risk factor for suicide and self-harm.¹⁵⁹

6.78 Of adolescents with mental health problems, only one-quarter receives professional help, and only half of those with a serious mental disorder receive treatment. Where treatment is obtained, it is generally provided by family doctors, school-based counsellors and paediatricians.¹⁶⁰ Research shows that young people do not seek treatment for a number of reasons including fear of stigma, lack of knowledge of available services, a belief that nothing can help or that they can manage the issues themselves.¹⁶¹

Pregnancy-related health care

6.79 One of the most common reasons for hospitalisation among young people between 2005 and 2006 was for pregnancy and childbirth.¹⁶² Sixteen in every 1000 adolescents aged 15-19 years become pregnant each year in Australia.¹⁶³ Although this is a decrease from 27.6 in every 1000 reported in 1980, Australia has one of the highest teenage pregnancy and abortion rates in the developed world.¹⁶⁴

6.80 Teenage pregnancy is a significant community concern because of its high associations with a range of poor health and socioeconomic outcomes. Young mothers are at greater risk of medical complications such as hypertension and their babies have a greater risk of low birth weight, prematurity, and stillbirth.¹⁶⁵ Teenage mothers often find it difficult to complete their education, are separated from the child's father, have little financial resources, and the health of their children is often worse. Children of adolescent

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- 159. D De Leo and T Heller, "Who are the kids who self-harm? An Australian self-report survey" (2004) 181(3) *Medical Journal of Australia* 140. See too Australian Institute of Health and Welfare, *Young Australians: their health and wellbeing 2007* (2007).
 - 160. MG Sawyer (et al), *Child and Adolescent Component of the National Survey of Mental Health and Wellbeing* (Commonwealth Department of Health and Aged Care, 2000), 33.
 - 161. MG Sawyer (et al), *Child and Adolescent Component of the National Survey of Mental Health and Wellbeing* (Commonwealth Department of Health and Aged Care, 2000), 43.
 - 162. Australian Institute of Health and Welfare, *Australia's Health 2008* (Cat no AUS99, Canberra), 280.
 - 163. Australian Bureau of Statistics, *Birth Rates Australia 2004* (Cat 3301.0, Canberra 2005). The 2005 rate is 4.3 times higher for young indigenous women aged 15-19 years. See also S Singh and J E Darroch, "Adolescent pregnancy and childbearing: levels and trends in developed countries" (2000) 32 *Family Planning Perspectives* 14.
 - 164. SR Skinner and M Hickey, "Current priorities for adolescent sexual and reproductive health in Australia" (2003) 179 *Medical Journal of Australia* 158, 161 citing a league table of teenage births and abortions in rich nations by UNICEF, *Innocenti Report Card no 3* (2001) Innocenti Research Centre, Florence, Italy.
 - 165. NSW Department of Health, Population Health Division. *The health of the people of New South Wales - Report of the Chief Health Officer*, (2006) available at http://www.health.nsw.gov.au/public-health/chorep/ses/ses_lomidhiteenmum.htm (accessed 23 July 2008). See also para 6.21.

parents have increased risk of developmental delay, behavioural problems, substance abuse, early sexual activity and becoming teenage parents themselves.¹⁶⁶

6.81 A significant number of births from unintended pregnancies occur to teenage mothers or young unmarried girls who do not live at home. The recent report of the National Youth Commission Inquiry into Youth Homelessness states that increasingly high numbers of pregnant homeless girls are presenting at some services, and rates are higher for Indigenous and refugee young women.¹⁶⁷ This group faces special medical risks and socioeconomic burdens.¹⁶⁸ There is widespread recognition of the need to encourage young women to access pregnancy-related health care, including infection-screening at the start of the pregnancy and careful monitoring of fetal and personal growth throughout the pregnancy, in order to improve health outcomes for both the mother and the child.¹⁶⁹

Termination of pregnancy

6.82 Although the rates of teenage pregnancy have declined,¹⁷⁰ when it does occur, most girls under 15 years choose to have an abortion. According to data from the Health Insurance Commission, there were 4310 abortions to teenage mothers in NSW in 2006, an increase of 204 from the previous year.¹⁷¹

6.83 An abortion is lawful where a doctor honestly and reasonably believes that the termination of pregnancy is necessary to preserve the mother from a serious danger to her life or physical or mental health which the continuance of the pregnancy would entail.¹⁷² Young women can consent to a lawful abortion without their parents' knowledge if they are *Gillick* competent. However, in practice, abortion clinics in NSW require the consent of a parent or guardian where the young woman is under 14 years old. Where a young woman aged 16 years or over, who lacks capacity to consent because of, for example, an intellectual disability, termination of pregnancy is a special treatment and can only be performed with the consent of the Guardianship Tribunal.¹⁷³

166. Australian Institute of Health and Welfare, *Young Australians: their health and wellbeing 2007* (Cat no PHE 87, Canberra), 87.

167. National Youth Commission Report, [17.18]-[17.21].

168. See para 6.32-6.34.

169. (2006) 8 (2) *Obstetrics and Gynaecology* (RANZOG) 25.

170. This is due in part to the prevalence of sex education in schools, the availability and use of contraceptives, and the greater inclination of young women to delay parenthood.

171. These figures only relate to abortions performed under Medicare. They do not include abortions performed in public hospitals. There is no nationally consistent data on abortion rates: see A Pratt, A Biggs and L Buckmaster, "*How many abortions are there in Australia? A discussion of abortion statistics, their limitations, and options for improved statistical collection*", Parliamentary Library of Australia, *Research Brief* No. 9 (2004–05).

172. *R v Wald* (1971) 3 DCR (NSW) 25 per Levine J (NSW Supreme Court). See also *Crimes Act 1900* (NSW) s 82.

173. *Guardianship Act 1987* (NSW) s 35. See also Chapter 8.

6.84 Where the young woman first consults a general practitioner, the doctor will usually encourage the young woman to talk to her parents and seek their support particularly because of the potential emotional and psychological consequences of abortion.¹⁷⁴ However, some young women will insist that their parents not be told. Where a young woman is competent to give consent, privacy is likely to be respected except in very exceptional cases, for example where there is evidence that the young woman has been a victim of sexual abuse, and mandatory statutory disclosure provisions apply.

6.85 Since 1977, a young woman of any age is permitted to consent to or refuse an abortion in New Zealand.¹⁷⁵ In the United States, on the other hand, a significant number of States have laws which require a medical practitioner to obtain the consent of a young girl's parents (or a court) for an abortion, or, at the least, notify the parents that their daughter seeks an abortion.¹⁷⁶ The rationale is that such laws will reduce the number of teenage pregnancies (and therefore abortions) and promote abstinence among young people. The success of this strategy is much debated in America.¹⁷⁷ Those opposed to the laws argue instead that it raises the possibility that young women who are too frightened to talk to their parents and too intimidated or time-pressed to seek court approval for an abortion will resort to illegal abortions or try to self-induce a termination, at grave risk to themselves.¹⁷⁸ They also argue that such laws may aggravate already violent or abusive situations, for example, if the young girl is pregnant as a result of sexual abuse by a family member. There are provisions in those American States that require parental notification for the young woman to seek a court order to prevent her parents from being notified. However, this raises its own set of problems. Even if a young woman were able to navigate her way around court processes, and could afford the expense of court proceedings, it takes time to get an approval, which she may not have.

174. C Read, *Sex and the Law: A guide for health and community workers in NSW*, FPA Health (2006), 86.

175. *Care of Children Act 2004* (NZ) s 38. This Act repealed and replaces the *Guardianship Act 1968* which had originally contained an exception, in the case of abortion, to the general rule that a young person under 16 cannot consent to a medical procedure and that such consent must be obtained from a parent or guardian: *Guardianship Act 1968* s 25A. Notwithstanding this, s 38 of the 2004 Act generated much debate; see New Zealand Parliament, *Hansard, Third Reading*, House of Representatives 9 November 2004 available at http://www.parliament.nz/en-NZ/PB/Debates/Debates/4/8/3/47HansD_20041109_00000802-Care-of-Children-Bill-Status-of-Children.htm.

176. For a brief overview of US State laws on parental involvement in abortion decisions by minors, see Guttmacher Institute, *Parental Involvement in Minors' Abortions*, State Policies in Brief (2008) available online at http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf. See also *Health Act 1911* (WA) that similarly requires parents to be notified where a dependant minor (defined as a girl aged under 16 years who is being supported by a parent) seeks a termination unless the young girl obtains an order from the Children's Court that her parents not be notified: s 334.

177. See, for example, E Musser, "Mandating parental involvement in minors' abortions" (1998) 13 *Berkeley Women's Law Journal* 282, 286.

178. E Musser, "Mandating parental involvement in minors' abortions" (1998) 13 *Berkeley Women's Law Journal* 282, 288.

6.86 Abortion arouses strong emotive sentiments in the community. While a majority of the community may support an adult woman's right to seek an abortion, social acceptance of young girls' access to abortion services is far less clear. Only three submissions addressed this issue specifically. All were broadly supportive of the view that young women should have access to abortion services, regardless of age or capacity to consent. The National Children's and Youth Law Centre submitted that it would be an unacceptable infringement of her right to bodily integrity if a young woman were forced to terminate a pregnancy that she wished to continue, or denied a termination if that was what she wanted.¹⁷⁹ The Doctors Reform Society submitted that all young women below 18 years should be deemed competent to consent to termination of pregnancy, even against their parents' wishes.¹⁸⁰ All the submissions which addressed this issue agreed that the treating doctor should strongly encourage the young woman to discuss her situation with her parents, but ultimately should preserve her confidentiality if she refused to involve her parents, and to offer her counselling.¹⁸¹

Barriers faced by young people to access health services

6.87 Research by the NSW Centre for the Advancement of Adolescent Health shows that the majority of young people, particularly young males, do not access health services despite acknowledging a myriad of health concerns.¹⁸² One-third of young women surveyed, and two-thirds of young men, aged between 12 and 17 years, said they would not seek help for their health concerns, and when they did, were most likely to seek help from family, friends, or others they trusted. When professional help was sought, young people again preferred someone they knew and trusted. The study demonstrated that young people were deterred from accessing health care services because of concerns about confidentiality, embarrassment, lack of knowledge of available services and structural issues related to the accessibility and characteristics of services.¹⁸³

6.88 For young people living in rural areas, the barriers to accessing health services are exacerbated.¹⁸⁴ Young people in these areas complained that there are few health care services available, and long waiting times. There is limited choice of service providers (for example, only one female doctor) in rural areas and hardly any services where bulk-billing

179. National Children's and Youth Law Centre, *Submission*, 12-13.

180. Doctors' Reform Society, *Submission*, 4.

181. National Children's and Youth Law Centre, *Submission*, 12; Dr S Seidlecky, *Submission*, 9; Doctors Reform Society, *Submission*, 4.

182. M Booth, D Bernard, S Quine, M Kang, T Usherwood, G Alperstein and D Bennett, "Access to health care among Australian adolescents: young people's perspectives and their sociodemographic distribution" (2004) 34 *Journal of Adolescent Health* 97.

183. M Booth, D Bernard, S Quine, M Kang, T Usherwood, G Alperstein and D Bennett, "Access to health care among Australian adolescents: young people's perspectives and their sociodemographic distribution" (2004) 34 *Journal of Adolescent Health* 97.

184. S Quine, D Bernard, M Booth, M Kang, T Usherwood, G Alperstein and D Bennett, "Health and access issues among Australian adolescents: a rural-urban comparison" (2003) 245 *Rural and Remote Health* 3
http://www.rrh.org.au/publishedarticles/article_print_245.pdf (at 24 July 2008).

is available. Concerns about confidentiality were more pronounced by young people in rural areas. General health concerns, including drug use, bullying, sexual health, stress and depression, were common among young people who lived in both urban and rural and regional areas. However, youth suicide and teenage pregnancy were almost exclusively singled out by young people living in rural areas.¹⁸⁵

The Commission's approach

6.89 Adolescence and puberty can be a tumultuous time for young people, not uncommonly marked by significant conflict with parents. These conflicts often flare as the young person grows and seeks to assert more autonomy from his or her parents. Even in positive and supportive family relationships, some young people will feel uncomfortable talking to their parents about certain matters such as their sexuality. They may also be apprehensive about seeking contraceptive advice or treatment from medical practitioners if they fear that their parents will find out that they are, or plan to be, sexually active. This is particularly true for young people from cultural or religious backgrounds that disapprove of pre-marital sex. For young people from these communities, their parents are less likely to understand or accept the need for such advice, much less agree to give consent to contraceptive advice or treatment.

6.90 Early prevention or intervention is desirable when it comes to adolescent health problems, with the parents of a young person usually the most appropriate persons to give consent to medical treatment. However, the Commission acknowledges that young people's concerns about confidentiality are a barrier to their accessing health services.¹⁸⁶ Submissions received by the Commission argued that young people are more likely to seek help and disclose information when they are confident that a service is confidential. While parental participation is important, focusing on the rights of parents risks negative health outcomes for many young people. There is widespread support from medical organisations and professional groups for adolescents' access to confidential medical care.

6.91 The overarching principle guiding the Commission is that the law should not impede the young person's timely access to quality health care. As the young person grows older and develops capacity and understanding, the Commission believes that he or she should have a greater role in health decisions. Most submissions received by the Commission agreed that priority should be given to increasing young people's access to health care services and health information; to remove impediments where possible; and to involve young people in decisions affecting their health and well-being by giving them

185. S Quine, D Bernard, M Booth, M Kang, T Usherwood, G Alperstein and D Bennett, "Health and access issues among Australian adolescents: a rural-urban comparison" (2003) 245 *Rural and Remote Health* 3 http://www.rrh.org.au/publishedarticles/article_print_245.pdf (at 24 July 2008).

186. L Sanci, S Sawyer, M Kang, D Haller and G Patton, "Confidential health care for adolescents: reconciling clinical evidence with family values" (2005) 183 *Medical Journal of Australia* 410.

information in a way that they can understand, and seeking their input, with assistance if necessary, regardless of their capacity to provide a valid consent.¹⁸⁷

6.92 In the area of sexual health, the Commission believes that a young person who is not competent to give consent should nonetheless be able to receive contraceptive advice and treatment without a valid consent where it is obvious to the medical practitioner that the young person will have, or continue to have, unprotected sex, risking infection with a sexually transmitted disease or an unwanted pregnancy. We agree with those submissions that argued that in some cases, particularly for contraceptive advice and prescription, and the treatment of sexually transmitted diseases, it is in the best interests of the health and well-being of the young person (who lacks capacity) to dispense with the requirement for parental involvement.¹⁸⁸

6.93 Equally, we believe it is important for young people to receive treatment for sexually transmitted diseases, regardless of whether or not they have capacity to consent to such treatment themselves. Because of the risk to the young person's health, and of others, an incompetent young person should nevertheless receive appropriate treatment for sexually transmitted diseases. Any issues of sexual abuse or exploitation that arise in the course of treatment do not detract from the need to treat the young person. Naturally, a medical practitioner who suspects abuse or neglect must report the same to the relevant authorities.

6.94 Encouraging pregnant young women to access pre-natal care is vital for the health of both the mother and the child.¹⁸⁹ Dispensing with the requirement for consent from a parent or substitute decision maker will make it easier, particularly for young homeless pregnant girls to access pregnancy-related health care.

6.95 The same is true for access to treatment for drug and substance abuse, and for mental health issues. The various studies on the state of health of our young people uniformly show that young people commonly present with two or more health problems. In order to deal effectively with these complex co-morbidity factors, experts in adolescent health advocate a youth-focused and holistic approach to treatment. Where young people have positive and supportive relationships with their parents, health outcomes are likely to be significantly improved. Sadly, however, not all young people enjoy supportive family relationships. In such cases, the value of compulsorily involving the young person's parents is negligible, and possibly detrimental.¹⁹⁰

187. Doctors Reform Society, *Submission*, 6; Commission for Children and Young People, *Submission*, 15-16; Redfern Legal Centre, *Submission*, 3; National Children's and Youth Law Centre, *Submission*, 12; Youth Action Policy Association, *Submission*, 1.

188. See, for example, NSW Commission for Children & Young People, *Submission*, [5.1]-[5.2], Redfern Legal Centre, *Submission*, 8.

189. National Children's and Youth Law Centre, *Submission*, 12; Dr S Siedlecky, *Submission*, 9.

190. L Sanci, S Sawyer, M Kang, D Haller and G Patton, "Confidential health care for adolescents: reconciling clinical evidence with family values" (2005) 183 *Medical Journal of Australia* 410, 413.

6.96 With the exception of termination of pregnancy – which raises significant moral and ethical issues, more appropriately warranting the consideration of Parliament than of a Law Reform Commission, especially within the confines of a reference such as this – there is a compelling argument that in some situations, young people should have ready access to medical treatment, even though they are not legally competent to consent, where that treatment is necessary and promotes their health and well-being, but where they will not seek treatment if it means that their parents will be informed. The treatment must, broadly, be in the best interests of the young person and they must not object to it.

6.97 Section 37(2) of the *Guardianship Act 1987* (NSW) permits minor treatment to be provided without a valid consent where:

- (a) *there is no person responsible for the patient, or*
- (b) *there is such a person but that person either cannot be contacted or is unable or unwilling to make a decision concerning a request for that person's consent to the carrying out of the treatment.*

In these cases, the medical or dental practitioner who provides, or supervises, the treatment can provide it without consent provided that:¹⁹¹

- he or she certifies in writing that the treatment is necessary and is the form of treatment that will most successfully promote the patient's health and well-being; and
- the patient does not object.

6.98 The treatment that may be provided under s 37(2) is, however, limited to “minor” treatment, which means “treatment that is not special treatment, major treatment or treatment in the course of a clinical trial.”¹⁹² “Minor treatment” would encompass many of the treatments considered in this section for example, contraception, STDs and other matters relating to sexual health, ante-natal treatment, and treatment during childbirth, treatment for substance abuse and treatment for mental health issues. However, it would not include termination of pregnancy (which is a special treatment for the purposes of the *Guardianship Act*).¹⁹³ Nor would it include, for example, treatments involving the administration of a long-acting injectable hormonal substance for the purpose of contraception or menstrual regulation (Depo-Provera being listed in a note as an example); nor those involving the administration of a drug of addiction.¹⁹⁴

6.99 One possible way of implementing the view in para 6.96 that young people should be able to access medical treatment without consent would be to provide that “treatment” for the purposes of the recommendation should be “minor treatment” as defined from time to time in the guardianship legislation. However, the classification of treatments into categories such as “special”, “major” or “minor” is necessarily dependent on the purposes of the particular legislation in which they are used. It is, for example, understandable that termination of pregnancy should be classified as a special treatment (requiring the approval of the Guardianship Tribunal) in the case of a disabled 17-year old woman who

191. *Guardianship Act 1987* (NSW) s 37 (3).

192. *Guardianship Act 1987* (NSW) s 33(1) (“minor treatment”).

193. *Guardianship Regulation 2005* (NSW) cl 8(b).

194. See *Guardianship Regulation 2005* (NSW) cl 10(a), (b).

is subject to the guardianship legislation. Just as it is understandable that such approval should not be required where the 17-year old woman is not disabled and is *Gillick*-competent; or if not *Gillick*-competent, where her parents are prepared to consent or refuse consent.

6.100 In Chapter 8, the Commission recommends that a panel of medical and other experts should identify the special treatments that are to be prescribed for the purposes of the legislation.¹⁹⁵ Our view is that such a panel should draw up a list of treatments that would be included in a category of “necessary” treatment that can be provided without consent for the purposes of Recommendation 13.

6.101 To limit any potential for abuse of the provision, the Commission recommends that only medical, nurse, midwife and dental practitioners be able to provide treatment to a young person without consent. We have included nurse and midwife practitioners to allow for the situation where access to general practitioners is difficult, as it may be in rural and remote areas. Nurse and midwife practitioners are registered and have undergone additional education and training at an advanced level, and are subject to guidelines limiting the scope of their practice. Working autonomously in an advanced and extended clinical role, but in collaboration with other health professionals as part of a multidisciplinary team, such practitioners may perform some of the functions traditionally performed by a medical practitioner, such as prescribing some medications, ordering diagnostic tests and making referrals when operating within approved guidelines. Nurse and midwife practitioners address workforce supply issues and thus improve access to health services for young people. They practise in areas where it is difficult to attract adequate numbers of general practitioners, including rural and remote areas.¹⁹⁶

Recommendation 13

The legislation should provide that a medical, nurse, midwife or dental practitioner may provide certain treatment to a young person without consent where, in the opinion of the medical, nurse, midwife or dental practitioner:

- the treatment is necessary; and
- the form of treatment will most successfully promote the young person's health and well-being; and
- the young person does not object to the treatment.

Regulations should specify the treatment that practitioners can provide without consent pursuant to this recommendation.

195. See Recommendation 17.

196. See Australian Institute of Health and Welfare, *Nursing and Midwifery Labour Force 2005* (2008), 2.

7. Emergencies

- Consent and emergency health care
- Suspected child abuse

CONSENT AND EMERGENCY HEALTH CARE

7.1 Section 174 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) allows medical practitioners and dentists to treat all children¹ and young persons² under 18 years of age without the consent of the child or young person or the consent of the child or young person's parents if, in the medical practitioner's or dentist's opinion, the medical or dental treatment is necessary as a matter of urgency matter to:

- save the child's or young person's life; or
- prevent serious damage to the child's or young person's health.³

7.2 Section 174 treats such emergency action by a medical practitioner or dentist as having been carried out with the relevant person's consent.⁴ However, the section does not exclude the medical practitioner or dentist from liability for negligence in giving the medical or dental treatment.⁵

7.3 Section 174 reflects the position relating to emergency medical treatment of young people at common law.⁶ It 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.⁷

7.4 The principal issues arising in the interpretation of section 174 are:

- What is "emergency" treatment?
- Should the availability of such treatment depend solely on the opinion of the medical practitioner or dentist?

The meaning of "emergency"

7.5 Section 174 of the *Children and Young Person's (Care and Protection) Act 1998* (NSW) establishes that "emergency treatment" is treatment that is:

- required as a matter of urgency; and

-
1. "Child" is a person under 16 years: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 3.
 2. "Young person" is a person of 16 or 17 years: *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 3.
 3. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 174(1),(2).
 4. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 174(3).
 5. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 174(4).
 6. See *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case)* (1992) 175 CLR 218, 310 (McHugh J).
 7. See also T Carney, "Regulation of treatment of severe anorexia nervosa: assessing the options" (2002) 11 *Australian Health Law Bulletin* 25, 27, n 17 and accompanying text.

- is necessary to save the child or young person's life or prevent serious damage to his or her health.⁸

7.6 It is the combination of these two factors that distinguishes “emergency” treatment from the “necessary” treatment that the Commission has identified in Recommendation 13. Both types of treatment do, however, share the characteristic that they are available without consent.

7.7 However, the Commission considers that the “emergency” treatment exception to the requirement of consent under our proposed legislation should continue to apply only to medical or dental treatment carried out by a medical practitioner or dental practitioner.

Urgency

7.8 What is a “matter of urgency” obviously varies with the circumstances of the particular case. In *Re Elm*, Justice Brereton held that specified treatment at birth of a baby (who was still in the womb but about to be born to a woman who was HIV positive) in order to reduce the risk of the baby contracting HIV at birth was “urgent.”⁹ The necessity for that treatment to continue for four weeks after birth did not affect this conclusion. His Honour said:¹⁰

“Carrying out” medical treatment, for the purpose of s 174, involves its continuation as well as its institution, at least so long as its continuation remains necessary to save life or prevent serious damage to health.”

Necessary to save life or prevent serious damage to health

7.9 The treatment must be necessary for one of the two purposes identified in the legislation. In this respect the legislation is similar to that made for emergency treatment in comparable legislative provisions. We have, however, examined two possible variations.

7.10 First, legislation in South Australia defines emergency treatment as “an imminent risk to life or health”.¹¹ On its face, this makes the test less stringent than the test in NSW, especially as the risk to health need not be “serious”. We note, however, that the South Australian legislation has the added protection that the opinion of the medical practitioner must generally be supported by a second opinion, unless it is impractical to obtain one in the circumstances.¹² As this must often be the case, we find no argument in support of restating the law of New South Wales in this way.

7.11 Secondly, emergency medical treatment in the *Guardianship Act 1987* (NSW) can, in addition to the two purposes mentioned here, be administered “to prevent the patient from suffering or continuing to suffer significant pain or distress”.¹³ This purpose is not, however, allowed to define the circumstances in which “special” medical treatment is

8. Australian Dental Association (NSW Branch), *Submission* at 1 gives an example of emergency dental treatment, such as a minor presenting to a dentist with a tooth knocked out in an accident, or in acute pain and the parent is not contactable.

9. *Re Elm* (2006) 69 NSWLR 145, [12].

10. *Re Elm* (2006) 69 NSWLR 145, [12].

11. *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 13(1)(b).

12. *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 13(1)(b).

13. *Guardianship Act 1987* (NSW) s 37(1)(c).

available. We see merit in allowing medical practitioners to give emergency treatment in such circumstances, except in the case of special medical treatment.

The opinion of the medical practitioner or dentist

7.12 It is the opinion of the medical practitioner or dentist that enlivens section 174, and that is decisive for the purposes of the section.¹⁴ Where the child or young person lacks competency, this means that the opinion of the practitioner can displace the consent of a competent parent, as was the case in *Re Elm*.

7.13 In Recommendation 7 the Commission preserves the right of a parent to consent to the medical treatment of a competent young person who is temporarily unable (for example, through loss of consciousness) to consent to medical treatment. If the situation is an emergency, the decision of the parent on the treatment that should be given to the young person would, however, be overridden by that of the doctor.

7.14 The practical importance of allowing the doctor to override parents' or young person's views in emergency cases is likely to arise in "refusal" cases, that is cases in which the emergency dictates that particular medical treatment should be given to a young person but the parents will not consent to that treatment. An example is where parents who are Jehovah Witnesses refuse on religious grounds to consent to the blood transfusion of their unconscious child even though that refusal, if followed through, would result in the death of their child. Moreover, it makes no difference if the situation is one of emergency and the young person is conscious and also refuses the treatment on religious grounds. The Commission's general test of competence does not distinguish between "consent" and "refusal of consent", and we see no reason why that distinction should be introduced here.¹⁵

7.15 Submissions to Issues Paper 24 generally supported this position. They did not believe that a parent of a child or a young person should be able to refuse emergency treatment where it is necessary to preserve the child or young person's life or to prevent significant long-term harm.¹⁶ A couple of submissions suggested a legal appeal mechanism if both the young person and parent(s) refused emergency treatment.¹⁷

14. Specifically, the 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* – BC9605880 (Unreported, NSW Court of Appeal, Priestly, Clarke JJA and Abadee AJA, 18 November 1996) 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 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).

15. The legislation in South Australia makes the child's health and well-being the paramount consideration where parents or guardians possess the ability to decide for the child in emergency situations: *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 13(5).

16. For example, Shopfront Youth Legal Centre, *Submission* at 9.

17. Doctors Reform Society, *Submission* at 4; S Siedlecky, *Submission*.

However the Doctors Reform Society noted “[t]here is an implied consent in emergency treatment...”.¹⁸

7.16 Some submissions commented on refusal of emergency care in the narrower context of palliative care. One submission¹⁹ could envisage the situation where a minor had a life-threatening illness and was continually being “saved” by emergency treatment, without the reasonable prospect of recovering from the illness or of having any appreciable quality of life. In such a case, it could be appropriate for the young person or parent of the child to apply for a court or tribunal order authorising them to refuse consent to any such treatment in the future. Another submission²⁰ also supported the idea of a formal procedure to be undertaken by a young person or his or her parents through a statutory body to gain authorisation to refuse medical treatment.

7.17 In the Commission’s view, palliative care decisions should not be brought within the ambit of “emergency treatment”. Palliative care should be considered as part of how best to manage the on-going care and case management of a life-threatening, chronic illness. In this context, palliative care decisions should be left to an expression of wish by the young person and/or his or her parents as to how they would like the young person’s illness to be case managed.

The Commission’s conclusion

7.18 No submissions to Issues Paper 24 suggested any significant changes to the content, language or operation of section 174 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). The submission of the NSW Commission for Children and Young People said that the language of section 174 provides “a clear legislative guide to practitioners and it is suggested that any new provision be drafted in a similar way to section 174.”²¹ However, the submission also noted that the present placement of section 174 within Chapter 9, Part 1 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), headed “Medical examination of children and young persons in need of care and protection” makes it unclear whether section 174 applies to *all* children and young persons, or only to those in need of care and protection. The NSW Commission for Children and Young People felt this should be clarified in the legislation.²² However, if our proposed legislation is enacted,²³ it will, of course, be clear that the provisions on emergency treatment apply to all young persons below the age of 18 years.

7.19 Section 174 appears to operate effectively in allowing medical practitioners and registered dentists to treat children and young persons without their or their parents’ consent in emergency situations. The substance of s 174(1), (2), (4) should be incorporated in the new legislation recommended in this Report, subject to its expansion to allow the administration of emergency treatment to prevent the patient from suffering or continuing to suffer significant pain or distress (except in the case of special medical treatment). Section 174(3) is unnecessary and does not need to be included in the new legislation. Once the substance of s 174(1), (2), (4) has been incorporated into the

18. Doctors Reform Society, *Submission* at 4.

19. Shopfront Youth Legal Centre, *Submission* at 9.

20. Doctors Reform Society, *Submission* at 4.

21. NSW Commission for Children and Young People, *Submission* at [7.2.3].

22. NSW Commission for Children and Young People, *Submission* at [7.2.2].

23. See Recommendation 1.

proposed new legislation, it should be deleted from its present position in Part 1 of Chapter 9 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

Recommendation 14

The legislation should provide for emergency health care for all young persons to the same effect as s 174(1), (2), (4) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), and should additionally authorise the administration of emergency treatment to prevent the patient from suffering or continuing to suffer significant pain or distress (except in the case of special medical treatment).

Recommendation 15

For the purposes of Recommendation 14, "health care" means medical or dental treatment provided respectively by a medical practitioner registered under the *Medical Practice Act 1992* (NSW) or by a dental practitioner registered under the *Dental Practice Act 2001* (NSW) or treatment by any person pursuant to directions given in the course of the practice of, respectively, medicine or surgery or dentistry by a practitioner so registered.

SUSPECTED CHILD ABUSE

7.20 Wide statutory powers under the *Children and Young Persons (Care and Protection) Act 1998* (NSW) are given to certain government authorities and courts to intervene in cases of suspected child abuse, including medical examinations of children without their or their parents' consent. Issues Paper 24 drew attention to the two different approaches taken to such medical examinations under section 173 (Medical examination of children in need of care and protection) and section 53 (Making of [Children's Court] assessment orders).²⁴

7.21 While the Commission is not examining children in care in this reference, we drew attention in Issues Paper 24 to the language of section 173 relating to the medical examination of children in need of care and protection, since it does not accord with the more participatory, inclusive approach to the general principles applicable to the interpretation and application of the legislation recommended in this report.²⁵ and with section 10 of the Act which establishes the same principle.²⁶

7.22 Submissions to Issues Paper 24 generally considered that in cases of suspected child abuse it is appropriate for a child to undergo a medical examination without his or her or parental consent.²⁷ However, since a forced medical examination is distressing for a child, one submission cautioned that it is always preferable to obtain the child's or parents' consent before proceeding.²⁸ Another submission observed that all attempts should be made to win the co-operation of the child. This submission also supported medical

24. NSW Law Reform Commission, *Minors' Consent To Medical Treatment*, Issues Paper 24 (2004) [5.31]-[5.36].

25. See Chapter 2 and Recommendation 2.

26. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 10 establishes the "principle of participation" to ensure that children and young persons are able to participate in decisions made under the Act with a significant impact on their lives.

27. Shopfront Youth Legal Centre, *Submission* at 9; NSW Commission for Children and Young People, *Submission* at [10.1.2]; S Siedlecky, *Submission*.

28. Shopfront Youth Legal Centre, *Submission* at 9.

examinations under section 173 being aligned with the more consensual approach of section 53 to medical examinations of children.²⁹

7.23 The Commission understands that section 173 is used primarily as an evidence gathering provision by the Department of Community Services and the police in emergency situations to protect children in high-risk family circumstances. Requiring a child's consent to a medical examination in such circumstances might unintentionally put that child under extreme emotional pressure from other family members, and potentially place that child at great risk of further abuse. Consequently, in the delicate balance between the law establishing a more participatory role for children in need of care and protection and the need to prevent risk of further abuse, the latter must prevail.

7.24 For similar reasons, the Commission also considers that the ability of a child or young person of sufficient understanding to refuse to submit to a medical examination ordered by the Children's Court under section 53(4) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) should be rebalanced. This could be simply achieved by moving section 53(4) into section 56(1). The effect would be to allow the Children's Court to override a child or young person's refusal to undergo a medical examination order, whereas presently it cannot. Instead, the Court would have to take the child or young person's refusal into consideration when making any assessment order.

29. S Siedlecky, *Submission*.

8. Special medical treatment

- Common law
- Legislation
- Should there be a special treatments regime?
- Principles guiding decision-making
- Sterilisation
- Effect of our legislation on other legislation
- Jurisdiction

8.1 In this report, we have discussed the involvement of young people, their parents and other caregivers in decisions about young people's health care. So far, the focus of our discussion has been on the laws that determine when young people should have responsibility for such a decision and, where they do not have that responsibility, the people who should be able to make that decision on their behalf, namely a parent or another caregiver. We have noted that the requirement for consent is derived from the common law tradition that insists that a valid consent be given before physical contact with another person can lawfully be made. Health care involving physical contact exposes a practitioner to liability in trespass if a valid consent to that contact has not first been obtained, except in emergencies.¹ At least in so far as it relates to young people, we have noted that the requirement for consent also serves a broader purpose beyond exculpating a practitioner from liability in trespass. It acts as an assertion of authority or responsibility for decisions concerning a young person's care.

8.2 Normally, where young people are not competent to make a decision about health care, the law recognises their parents as having the authority to decide on their behalf. As we have seen, that authority is not limitless: at common law, the courts have an overarching supervisory power as part of their *parens patriae* jurisdiction, to protect a young person's best interests. This allows them to intervene in a decision affecting a young person's health care and act contrary to a parent's wishes. In addition to this more general *parens patriae* power, legislation also empowers courts to act to protect young people's best interests.

8.3 This chapter looks at another aspect of the limitation on parents' authority to consent to health care for their children. Derived from the basic responsibility of the courts to protect the best interests of the child, the law has developed a narrow class of treatments which are considered to be of such a serious nature that they are beyond the scope of parental consent altogether. Instead, the law vests the authority to consent to these treatments in the courts or in the Guardianship Tribunal. These are seen to act as a form of procedural safeguard in protecting the best interests of the young person concerned.² And so, a practitioner cannot provide a treatment in this class to a young person on the basis of a parent's consent alone. He or she must obtain court or Tribunal authorisation.³

8.4 Treatments in this class, requiring authorisation from a court or tribunal, are sometimes called "special treatments" or "special medical treatments", or sometimes "special cases". There is not a single term of art for the treatments so designated. A commonly cited example of special medical treatment is sterilisation. In New South Wales, a young person, at least a person below the age of 16,⁴ cannot be sterilised without

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1. See Chapter 7.
 2. *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218, 249.
 3. This assumes that the young person himself or herself lacks capacity to consent. Where the young person is competent, the common law and legislation differ as to whether he or she is able to provide a lawful consent for a special treatment: see para 8.17, 8.24.
 4. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(1), (2), (5).

authorisation from the Family or Supreme Courts, or the Guardianship Tribunal, even if the young person and/or his or her parent consents to the sterilisation.

8.5 This chapter discusses the law on consent to special medical treatment. It includes recommendations for statutory provisions regulating the authorisation of this class of treatments, to be inserted into our proposed legislation dealing with consent to young people's health care. The provisions which we recommend largely mirror existing provisions relating to special medical treatment in the *Children and Young Persons (Care and Protection) Act 1998* (NSW), with some fine tuning to redress gaps in the current legislative scheme and overcome potential problems arising as a result of concurrent common law and statutory regimes.

8.6 Before taking a more detailed look at these recommendations, we begin by considering the current law in this area. As with the law on consent more generally, the current law on consent to special medical treatment is a mixture of common law and legislation. Uncertainties arise both within each regime and from the interaction of the two. The first part of this chapter examines the common law relating to special medical treatment, then the relevant legislation, before considering the ways in which these two interact. The second part discusses the changes to the law which we recommend, and the ways in which these recommendations differ from the current law.

COMMON LAW

Certain procedures are considered "special cases"

8.7 At common law, as we have already noted, a parent can generally consent to treatment for a young person who is not *Gillick* competent. However, in the leading case of *Secretary, Department of Health and Community Services v JWB and SMB* ("*Marion's case*"),⁵ the High Court decided that it is outside the scope of parents' power to consent on behalf of their children to certain procedures designated by the Court as "special cases".⁶ At common law, the power to consent to these special cases instead rests with the courts.

8.8 There is no fixed list of procedures that constitute special treatment at common law. *Marion's case* itself involved the proposed sterilisation of a girl with an intellectual disability. The Court considered whether the procedure constituted a special case so as to place it beyond the scope of parental authority to consent to,⁷ concluded that it did,⁸ and left open the possibility of there being other such procedures.⁹ It is worth emphasising

5. *Secretary, Department of Health and Community Services v JWB and SMB* (*Marion's case*) (1992) 175 CLR 218.

6. *Marion's case* (1992) 175 CLR 218, 249, 253. Previous decisions were divided on this subject, with two holding that parental consent was sufficient (*Re a Teenager* (1988) 94 FLR 181; *Re S* (1989) 98 FLR 41) and two holding that court authorisation was required (*Re Jane* (1988) 94 FLR 1; *Re Elizabeth* (1989) 13 Fam LR 47).

7. *Marion's case* (1992) 175 CLR 218, 239.

8. *Marion's case* (1992) 175 CLR 218, 253.

9. *Re Alex* (2004) 180 FLR 89, 120.

here that a treatment that may otherwise be classified as a special case requiring court authorisation, if “required for medical and therapeutic reasons”, does not need the court’s consent to be carried out.¹⁰ An example of this is sterilisation that is a by-product of surgery carried out to treat a disease,¹¹ such as a hysterectomy carried out in the process of treating certain forms of cancer. In this situation, assuming the young person was not competent, the authority to consent would normally lie with the parent.

8.9 While sterilisation features most commonly in the few reported cases on special medical treatment,¹² other procedures which have been held at common law to constitute special cases include surgical gender reassignment,¹³ a bone marrow harvest from a healthy child for transplant to an adult relative,¹⁴ hormonal treatment,¹⁵ and even termination of pregnancy.¹⁶

Features of a procedure that are indicative of a special case

8.10 The High Court in *Marion* described sterilisation as a procedure involving surgery that is “invasive, irreversible and major”.¹⁷ But this description in itself does not provide a formula for predicting which procedures constitute special cases, as it could equally apply to, for example, an appendectomy and some cosmetic surgery,¹⁸ both of which, according to the High Court,¹⁹ fall within the ordinary scope of parental authority to consent.

8.11 On the other hand, the High Court has identified two features which are indicative of a procedure of such a serious nature as to necessitate court authorisation and therefore bring it within the class of special cases. These two features are:

1. the significant risk of making the wrong decision, either as to the young person’s present or future capacity to consent, or about what are the best interests of a young person who cannot consent; and
2. the grave consequences of a wrong decision.

Risk of making the wrong decision

8.12 The High Court regarded the following factors as contributing to this risk:

- ***The complexity of the question of consent.*** The question of what constitutes informed consent²⁰ – whether on the part of the parents or of the child in question – is

10. *Re Marion (No 2)* (1992) 17 Fam LR 336, 355.

11. *Marion’s case* (1992) 175 CLR 218, 250.

12. *Eg Marion’s case* (1992) 175 CLR 218.

13. *Re A* (1993) 16 Fam LR 715.

14. *Re W* (1997) 136 FLR 421.

15. *Re Alex* (2004) 180 FLR 89.

16. *Queensland v B* [2008] QSC 231, [17].

17. *Marion’s case* (1992) 175 CLR 218, 250.

18. See discussion at para 1.43 – 1.47.

19. *Marion’s case* (1992) 175 CLR 218, 250.

20. This is the term used by the High Court: *Marion’s case* (1992) 175 CLR 218, 250; compare discussion at para 1.10.

problematic. Even if there were a settled rule, its application would still be fraught with difficulty. For example, the Court expressed concern that some sterilisations in the past may have been performed too readily and the child's capacity to consent and later, to care for a child, wrongly assessed. Doctors and others attempting to determine capacity may be affected by commonly held misconceptions about those with intellectual disabilities.

- **Role of the medical profession.** Absolute faith in the integrity of all practitioners cannot be assumed, while even those acting in good faith may have too limited a frame of reference in which to make correct assessments. Furthermore, a decision concerning a "special medical treatment" may in fact be not only a medical issue, but also a social and psychological one.
- **Possible conflict of interests.** A parent may have regard to interests additional to those of the child who is the patient. While these may be legitimate and relevant, they may also conflict with those of the child, whereas the court's role is to ensure that the child's interests prevail.

Potentially grave consequences

8.13 In *Marion's case* the Court recognised the potentially serious social and psychological consequences flowing from the deprivation of the ability to reproduce and from the violation of the person, having been treated contrary to his or her wishes or best interests.²¹

LEGISLATION

8.14 The two relevant statutes in NSW are the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and the *Guardianship Act 1987* (NSW).

Scope of legislation

8.15 Section 175(1) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) makes it an offence to carry out special medical treatment on a person under the age of 16 otherwise than in accordance with the section. Such treatment may be carried out if necessary as a matter of urgency in order to save the child's life or prevent serious damage to health,²² or with authorised consent.²³

8.16 Part 5 of the *Guardianship Act 1987* (NSW) applies to a person above the age of 16 who is incapable of giving consent to medical treatment.²⁴ Special treatment may be carried out if necessary as a matter of urgency to save the patient's life or prevent serious damage to health, or with the consent of the Guardianship Tribunal.²⁵

21. *Marion's case* (1992) 175 CLR 218, 252.

22. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(2)(a).

23. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(2)(b), (c). See also n 48.

24. *Guardianship Act 1987* (NSW) s 33(2), 34(1).

25. *Guardianship Act 1987* (NSW) s 36(1), 37(1). Major or minor treatment, defined in the Act at s 33(1), are irrelevant for the purposes of this discussion.

8.17 The combined effect of the two Acts is that no person under 16, regardless of competence, nor persons over 16 who are incapable of giving consent, can consent to a treatment specified as a special medical treatment, and it is outside the scope of parents' or guardians' power to consent on such a child's behalf.

What treatments are covered

8.18 The two Acts are similar but not identical. They list a number of treatments, as follows, some (but not all) of which require authorisation from the Guardianship Tribunal:

- sterilisation of the type that might be thought of as "planned sterilisation" (in contrast with those cases where sterilisation is an unwanted consequence of life-saving treatment);²⁶
- administration of a drug of addiction within the meaning of the *Poisons and Therapeutic Goods Act 1966* (NSW) for more than 10 days in any 30;²⁷
- an experimental procedure that does not conform to the National Health and Medical Research Council's *National Statement on Ethical Conduct in Research Involving Humans*;²⁸
- a new treatment that has not yet gained the support of a substantial number of medical practitioners or dentists specialising in the area;²⁹
- administration of a psychotropic drug to a child in out-of-home care in order to control his or her behaviour;³⁰
- administration of certain restricted substances for the purpose of affecting the central nervous system;³¹
- use of androgen reducing medication to control behaviour;³²
- termination of pregnancy;³³

26. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(5); *Guardianship Act 1987* (NSW) s 33(1), *Guardianship Regulation 2005* (NSW) cl 8(c).

27. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(5), *Children and Young Persons (Care and Protection) Regulation 2000* (NSW) cl 15(1)(a). See also *Guardianship Act 1987* (NSW) s 33(1), *Guardianship Regulation 2005* (NSW) cl 8(a).

28. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(5), *Children and Young Persons (Care and Protection) Regulation 2000* (NSW) cl 15(1)(b).

29. *Guardianship Act 1987* (NSW) s 33(1).

30. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(5), *Children and Young Persons (Care and Protection) Regulation 2000* (NSW) cl 15(1)(c).

31. *Guardianship Act 1987* (NSW) s 45(3)(b), *Guardianship Regulation 2005* (NSW) cl 9(a).

32. *Guardianship Act 1987* (NSW) s 45(3)(b), *Guardianship Regulation 2005* (NSW) cl 9(b).

33. *Guardianship Act 1987* (NSW) s 33(1), *Guardianship Regulation 2005* (NSW) cl 8(b).

- use of an aversive stimulus.³⁴

8.19 Those treatments above that are listed in the *Children and Young Persons (Care and Protection) Act 1998* (NSW) or *Children and Young Persons (Care and Protection) Regulation 2000* (NSW) apply to all children under 16.³⁵ Those that appear in the *Guardianship Act 1987* (NSW) or *Guardianship Regulation 2005* (NSW) apply to young persons above 16 who lack the capacity to give consent.³⁶ This can give rise to apparent anomalies, explicable only by reference to the purposes of the *Guardianship Act 1987* (NSW). For example, regarding termination of pregnancy, the parents of young persons who are not competent may give consent if the young person is under 16 but not if over this age.

SHOULD THERE BE A SPECIAL TREATMENTS REGIME?

Common law

8.20 In his dissenting judgment in *Marion's case*, Justice Brennan is critical of what he refers to as "judicial imperialism": "the proposition that a court can assume a power to dispense from the criminal laws which protect personal integrity when the judge believes the dispensation is for the welfare of a child."³⁷ The court, he says:³⁸

is an instrument of State power, and the powers of the State to authorize interference with the personal integrity of any of its subjects otherwise than for therapeutic purposes is not self-evident. If such a power can be exercised to secure what the court may deem to be the welfare of an intellectually disabled child, might not a like power be exercised to secure what the court may deem to be the welfare of any child? It is a power which would be exercised not by an anxious and anguishing parent or guardian who can be called to account, but by a judge to whom the case is assigned in a court's list and who, having exercised his or her discretion, is discharged from all responsibility for the consequences.

8.21 To the majority in *Marion's case*, the court's determination of an application – at a remove – represents a safeguarding of the child's interests, whereas for Justice Brennan this has disturbing implications, given past eugenic practices and other "base purposes" underlying sterilisation operations.³⁹

Legislation

8.22 The precursor to the *Children and Young Persons (Care and Protection) Act 1998* (NSW) was the *Children (Care and Protection) Act 1987* (NSW). The original Act

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- 34. *Guardianship Act 1987* (NSW) s 33(1), *Guardianship Regulation 2005* (NSW) cl 8(d).
 - 35. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(1).
 - 36. *Guardianship Act 1987* (NSW) s 34(1).
 - 37. *Marion's case* (1992) 175 CLR 218, 284.
 - 38. *Marion's case* (1992) 175 CLR 218, 283-284.
 - 39. *Marion's case* (1992) 175 CLR 218, 275 (Brennan J).

contained no reference to special medical treatments. This was changed with the insertion of s 20B,⁴⁰ which defined them in sub-section (3) as:

- a) any medical treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out; or
- b) any other medical treatment that is declared by the regulations to be special medical treatment for the purposes of this section.

Section 20B provided that special medical treatment could be carried out on a person under 16 years only if a medical practitioner thought it necessary as a matter of urgency in order to save the patient's life or prevent serious damage to health, or with the Supreme Court's consent.⁴¹ A subsequent amendment⁴² "[strengthened] ... the protective effect" of the Act "by ensuring that the Supreme Court consents to the carrying out of any treatment that is likely to result in a child being rendered infertile only if the court is satisfied that the treatment is necessary to save the child's life or to prevent serious damage to the child's health."⁴³

8.23 The evolution of the NSW legislation would seem to indicate that the concept of special medical treatment was introduced principally to prevent young people from being subjected to sterilisation undertaken without independent scrutiny. Other types of treatment were added soon after.⁴⁴ During Parliamentary debate it was stated that the principal purpose of the above definition of "special medical treatment" was:⁴⁵

to make it unlawful to carry out sterilization, except in a case where it is necessary to save the life of the patient or to prevent serious damage to the patient's health, or unless the Guardianship Board has held a hearing concerning the matter and has given its consent. There have been allegations over a number of years that intellectually disabled people in particular have been improperly sterilized as a means of social control and this practice was condemned by the Anti-Discrimination Board in a report which it produced in 1981. There would be few people in a civilized community who would condone such a thing and it is a principal purpose of this bill to outlaw the practice.

8.24 The legislature's approach has been more paternalistic than that of the common law. Unlike the common law, the *Children and Young Persons (Care and Protection) Act*

40. Inserted by the *Children (Care and Protection) (Disability Services and Guardianship) Amendment Act 1987* (NSW), an Act cognate with the *Disability Services and Guardianship Act 1987* (NSW).

41. *Children (Care and Protection) Act 1987* (NSW) s 20B(1), (2).

42. *Children (Care and Protection) Further Amendment Act 1988* (NSW).

43. NSW, *Parliamentary Debates*, Legislative Council, 13 October 1988, 2202 (Virginia Chadwick, Minister for Family and Community Services).

44. The *Children (Care and Protection – General) Regulation 1988* (NSW) contained no reference to special medical treatments. Other special medical treatments were declared when the Regulation was amended in 1989 (No 502).

45. NSW, *Parliamentary Debates*, Legislative Assembly, 12 November 1987, 15939 (John Aquilina, Minister for Youth and Community Services).

1998 (NSW) applies to all young persons under 16, regardless of competence, and the *Guardianship Act 1987* (NSW) extends this protection to young people over 16 who are incapable of giving consent (as defined in the Act).⁴⁶ Furthermore, the legislation requires court or tribunal authorisation in circumstances where the common law arguably does not, that is, in cases of medical necessity.

The Commission's view

8.25 The Commission respectfully agrees with the position taken by both the majority of the High Court and the NSW legislature, that a special treatments regime is necessary to safeguard the rights and well-being of young persons, especially those with disabilities. The authorisation of a court or tribunal helps ensure that independent scrutiny and objective decision-making are brought to bear before procedures with potentially serious repercussions can be performed on children. The Court endorsed the view of Chief Justice Nicholson of the Family Court of Australia that there was less likelihood of abuse of the rights of young people if an application to a court were mandatory.⁴⁷ The continuing development of the common law through the court's *parens patriae* jurisdiction assists in protecting potentially vulnerable young people.

8.26 The Commission endorses the protective policy contained in s 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) that extends to *all* young persons under the age of 16, and which prevents them and their parents from consenting to a range of specified treatments. This ensures, amongst other things, that all sterilisation procedures (other than those excepted in sub-paragraphs (i) and (ii) of the definition of "special medical treatment" in s 175(5)(a)) must be authorised, obviating the need to attempt distinguishing, as the common law must, between the "therapeutic" and "non-therapeutic".⁴⁸ We recommend that a provision similar to s 175 be incorporated in the proposed new Act. The provision should contain a definition of special medical treatment that accords with the present definition contained in s 175(5)(a), (c) and (d), and which refer to treatments affecting reproductive capacity and any others declared special medical treatments by the regulations.⁴⁹ Express reference to treatments for the purpose of contraception or menstrual management, as provided for in the definition of "special medical treatment" in s 175(5)(b), is unnecessary.⁵⁰

46. *Guardianship Act 1987* (NSW) s 33(2). See also Rec 9.

47. *Marion's case* (1992) 175 CLR 218, 253.

48. Nicholson CJ acknowledged the potential problem of "disentangling therapeutic from non-therapeutic aims" as there could be "mixed aims" associated with a procedure: *Re Jane* (1988) 94 FLR 1, 30. The High Court also commented on the uncertainty of the distinction: *Marion's case* (1992) 175 CLR 218, 250. *Marion's case* itself illustrated the problem for, as Nicholson CJ stated, it "[i]ronically enough ...[fell] into the category of cases where the court's consent is unnecessary since ... the procedure was required for medical and therapeutic reasons": *Re Marion (No 2)* (1992) 17 Fam LR 336, 355.

49. See para 8.30.

50. Previous specific references to long-acting injectable hormonal substances that appeared in earlier versions of both the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and Regulations have been deleted, and presently no

8.27 Having access to a Tribunal-based system is also a strong case for retaining the current legislative regime. The expertise of panel members, relative informality and flexibility of the proceedings, and the lower cost and delay involved in hearings before the Tribunal, in comparison with a court, must have a beneficial effect for families caught up in the potentially difficult and stressful situations that necessitate the bringing of such applications. As an alternative to the Tribunal, the Regulations may specify other conditions pertaining to the giving of consent.⁵¹

8.28 A further issue is whether the provision should apply only to young people under the age of 16. In the Commission's view it should. This accords both with the previous

treatment for the purpose of contraception or menstrual regulation is declared by the Regulations. Furthermore, the NSW Guardianship Tribunal, in *Application for consent to special medical treatment for Miss CJ*, March 2001, stated:

"This application brought home to the Tribunal the inappropriateness of Depo-Provera or preparations very similar to it being defined as special medical treatment in section 175 of the Children and Young Persons (Care and Protection) Act whilst all other forms of contraception short of sterilisation are not so included. The Tribunal could not see the social benefit in this provision, nor could it identify who was being protected by it. Indeed, this case indicated that if the Tribunal had not been satisfied as to the test required in section 175(3), Miss J may well have been placed in a situation where she was likely to face a second pregnancy while still a child and as a result suffer serious damage to her psychological health.

Children and young persons in Miss J's situation are in need of careful support and training and ready access to contraceptive medication appropriate to their particular needs. This provision seems to be contrary to the general thrust of the legislation. In operation, it appears to have the exact opposite effect of the intent of protecting children and young persons from health threatening situations."

On the basis of its experience in this application, the Tribunal considers that there is a case for removing this provision from the Act.

51. As currently worded s 175 contains an ambiguity. According to s 175(2)(b) a medical practitioner may carry out special treatment if the Guardianship Tribunal has consented to the sterilisation procedures listed in paragraphs (a), (b) and (c) of the definition of special medical treatment in s 175(5). There is also, however, a paragraph (d) within that definition, which alludes to "any other medical treatment that is declared by the regulations to be special medical treatment for the purposes of this section". It is unclear whether the Tribunal is authorised to consent to these other treatments appearing in cl 15 of the *Children and Young Persons (Care and Protection) Regulation 2000* (NSW). Section 175(2)(c) provides that a medical practitioner may carry out special medical treatment if "consent is granted to the carrying out of the treatment in accordance with the regulations." Again, as there is no reference in cl 15 to the Tribunal, it is unclear whether it has authority to consent to the treatments listed. There is also some ambiguity regarding the NSW Supreme Court's authority to consent to special medical treatments under this Act. Section 175(1) states that "a person must not carry out special medical treatment on a child otherwise than in accordance with this section." Although a previous reference to the Supreme Court in s 20B(2) of the *Children (Care and Protection) Act 1987* (NSW) has been replaced by a reference to the Tribunal in the present provision, s 247 of the current Act states that nothing in this Act limits the jurisdiction of the Supreme Court.

determination by the NSW Parliament, as reflected in existing legislative protection, and with the presumption of competence contained in Recommendation 6 of this report. However, it does not follow automatically that competent 16 to 18 year olds could therefore consent to major medical procedures that include sterilisation. The likelihood either that a young person would seek such a procedure or that a medical practitioner would be willing to carry it out is remote. In any event the *parens patriae* jurisdiction would permit court intervention where notified and warranted. In the case of 16 and 17 year olds lacking *Gillick* competence (and if Recommendation 4 is enacted) there should be an exception requiring that they also obtain Tribunal or court authorisation before undergoing a special medical treatment. We see no reason why their parents should, at this point, acquire the power to consent to special medical treatment on their behalf.

Recommendation 16

The legislation should provide that a person not carry out special medical treatment on a young person under the age of 16 unless the Guardianship Tribunal consents to the carrying out of the treatment, or unless the treatment is carried out in accordance with the regulations.

The legislation should provide that a person not carry out special medical treatment on a young person aged 16 or over but less than 18 who does not meet the test for competence in Recommendation 4 unless the Guardianship Tribunal consents to the carrying out of the treatment, or unless the treatment is carried out in accordance with the regulations.

The definitions of "medical treatment" and "Guardianship Tribunal" should be in similar terms to those appearing in sub-section 175(5) of the current *Children and Young Persons (Care and Protection) Act 1998* (NSW). The definition of "special medical treatment" should be in similar terms to that appearing in sub-section 175(5)(a), (c) and (d).

Which procedures should require authorisation?

8.29 The Commission's view, that there should exist a legislative regime governing the authorisation of special medical treatments, raises the question of which procedures this should apply to. There is significant overlap in the list of treatments contained in the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and the *Guardianship Act 1987* (NSW), although they are not identical.⁵² Understandably, the lists compiled at different dates and for different purposes are not on all fours. Submissions received by the Commission suggested various procedures that should require authorisation. These include sterilisation,⁵³ electro-convulsive therapy,⁵⁴ gender reassignment,⁵⁵ donation of

52. See list above at para 8.18.

53. Doctors Reform Society, *Submission*, 4; National Children's and Youth Law Centre, *Submission*, 14; NSW Commission for Children and Young People, *Submission*, 9; S Siedlecky, *Submission*, 10.

54. Doctors Reform Society, *Submission*, 4; National Children's and Youth Law Centre, *Submission*, 15; S Siedlecky, *Submission*, 10.

55. Doctors Reform Society, *Submission*, 4; National Children's and Youth Law Centre, *Submission*, 15; S Siedlecky, *Submission*, 10.

reproductive material, organs or bone marrow,⁵⁶ psychosurgery,⁵⁷ cosmetic surgery,⁵⁸ administration of an addictive drug,⁵⁹ experimental procedures,⁶⁰ and new treatments not yet supported by a substantial number of practitioners specialising in the area.⁶¹ It was also suggested that, in addition to third party authorisation, treatment related to gender reassignment should not be carried out until the child is competent to consent.⁶²

8.30 In Recommendation 16, we adopt the definition of “special medical treatment” in s 175(5) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), in so far as it encompasses treatments relating to reproductive capacity. In the light of the development of the common law and of relevant statute law, we consider this appropriate.⁶³ Beyond this, we express no opinion as to the treatments that should be designated special for the purpose of our proposed legislation. Clearly, the very important task of deciding which treatments should be so designated is outside the Commission’s expertise. A panel comprising medical and other experts in relevant fields should be appointed to advise the government on this matter. If the identification of such treatments is to be kept current, the advice of the panel should be effected by regulation, as s 175(5)(d) envisages.⁶⁴

8.31 Our substantial adoption of the definition of “special medical treatment” in s 175(5) of the *Children and Young Persons Care and Protection Act 1998* (NSW) leaves a major difference between this definition and the definition of “special treatment” in s 33 of the *Guardianship Act 1987* (NSW). The latter definition includes “any new treatment that has not yet gained the support of a substantial number of medical practitioners or dentists specialising in the area of practice concerned”.⁶⁵ We do not believe that it is appropriate to extend the definition of “special medical treatment” in our legislation to include new or innovative therapy. Such therapy may not yet have received peer support because it may not yet have been fully assessed for safety or efficacy in human subjects or because there may be only one person or team working in the field. Where orthodox treatments have

56. National Children’s and Youth Law Centre, *Submission*, 15.

57. Doctors Reform Society, *Submission*, 4; S Siedlecky, *Submission*, 10.

58. Doctors Reform Society, *Submission*, 4; S Siedlecky, *Submission*, 10; National Children’s and Youth Law Centre, *Submission*, 15, and NSW Commission for Children and Young People, *Submission*, 10, both referred to “non-therapeutic cosmetic surgery”.

59. National Children’s and Youth Law Centre, *Submission*, 15.

60. National Children’s and Youth Law Centre, *Submission*, 15.

61. NSW Commission for Children and Young People, *Submission*, 9.

62. Shopfront Youth Legal Centre, *Submission*, 7; S Siedlecky, *Submission*, 10; Androgen Insensitivity Syndrome Support Group, *Submission*, 15-16, 20.

63. See para 8.8-8.13, 8.22-8.23.

64. The National Children’s and Youth Law Centre, *Submission*, 15 and the Shopfront Youth Legal Centre, *Submission*, 7 support this approach.

65. Currently the *Children and Young Persons (Care and Protection) Regulation 2000* (NSW) cl 15(1)(b) applies only to “experimental” procedures” (and needs updating to reflect the fact that the ethics guidelines referred to are revised every few years, most recently in 2007). We do not suggest that clear distinctions can be drawn between innovative therapy and “experimental procedures” beyond the inclusion of the latter in a formal research program: see E Jackson, *Medical Law: Text, Cases, And Materials* (2006), 459-460.

been exhausted and such therapy offers the only hope of saving life, restoring health or alleviating suffering, the normal rules relating to consent ought to apply.⁶⁶ It must be remembered that the “normal rules” necessarily encompass, and are subject to, the *parens patriae* jurisdiction,⁶⁷ and that the therapy in question will invariably have received approval from the relevant scientific advisory and medical ethics committees of a hospital.

Recommendation 17

The Government should appoint a panel of experts to consider from time to time, or as needed, the medical treatments that should be declared to be special medical treatments in the regulations.

PRINCIPLES GUIDING DECISION-MAKING

Common law

8.32 In deciding whether to authorise a special medical treatment the court acts in the best interests of the child.⁶⁸ In the context of sterilisation, the Court explained that its function:

is to decide whether, in the circumstances of the case, that is in the best interests of the child. We have already said that it is not possible to formulate a rule which will identify cases where sterilization is in his or her best interests. But it should be emphasized that the issue is not at large. Sterilization is a step of last resort. And that, in itself, identifies the issue as one within narrow confines.

In the context of medical management, “step of last resort” is a convenient way of saying that alternative and less invasive procedures have all failed or that it is certain that no other procedure or treatment will work. The objective to be secured by sterilization is the welfare of the disabled child. Within that context, it is apparent that sterilization can only be authorized in the case of a child so disabled that other procedures or treatments are or have proved inadequate, in the sense that they have failed or will not alleviate the situation so that the child can lead a life in keeping with his or her needs and capacities.

It is true that the phrase “best interests of the child” is imprecise, but no more so than the “welfare of the child” and many other concepts with which courts must grapple. As we have shown, it is confined by the notion of “step of last resort”, so that, for example, in the case of a young woman, regard will

66. This accords with World Medical Association, *Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects* (2000) art 32, <<http://www.wma.net/e/policy/b3.htm>> (at 15 September 2008). For the position under the *Guardianship Act 1987* (NSW) see para 8.33.

67. See para 8.2. And consider *Simms v Simms* [2003] 1 All ER 669.

68. *Marion’s case* (1992) 175 CLR 218, 259.

*necessarily be had to the various measures now available for menstrual management and the prevention of pregnancy. And, if authorization is given, it will not be on account of the convenience of sterilization as a contraceptive measure, but because it is necessary to enable her to lead a life in keeping with her needs and capacities.*⁶⁹

8.33 Note that, while the Court alludes to the giving of authorisation where it is “necessary”, it is not restricted to necessity of a medical kind but something broader. Secondly, the Court expressed the view that judges would develop guidelines to give “further content” to the phrase “best interests of the child” in order to respond to the situations that arose.⁷⁰ This Chief Justice Nicholson did in *Re Marion (No 2)*,⁷¹ in which he set out the following factors to determine whether the procedure is in the best interests of the child:

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

69. *Marion’s case* (1992) 175 CLR 218, 259-260.

70. *Marion’s case* (1992) 175 CLR 218, 259-260.

71. *Re Marion (No 2)* (1992) 17 Fam LR 336, 351-352.

- (c) a person who is responsible for the daily care and control of the child;
- (d) the child

to the proposed procedure or treatment and to any alternative procedure or treatment.

8.34 While sterilisation was singled out as a “special case”, courts have applied the reasoning laid down by the High Court to bring other procedures within the open-ended special medical treatments rubric.⁷² In its determination the court must subject the application to the “best interests” tests, and in so doing take into account the considerations enunciated by Chief Justice Nicholson in *Re Marion (No 2)*.⁷³

The Guardianship Tribunal

8.35 The Guardianship Tribunal’s authority to consent to special medical treatment is contained in two statutes, the *Children and Young Persons (Care and Protection) Act 1998* (NSW), which pertains to all persons under the age of 16, and the *Guardianship Act 1987* (NSW), which applies to any persons over 16 (including adults) who are incapable of giving consent.

8.36 In formulating statutory provisions relating to special medical treatment, an important issue is the test that the Tribunal should apply when considering whether to give consent. At present, differences exist between the two Acts in the range of matters the Tribunal must take into account when deciding an application.

8.37 Section 175(3) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) states:

Consent to the carrying out of special medical treatment on a child must not be given by the Guardianship Tribunal unless the Guardianship Tribunal is satisfied that it is necessary to carry out the treatment on the child in order to save the child’s life or to prevent serious damage to the child’s psychological health or physical health.

8.38 Part 5 of the *Guardianship Act 1987* (NSW) deals with a wider range of circumstances involving medical treatment than Chapter 9 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). This may go some way to explain the former Act’s multi-layered restrictions on the Tribunal’s power to give consent. For example, in the case of any medical or dental treatment, the Tribunal must not give its consent unless satisfied that the treatment “is the most appropriate form of treatment for promoting and maintaining the patient’s health and well-being.”⁷⁴ Additionally in the case of special treatment the Tribunal must not give consent unless:

...satisfied that the treatment is necessary

72. See para 8.8.

73. *Re Marion (No 2)* (1992) 17 Fam LR 336, 351-352.

74. *Guardianship Act 1987* (NSW) s 45(1).

- (a) *to save the patient's life, or*
- (b) *prevent serious damage to the patient's health,*

*or unless the Tribunal is authorised to give consent under subsection (3)*⁷⁵

Subsection (3) is fairly convoluted but its effect is to establish, in the case of particular special treatments, alternative criteria according to which the Tribunal may give consent. In the cases of a new treatment that has not yet gained the support of a substantial number of medical practitioners specialising in the area,⁷⁶ and "prescribed special treatment",⁷⁷ the Tribunal may give consent if it is satisfied that the treatment is the only or most appropriate way of treating the patient, that it is manifestly in the best interests of the patient, and that there is compliance with any relevant guidelines prescribed by the National Health and Medical Research Council.⁷⁸ The medical necessity test contained in subsection (2) is thus only mandatory in the case of sterilisation and the other special treatments contained in the regulations.⁷⁹

8.39 More generally, s 44(2) lists matters the Tribunal is to have regard to when considering an application for consent to medical or dental treatment, such as any views that may be held by the patient or the person proposing that the treatment be carried out, as well as the objects of Part 5.⁸⁰ These include ensuring that any medical or dental treatment carried out on people lacking the capacity to consent is "for the purpose of promoting and maintaining their health and well-being."⁸¹

8.40 To gain some understanding of the most suitable test for special medical treatment determinations we look at sterilisation as a case study.

STERILISATION

Common law

8.41 At common law court authorisation is required only for so-called non-therapeutic sterilisations, while parental consent is sufficient to authorise a therapeutic sterilisation. The expression "therapeutic" connotes the treatment of some disease or malfunction.⁸²

75. *Guardianship Act 1987* (NSW) s 45(2).

76. *Guardianship Act 1987* (NSW) s 45(3)(a).

77. *Guardianship Act 1987* (NSW) s 45(3)(b), *Guardianship Regulation 2005* (NSW) cl 9 ("treatment that involves the administration ... of one or more restricted substances for the purpose of affecting the central nervous system of the patient..." and "treatment that involves the use of androgen reducing medication for the purpose of behavioural control").

78. *Guardianship Act 1987* (NSW) s 45(3)(c) and (d).

79. *Guardianship Regulation 2005* (NSW) cl 8.

80. *Guardianship Act 1987* (NSW) s 32.

81. *Guardianship Act 1987* (NSW) s 32(b).

82. *Re Jane* (1988) 94 FLR 1, 11.

8.42 The test applied at common law is the “best interests” test which incorporates the notion of the “step of last resort”.⁸³ While this means that a court has some discretion to take into consideration a range of circumstances, this must not be exercised lightly.⁸⁴ The Court must recognise the width of the inquiry necessary to be undertaken.⁸⁵

[T]he decision to sterilize, at least where it is to be carried out for contraceptive purposes, and especially now when technology and expertise make the procedure relatively safe, is not merely a medical issue. This is also reflected in the concern raised in several of the cases reviewed, that the consequences of sterilization are not merely biological but also social and psychological. The requirement of a court authorization ensures a hearing from those experienced in different ways in the care of those with intellectual disability and from those with experience of the long term social and psychological effects of sterilization.

The Court has given consideration to the following factors in deciding whether to authorise sterilisation.

Medical need

8.43 *Marion’s case* and *Re Marion (No 2)*⁸⁶ concerned a 14 year-old girl who was severely intellectually disabled, epileptic and deaf. Her mental age was estimated to be between 18 months and 3 years. Her parents applied to the court for authorisation of an ovariectomy and hysterectomy to be performed on their daughter. Evidence before the court showed that prior to the commencement of each menstrual period Marion would become very aggressive and violent, and was prone to epileptic fitting. This had the potential to cause further brain damage. She also had difficulties managing menstruation, being unable to put on sanitary pads, and having a tendency to remove them or touch them when out in public. The contraceptive Depo Provera was administered as an alternative, but proved unsatisfactory.

8.44 Chief Justice Nicholson found on the facts that the critical issue was the need to minimise Marion’s seizures and reduce the possibility of further brain damage.⁸⁷ Having thus found the sterilisation warranted on medical grounds, his Honour found it unnecessary to consider other reasons that had been advanced.

Menstrual management and ease of care generally

8.45 Courts have made it clear that convenience is not a sufficient reason to authorise sterilisation,⁸⁸ but they will not exclude such considerations from the totality of circumstances taken into account in arriving at a decision. In *Re Marion (No 2)*, Chief

83. See para 8.32.

84. *Marion’s case* (1992) 175 CLR 218, 259-260.

85. *Marion’s case* (1992) 175 CLR 218, 251.

86. *Re Marion (No 2)* (1992) 17 Fam LR 336.

87. *Re Marion (No 2)* (1992) 17 Fam LR 336, 353, 355.

88. *Marion’s case* (1992) 175 CLR 218, 260.

Justice Nicholson observed that while not wishing to diminish the validity of parental concerns:⁸⁹

it must be remembered that these are proceedings where the welfare of the child is paramount. ...[T]he decision cannot be made to suit the convenience of caregivers, however valid their concerns may be. However it may be valid to take such matters into account in circumstances where the caregivers may be unable to continue to care for the child if the procedure is not carried out. In such circumstances it may be that the welfare of the child could require the carrying out of such a procedure if the alternative were the institutionalisation of the child or the absence of any other caregiver.

8.46 In *P and P and Legal Aid Commission of NSW*⁹⁰ (“*P and P*”) the Court expressed its agreement with the view of the trial judge that menstrual management alone could not justify sterilisation, but added that it could not be ignored either.

8.47 Women and girls with intellectual disability may be unable to manage their periods. In some cases temporary and reversible measures may be taken to suppress menstruation, for example through injecting the long-acting synthetic hormone Depo-Provera. Long-term use, however, of such treatments may bring a risk of adverse health outcomes,⁹¹ especially if the patient is on other medications.

Prevention of pregnancy

8.48 *P and P* was an appeal to the Full Court of the Family Court following the dismissal of an application for a hysterectomy for a seventeen-year-old girl.⁹² “Lessli” had been assessed as functioning within the low to moderate range of intellectual disability. Broad grounds for seeking approval of sterilisation were the prevention of menstruation and the risk of pregnancy.⁹³ The court-appointed neurologist thought Lessli vulnerable to sexual abuse, but also thought it likely that she might in the future engage in consensual sexual activity, possibly with others having similar disabilities to herself.⁹⁴ The Full Court accepted this, adding that Lessli should not be deprived of such experiences and that doing so would discriminate against her because of her disability. The trial judge had previously taken the view that Lessli was unable to engage in consensual intercourse, and that therefore any such act would constitute a sexual assault.⁹⁵ Despite the fact that Lessli had been assaulted once on a previous occasion, the trial judge was not satisfied that she would be at sufficient risk to warrant such an invasive procedure. The Court observed:⁹⁶

[The trial judge] commented that it was fully recognised that the intellectually disabled have every right to experience sexual pleasure and to enjoy a sexual relationship. However, her Honour appears to have considered that

89. *Re Marion (No 2)* (1992) 17 Fam LR 336, 352-353.

90. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 23.

91. Western Australian Law Reform Commission, *Consent to Sterilisation of Minors*, Report No 77(II) (1994) [2.35] – [2.37], [2.44].

92. For overlap of State and federal jurisdictions see para 8.69.

93. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 10.

94. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 14.

95. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 11.

96. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 14.

the degree of disability suffered by Lessli in some way disqualified her from exercising that right. In this regard we think that her Honour confused the possible criminal law consequences to others of engaging in sexual conduct with Lessli with Lessli's own rights in that regard. Further, if Lessli were to engage in consensual intercourse with a male suffering a similar level of intellectual disability, we doubt the correctness of the proposition that she would be regarded as the victim of a sexual assault. While not discounting the vulnerability of young women with intellectual disabilities to criminal sexual assault the greater problem lies in the risk of pregnancy resulting from such activity, or from a sexual assault in the criminal sense.

8.49 The Court was prepared to sanction a sterilisation in order that Lessli might engage in sexual activity free of the possible consequence of pregnancy.⁹⁷ In his earlier dissenting judgment in *Marion's case*, Justice Brennan had observed that:⁹⁸

[w]here it is desirable to avoid the risk of pregnancy, the risk may be avoidable by means which involve no invasion of the girl's personal integrity. Those who are charged with responsibility for the care and control of an intellectually disabled girl ... have a duty to ensure that the girl is not sexually exploited or abused. If her disability inclines her to sexual promiscuity, they have a duty to restrain her from exposing herself to exploitation. It is unacceptable that an authority be given for the girl's sterilization in order to lighten the burden of that duty, much less to allow for its neglect. ... If a non-therapeutic sterilization could be justified at all, it could be justified only by the need to avoid a tragedy that is imminent and certain. Such a situation bespeaks a failure of care, and sterilization is not the remedy for the failure.

The Full Court responded⁹⁹ that the purpose of sterilisation:

is not to lighten the burden of the carers but to avoid the risk to the child of an unwanted pregnancy. We would nevertheless be concerned if the burden placed on the carers was to be so high as to require them to render a child such as Lessli a virtual prisoner. We think that there is much to be said for the approach of Lessli's mother in this case, which according to the evidence, is to enable Lessli to live as open a life as possible, within her capacities. However it must be recognised that such an approach carries with it certain risks. ...

The real purpose of the procedure is ... to protect the child from the consequences of sexual intercourse, which ... need not necessarily occur as a result of intentional sexual abuse, but would in this case have a serious effect upon her welfare.

8.50 The Court agreed with the trial judge's assessment that Lessli's welfare would be detrimentally affected by a pregnancy or by a termination of one.¹⁰⁰ However it rejected

97. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 17.

98. *Marion's case* (1992) 175 CLR 218, 276.

99. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 17.

100. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 15.

her proposition that preserving Lessli's fertility would help protect her from, and enable the detection of, sexual assault. It would neither protect her from the risk of assault nor necessarily reveal the identity of the perpetrator. Sterilisation, likewise, would not protect her from an assault, only from the possible consequence of pregnancy.¹⁰¹ The Court might have added that, conversely, absence of pregnancy is not evidence of absence of abuse.

Compartmentalisation

8.51 The Full Court of the Family Court has considered, and rejected, the notion of "compartmentalisation". This term describes the approach that considers in isolation, rather than as part of a larger picture, the various grounds that might underpin an application for sterilisation. For example, in its report on the sterilisation of children, the Family Law Council recommended that legislation governing the area should indicate four situations in which the procedure could never be authorised. These scenarios included sterilisation "purely for contraceptive purposes" and "as a means of ... avoiding the consequences of sexual abuse".¹⁰² The Court commented:¹⁰³

The [Family Law] Council has said that sterilisation can never be justified to prevent pregnancies arising from sexual abuse or solely as a means of contraception. The difficulty about these cases is that the relevant circumstances can rarely be looked at in isolation as this approach tends to do.

...The danger involved with the Council's approach is that, taken literally, it may lead to the adoption of an approach that these factors are to be ignored in the decision making process, which in our opinion would make a travesty of it. The other danger is that of compartmentalisation, which may lead a decision maker to lose sight of the overall object, which is that the best interests or welfare of the particular child are paramount.

8.52 In contrast with a compartmentalised approach, the Court's view in *P and P* is that the various factors are "interactive and cumulative".¹⁰⁴ This extends to the fact of the applicant's intellectual disability. The Court disapproved of the trial judge's importation into her assessment of a "but for" test, that is asking whether the procedure would be performed "but for" the disability, if it would not be performed on a girl of similar age with normal intelligence.¹⁰⁵ It stated:

While it may be superficially attractive to impose this sort of test upon the basis that it is non discriminatory and equates the intellectually handicapped person with the non intellectually handicapped, we think that upon analysis it has the opposite effect. ...

We are unconvinced that there is any relevant conclusion to be drawn with regard to the best interests of a particular child by an artificial exercise which

101. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 15-16.

102. Family Law Council, *Sterilisation and Other Medical Procedures on Children*, Report (1994) Rec 3.

103. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 18.

104. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 21.

105. *P and P and Legal Aid Commission of NSW* (1995) 19 Fam LR 1, 20.

compartmentalises a finding of fact about an immutable characteristic and then hypothesises that it were not so. Lessli's intellectual disability cannot be isolated as a factor and then "subtracted" from the constellation of facts about her, any more than one can simply imagine that she no longer suffers from epilepsy, or that she is infertile, or that she is not a female.

Legislative requirements

8.53 Unlike that of some other States, NSW legislation does not contain specific grounds upon which sterilisation applications may never be approved. As mentioned previously,¹⁰⁶ for young persons between the ages of 16 and 18 (as well as adults above this age) the *Guardianship Act 1987* (NSW) restricts the Tribunal from giving consent unless it is satisfied that the proposed treatment is necessary to save life or prevent serious damage to health.¹⁰⁷ In the case of young persons under the age of 16 the *Children and Young Persons (Care and Protection) Act 1998* (NSW) requires the Tribunal to be 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.¹⁰⁸

8.54 Most applications for sterilisation concern persons over 16. The Guardianship Tribunal has examined only two cases, "BH" and "VF", that fall under the *Children and Young Persons (Care and Protection) Act 1998* (NSW), both involving girls aged 14. The Reasons for Decision in both cases referred to the decision of the NSW Supreme Court in *JLS v JES*,¹⁰⁹ involving an application for consent to sterilisation under s 20B of the earlier *Children (Care and Protection) Act 1987* (NSW). Section 20B(2A) of that Act stated that consent to the carrying out of special medical treatment on a person under 16 could not be given unless the Court was satisfied that the treatment was necessary "to save the child's life or to prevent serious damage to the child's health." This provision was therefore more akin to the present s 45 of the *Guardianship Act 1987* (NSW) than the arguably less restrictive section under which "BH" and "VF" actually fell to be decided, namely s 175(3) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). In *JLS v JES* Justice Bryson stated:¹¹⁰

The test stated in [sub-section] 2A means that the consent of the court under s 20B cannot be given on grounds related only to views about the child's management and social integration, or to perceptions of the child's well-being that are not related to the prevention of serious damage to the child's health.

106. See para 8.15 – 8.16.

107. *Guardianship Act 1987* (NSW) s 45(2).

108. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175(3).

109. *JLS v JES* (1996) 20 Fam LR 485.

110. *JLS v JES* (1996) 20 Fam LR 485, 486.

8.55 In its Reasons for Decision in the matter of “BH”¹¹¹ the Tribunal considered an application for a hysterectomy being sought to manage menstrual problems. The Tribunal commented:

[i]n accordance with the terms of the [Children and Young Persons (Care and Protection) Act 1998 (NSW)], the Tribunal in this matter had to be satisfied that the proposed treatment was necessary, in that no alternative treatment could adequately address the needs of Miss H.

Further, it was required to focus on the interests of BH, noting in particular that the proposed surgery was “significant” and irreversible. As no other options had been explored, the Tribunal felt it had insufficient evidence to determine whether the procedure sought was necessary. The hearing was adjourned for six months to allow further information to be provided, however the matter was ultimately withdrawn.

8.56 Consent to sterilisation was granted in the case of “VF”.¹¹² Due to a severe congenital abnormality, VF suffered a great deal of pain, as well as disruption to her school life and social and sporting activities. She had undergone surgery a number of times, but this had not resolved the problems. The Tribunal found that the proposed treatment was necessary. It was satisfied that there was no viable alternative, and that without it she would suffer serious damage to her physical and psychological health and her life would be endangered.

8.57 The Tribunal stated that in interpreting s 175(3) it could be guided and directed by the objects and principles of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), particularly those focusing on the child’s safety, welfare and well-being, which are the paramount consideration.¹¹³ It was satisfied that the “stringent requirements” of s 175 had been met in this case.

8.58 “LQ”¹¹⁴ concerned an application brought under the *Guardianship Act 1987* (NSW) for the sterilisation of a 21-year-old woman with a moderate intellectual disability. The Tribunal found she was unable to manage menstruation “in a way which [would] allow her to carry out her normal activities.” It took into account a dictionary definition of health as being “spiritual, moral or mental soundness”, observing that “it is well recognised that ‘health’ is a concept encompassing much more than physical or bodily well being and refers to the whole person.” The Tribunal accepted evidence “as to the likely detrimental effects on “LQ’s” social and work opportunities and access to activities which are currently available to her, if some method of managing her menstruation is not found.” The Tribunal concluded:

111. NSW Guardianship Tribunal, *Application for consent to special medical treatment for Miss BH*, November 2005. The matter was adjourned in order to allow further evidence to be put before the Tribunal in support of the application which was ultimately withdrawn.

112. NSW Guardianship Tribunal, *Application for consent to special medical treatment for Miss VF*, February 2007.

113. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 8, 9.

114. NSW Guardianship Tribunal, *Application for consent to special medical treatment for Miss LQ*, March 2003.

that this deprivation would, on the balance of probabilities, be damaging to LQ's mental and spiritual health. This finding has to be made in the context of the actual circumstances of LQ's life. LQ's disability closes some opportunities to her open to an entirely independent person of her age without that disability. The effect on her of a further restriction of social opportunities and life satisfaction must be evaluated in the light of that fact and is, therefore, more serious for her than it might be for a person who is not similarly disabled.

8.59 The Tribunal stated that it had to take into account that “the dislocation and distress caused to LQ by the continuation of menstruation will be likely to be repeated twelve times a year for thirty years”, the “likely cumulative, long term effect” of which would be “serious”. It was not in accordance with the legislative provisions that LQ “be put through the experience of suffering distress and social deprivation, risking damage to her mental health, to prove conclusively that such damage will actually occur.”

8.60 In the Commission's view, “LQ” seems to have more in common with *Marion's case* and *P and P* than *JLS v JES*, in terms of the test applied, which seems closer to a “best interests” approach than one that would normally be understood as purely a “medical necessity”.

8.61 The NSW Guardianship Tribunal is not a court of precedent, so is not bound by its previous decisions. It is an independent decision-making body. Each three-person Tribunal panel, constituted from amongst some 77 part-time members,¹¹⁵ must apply the relevant legislative provisions to the circumstances of each particular case. The Tribunal is able to take a range of evidence into account before making a decision as it is not bound by the rules of evidence and may inform itself in any manner it thinks fit. Its focus is on

*the physical, psychological, social and emotional needs of the person the hearing is about. This enables the Tribunal to take a holistic approach to its decision-making.*¹¹⁶

The Commission's view

8.62 In the Commission's view the Guardianship Tribunal's stated “holistic” approach, in taking various needs of the applicant into account, is necessary to ensure that all relevant factors are considered before making decisions with potentially serious and life-changing consequences. In order to do so, the Tribunal appears to have taken a broad interpretation of its powers under the two relevant Acts. The current test contained in s 175(3) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), as applied in the Reasons for Decision cited earlier, seems to be working well, although the number of matters heard has been small.

8.63 Looking at the bigger picture, however, the Commission is concerned that as far as practicable, the statutory regime should encourage parents and carers to seek authorisation before undertaking a special medical treatment for a young person. It is

115. NSW, Guardianship Tribunal, *Annual Report 2005-2006*, 5.

116. NSW, Guardianship Tribunal, *Annual Report 2005-2006*, 5.

possible that as things stand, procedures such as sterilisation are undertaken without lawful authorisation having been sought. Reliable statistics are probably impossible to obtain.¹¹⁷ Bypassing the courts or Guardianship Tribunal to perform special treatments without authorisation carries the risk that insufficient scrutiny and care inform these decisions, and that the human rights of young persons, especially those with disabilities, may be abused.

8.64 In IP 24 we discussed the overlapping power of various forums with jurisdiction in this area, and the potential uncertainty or confusion regarding the limits of, and the different criteria operating within, each jurisdiction.¹¹⁸ Additionally this opens up the possibility of “forum-shopping”,¹¹⁹ whereby the parents may bring consecutive applications in various courts or the Tribunal if the initial application has failed. This situation may lead to added cost, delay and an ineffective use of judicial resources, the antithesis of what a tribunal should achieve. The Commission believes that such detriments would be alleviated to a large extent if there were greater consistency between the tests operating in different jurisdictions. As well as acting as a deterrent to forum-shopping, consistency would also simplify the application of the law in this area by removing potentially confusing parallel tests, and providing a greater body of case law that could be drawn on to assist tribunals in interpretation.

8.65 The Family Law Council, whose function is to advise and make recommendations to the Commonwealth Attorney-General in relation to family law, called for “a statutory framework which clarifies the existing confusing array of provisions and ensures that a consistent national approach is adopted for the protection of all Australian children”.¹²⁰ The sterilisation of young people has been the subject of numerous other reports and has recently been examined by the Standing Committee of Attorneys-General (“SCAG”) to see whether a nationally consistent approach to authorisation can be formulated. In March 2008, SCAG decided not to pursue the development of national model legislation because existing legislation governing sterilisation in each jurisdiction appears to be working adequately and because of recent improvements in treatment options and education initiatives.¹²¹

8.66 In the Commission’s view it would be difficult to sustain an argument that the rights of young persons would be compromised if, in place of a “medical necessity” test, the best interests test, as applied by the courts in determining applications, were adopted by the legislature and applied by the Guardianship Tribunal. As we have said earlier, courts have been careful to enunciate strict limits on the power to authorise special medical

117. Susan Brady, John Briton and Sonia Grover, *The Sterilisation of Girls and Young Women: Issues and Progress* (Human Rights and Equal Opportunity Commission, 2001) 14-20, 56.

118. NSW Law Reform Commission, *Minors’ Consent to Medical Treatment*, Issues Paper No 24 (“IP 24”) (2004) [4.27] – [4.33].

119. IP 24 [4.29].

120. Australia, Family Law Council, *Sterilisation and Other Medical Procedures on Children*, Report (1994), 5.

121. Commonwealth, Attorney-General, media releases *28 March 2008 Communique – Standing Committee of Attorneys-General*, available at http://www.attorneygeneral.gov.au/www/ministers/robertmc.nsf/Page/Media_Releases (at 9 May 2008).

treatments, and it cannot be envisaged that the application of a best interests test could result in a young person undergoing a procedure that was not necessary to prevent serious damage to his or her physical and/or psychological health.

8.67 Other States' statutes provide useful models. For example chapter 5A of the *Guardianship and Administration Act 2000* (Qld) is concerned with consent to sterilisations of children with impairments, children being defined as those under 18.¹²² The Queensland Guardianship and Administration Tribunal may only consent to the sterilisation of a child if satisfied that it is in his or her best interests.¹²³ It is only regarded as being in the child's best interests if one or more of the following applies:¹²⁴

- (i) the sterilisation is medically necessary;
- (ii) the child is, or is likely to be, sexually active and there is no method of contraception that could reasonably be expected to be successfully applied;
- (iii) the child has problems with menstruation and its cessation by sterilisation is the only practicable way of overcoming this.

Other considerations to be taken into account include the feasibility of postponing the procedure, and whether the sterilisation is otherwise in the child's best interests. Similar grounds are prescribed by the *Guardianship and Administration Act 1993* (SA).¹²⁵ Sterilisation is not permitted by the Queensland statute for eugenic reasons or to remove the risk of pregnancy resulting from sexual abuse.

Recommendation 18

The legislation should provide that the Guardianship Tribunal must not consent to the carrying out of special medical treatment on a young person under the age of 16, or a young person aged 16 or 17 who is not competent to consent to health care, unless the Tribunal is satisfied that in all the circumstances it is in the best interests of the young person.

EFFECT OF OUR LEGISLATION ON OTHER LEGISLATION

8.68 Section 175 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) falls within Part 1 of Chapter 9, which deals with medical examination and treatment. Part 1 is entitled "Medical examination of children and young persons in need of care and protection". Section 175 deals exclusively with special medical treatment, and applies universally to young persons under 16, not just those in need of care and protection. Therefore, if our legislation is enacted there is no need for s 175 to remain in

122. *Guardianship and Administration Act 2000* (Qld) s 80A. Chapter 5 deals with special treatments for adults.

123. *Guardianship and Administration Act 2000* (Qld) s 80C(2).

124. *Guardianship and Administration Act 2000* (Qld) s 80D.

125. *Guardianship and Administration Act 1993* (SA) s 61.

the existing Act. Other provisions in Chapter 9 that relate to young people in need of care and protection or in out-of-home care should not be affected.

Recommendation 19

If Recommendations 16 to 18 are implemented, Chapter 9 Part 1 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), should be restricted in its application to young persons in need of care and protection.

JURISDICTION

8.69 The proposed legislation will not oust the jurisdiction of the Supreme Court or the Family Court to authorise special medical treatments. This is why the possibility of forum-shopping, referred to earlier, continues to be a live issue, regardless of whether new legislation is enacted or not. However, the adoption of Recommendation 18 would make this much less likely.

8.70 Section 247 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) states that nothing in that Act limits the jurisdiction of the NSW Supreme Court. In a similar way the provision concerned with special medical treatments in the proposed Act should, for the sake of clarity, acknowledge that the Supreme Court may also authorise such applications. The *Guardianship Act 1987* (NSW) already makes clear that the Supreme Court may hear appeals from decisions of the Guardianship Tribunal.¹²⁶

Recommendation 20

The legislation should contain a provision stating that nothing in the Act limits the jurisdiction of the Supreme Court.

126. *Guardianship Act 1987* (NSW) s 67.

9. Complying with the new legislation

- Existing grounds of liability
- The new legislative scheme

EXISTING GROUNDS OF LIABILITY

9.1 In the preceding chapters, the Commission spoke of certain “rights” which underlie the decision-making process for young people’s health care: a right to autonomy, a right to participate, a right to decide, a right to exercise parental control over your child. To some extent, discussion in this area has been shaped by the case law and commentary in other Western countries that give legal recognition to these rights.¹ In Australia, there is very little constitutional or legislative recognition of human rights as legally enforceable entitlements. Instead, it has been left mainly to the common law, with modifications and additions made by legislation, to develop responses to situations where a health practitioner acts contrary to the decision of the person authorised to make a decision about the health care in question. As a consequence, the responses – and the reasoning underlying those responses – have been limited, and have been built largely on long-established common law principles, rather than on a broader and more modern consideration of the rights of those involved in the decision-making.

9.2 Currently, health practitioners who provide health care without first receiving a valid consent from the person authorised to give that consent, may face the following consequences.²

Civil liability for trespass to the person

9.3 A practitioner who provides treatment without the requisite consent may be civilly liable for trespass to the person, that is, for battery, assault or false imprisonment.

9.4 To be civilly liable for battery, it must be shown³ that one person directly caused some physical contact with another person, and that that person did not consent to the physical contact. There is no need for the touching to be accompanied or motivated by hostile intent, nor is it necessary to show that the person with whom contact was made suffered any injury as a result of the physical contact. A health practitioner who touches a person in the process of treating him or her, and mistakenly believes that a legally valid consent has been obtained, may therefore be civilly liable for battery.

9.5 A practitioner may be liable for assault if he or she causes a person to apprehend the infliction of bodily harm. Assault and battery may be committed in quick succession.

9.6 False imprisonment occurs when a voluntary act of one person directly subjects another person to total deprivation of freedom of movement, and the person restrained did not consent to the restraint. 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.⁴ It is not necessary that the person restrained be aware of the

1. See para 1.13-1.17.

2. The practitioner will not be liable where consent is not a prerequisite to treatment: see Chapter 7.

3. For battery, assault and false imprisonment, the civil standard of proof is required, that is, the plaintiff’s case must be proven on the balance of probabilities.

4. See *Bridgett v Coyney* (1827) 1 Man & Ry 211, 215-216.

restraint at the time,⁵ nor that the act occasioning the false imprisonment be motivated by malice.⁶ A health practitioner who acted with a patient's best interests in mind could still be liable for false imprisonment.

9.7 It is not necessary to prove damage in order to establish a claim for trespass. Compensation may be payable for outraged feelings, and may include aggravated damages. Exemplary damages are also awardable but where there has been no loss, damages may be nominal.⁷

Civil liability for negligence

9.8 A health practitioner may be civilly liable in negligence for failing to disclose all the material risks of the proposed treatment, as a result of which the person receiving the treatment suffers damage. A risk is a material risk (and therefore one that should be disclosed) if, in the circumstances of the 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 health practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

9.9 Negligence focuses not on the patient's consent, and his or her competence to give that consent, but on the information that is passed on by the practitioner to the patient. However, as we mentioned in Chapter 1,⁸ the test for competence for young people to consent to treatment contains elements of the doctrine of negligence, in so far as it considers the extent to which a young person understands not just the general nature of the proposed treatment, but also its consequences (including, presumably, its foreseeable risks).⁹

9.10 Unlike trespass, a claim in negligence requires proof of injury resulting from the negligent act or omission. Part 2 of the *Civil Liability Act 2002* (NSW) now limits the recovery of damages for negligence in New South Wales. The Act excludes recovery of exemplary or aggravated damages for negligence.¹⁰

Criminal liability

9.11 Just as a health practitioner may be civilly liable for trespass to the person, so may he or she be criminally liable for unauthorised physical contact, or the apprehension of unauthorised contact, or the physical deprivation of liberty. A practitioner may be liable for assault occasioning actual bodily harm under s 59 of the *Crimes Act 1900* (NSW), or for assault not occasioning actual bodily harm under s 61 of the *Crimes Act 1900* (NSW). A practitioner may also be liable for the common law offence of false imprisonment. Section 49 of the *Minors (Property and Contracts) Act 1970* (NSW), in so far as it gives

5. *Meering v Grahame-White Aviation Co Ltd* (1919) 122 LT 44; *Murray v Ministry of Defence* [1988] 2 All ER 521.

6. See *Cowell v Corrective Services Commission of NSW* (1988) 13 NSWLR 714.

7. See Law Book Company, *Laws of Australia*, vol 33 (at 3 August 2007) [33.10.230].

8. See para 1.11-1.12.

9. This is not affected by the *Civil Liability Act 2002* (NSW).

10. See *Civil Liability Act 2002* (NSW) s 21.

protection from “a claim for ... assault and battery”, protects medical and dental practitioners from civil liability only, not from criminal liability.

Disciplinary action

9.12 A health practitioner who treats a patient without a legally valid consent may face disciplinary action either by way of a complaint made to the Health Care Complaints Commission, or to the relevant health registration authority if the practitioner is registered under a health registration Act.

9.13 The *Health Care Complaints Act 1993* (NSW) provides a scheme for complaints against health practitioners to be heard and dealt with by the Health Care Complaints Commission, in addition to or instead of¹¹ any authority that oversees the health profession of which the practitioner in question is a member (such as the Medical Board for doctors). The primary object of the Health Care Complaints Commission is to protect the health and safety of the public.¹² As such, its focus is not on compensating individuals for wrongdoing done to them by health practitioners. Instead, it assesses consumers’ concerns about the provision of health services. In appropriate cases, it prosecutes practitioners before the relevant disciplinary body to ensure that those not meeting expected levels of professional conduct are dealt with by their professional body. It also investigates and sometimes makes recommendations for change to health services against which there has been a complaint.¹³

9.14 The Health Care Complaints Commission may respond to a complaint in a number of ways including conciliating the matter or referring it to the Director of Proceedings who may choose to prosecute the matter before a disciplinary body. There are also mechanisms for the Health Care Complaints Commission to deal with complaints against unregistered health practitioners.¹⁴ The grounds on which a complaint may be made to the Commission are very broad, and include a complaint “about the professional conduct of a health practitioner”.¹⁵ In consultation, the Health Care Complaints Commission took the view that the grounds for complaining against a health practitioner under the *Health Care Complaints Act 1993* were currently broad enough to encompass a complaint against a practitioner for treating a young person without first obtaining a valid consent. It noted, however, that such complaints are extremely rare, although it is not possible to know

11. Section 14 of the *Health Care Complaints Act 1993* (NSW) provides that a health registration authority must not take any action in relation to a complaint while it is the subject of an investigation by the Health Care Complaints Commission. Section 39(1)(c) provides that the Health Care Complaints Commission may take action against a complaint which it has investigated by (among other things) referring it to the health registration authority involved (if any) in order for the authority to consider taking action under the relevant health registration Act.

12. *Health Care Complaints Act 1993* (NSW) s 3(2).

13. See NSW, Health Care Complaints Commission, *Annual Report 2007-2008*, 2, 10.

14. See *Health Care Complaints Act 1993* (NSW) Part 2 Division 6A.

15. See *Health Care Complaints Act 1993* (NSW) s 7(1).

whether this is due to the fact that such incidents seldom arise, or whether young people, their parents, and other interested people are not aware that they can complain.¹⁶

9.15 In conjunction with the mechanisms set up under the *Health Care Complaints Act 1993* for making complaints against health practitioners, there is a number of Acts governing specific registered health professions which allow for complaints to be made regarding a practitioner's conduct.¹⁷ For example, Part 4 of the *Medical Practice Act 1992* (NSW) provides for complaints to be made to the Medical Board or the Health Care Complaints Commission against a registered medical practitioner. The Part sets out the grounds on which such a complaint may be made. These include a claim that the practitioner has been guilty of unsatisfactory professional conduct or professional misconduct.¹⁸ "Unsatisfactory professional conduct" is defined to include conduct that is significantly below the standard reasonably expected of a practitioner of an equivalent training and experience, as well as any other improper or unethical conduct relating to the practice of medicine.¹⁹ "Professional misconduct" is defined as unsatisfactory professional conduct that is of a sufficiently serious nature to justify suspension from practising medicine or removal from the Register.²⁰

9.16 It is clear that the grounds on which a complaint can be made either to the Health Care Complaints Commission or the relevant registration authority of a registered health profession are broad. While there is no specific ground for complaining that health care has been provided without a valid consent, notions of a practitioner's "professional conduct" and "unsatisfactory professional conduct" appear general enough to cover situations where no valid consent for treatment has been obtained. However, in the absence of any express legislative provision which spells out the availability of this complaint mechanism for complaints relating to young people's consent, it is possible that people are not aware that they can complain. It may also be difficult to establish that a practitioner was guilty of unsatisfactory professional conduct by not obtaining a valid consent: given the uncertain state of the current law and the widespread confusion among practitioners about what the law is, it could be difficult to establish that a particular practitioner's conduct in relation to a young person was significantly below the standard that could be expected of a practitioner of that level of training and experience.

Young people's health care not involving physical contact

9.17 For the most part, the grounds for civil and criminal liability for providing health care to a person without consent have been based on the premise that the health care involves physical contact of some kind. The common law developed these lines of liability based on the notion of the physical integrity of the individual, and a general prohibition against

16. See NSW, Health Care Complaints Commission, *Consultation*.

17. See *Chiropractors Act 2001* (NSW); *Dental Technicians Registration Act 1975* (NSW); *Medical Practice Act 1992* (NSW); *Nurses and Midwives Act 1991* (NSW); *Optical Dispensers Act 1963* (NSW); *Optometrists Act 2002* (NSW); *Osteopaths Act 2001* (NSW); *Pharmacy Act 1964* (NSW); *Physiotherapists Act 2001* (NSW); *Podiatrists Act 2003* (NSW); *Psychologists Act 2001* (NSW).

18. *Medical Practice Act 1992* (NSW) s 39.

19. *Medical Practice Act 1992* (NSW) s 36.

20. *Medical Practice Act 1992* (NSW) s 37.

trespass to the person. An exception to this requirement for physical contact as a precondition to liability is civil liability for negligence. Negligence does not require physical contact, focusing instead on the conduct of the health practitioner in so far as this relates to the patient's understanding of the proposed treatment.

9.18 It follows that a practitioner who treats a young person without a valid consent, where the treatment does not involve physical contact, may be uncertain as to what grounds of liability, if any, he or she potentially faces. For example, a medical practitioner who prescribes a thirteen-year-old girl the oral contraceptive Pill, where that young girl is not competent to consent to such treatment, may be unsure of the consequences, if any, that will follow. There has been no physical contact with her, and in most cases it seems unlikely that the practitioner will be found to have deprived the young patient of her freedom to the extent of being liable for false imprisonment. It is possible that he or she may be found liable in negligence, but such a claim could only succeed if it can be shown that the young girl suffered damage as a result of the practitioner's negligent act.

Injunctive or declaratory relief

9.19 A person may apply for an injunction to stop the doing of a wrongful act or to require that a particular act be done. In the context of providing health care to a young person, for example, a parent could apply to the court for an injunction to stop a practitioner from treating a young person based on that young person's consent, on the basis that the consent is not valid and that consent should instead be sought from the parent.

9.20 Alternatively, a declaration may be sought from a court that declares the nature of the legal rights and obligations of the parties in relation to the dispute before the court.²¹ For instance, in *Gillick*, Mrs Gillick sought a declaration as to the legality of the guidance that had been issued by the health service.

21. Law Book Company, *Laws of Australia*, vol 15 (at 1 July 1998) [15.5.1].

THE NEW LEGISLATIVE SCHEME

Recommendation 21

The legislation should provide for it to be a ground for complaint to the Health Care Complaints Commission and/or to the relevant health registration authority that a health practitioner acted in breach of the provisions of the legislation. The legislation should make it clear that any action available to the Health Care Complaints Commission and/or to a health registration authority under the *Health Care Complaints Act 1993* (NSW) or a health registration Act (as defined in Recommendation 3), including alternative dispute resolution, is available to resolve complaints about breaches of this legislation relating to young people's competence.

Recommendation 22

The legislation should make it clear that nothing in Recommendation 21 affects any other grounds of liability that might arise from a complaint against a practitioner for breaching the provisions of the legislation.

Recommendation 23

The legislation should provide for a defence for health practitioners from civil or criminal liability, or from a complaint made to the Health Care Complaints Commission or a health registration authority, where such action is based on a practitioner's assessment of a young person's competence, according to Recommendation 4 (but not where it is based on grounds other than competence, such as negligence). The defence should be available if the health practitioner reasonably but mistakenly believes that the young person is competent or incompetent, according to the criteria set out in Recommendation 4.

9.21 There are clearly a number of avenues of complaint already available against a health practitioner who may have acted without obtaining a valid consent. The possible shortcomings in the current law relate primarily to complaints involving non-touching treatment, as well as a practitioner's refusal to treat a young person based only on the young person's (possibly valid) consent. In the first of these situations, the most likely civil action currently lies in negligence, although liability cannot be established if there is no proof of injury. In the latter situation, there is the possibility of complaint to the Health Care Complaints Commission, or to the relevant health registration authority, but no real ground for civil liability.

9.22 In both these types of situations, the crux of the complainant's grievance relates more to outraged feelings than to any physical injury or damage to property, something which the current law is ill-equipped to address. The Commission has debated the possibility of recommending the introduction of a separate cause of civil action to redress this shortcoming, an action that would not be linked to the need for any physical contact or injury. Ultimately, we have decided against doing this because we consider that it is more appropriate to deal with these types of grievances through the existing avenues of complaint available with the Health Care Complaints Commission and the relevant health registration authorities.

9.23 To this end, under Recommendation 21, the legislative scheme which we are recommending will include a provision expressly referring complaints for breaches of the legislation to the Health Care Complaints Commission and/or the relevant health registration authority. We concede that this recommendation is strictly unnecessary, in so far as the existing legislation is broad enough already to include treatment without a valid consent as a ground for complaint. Nevertheless, it is worthwhile to state this expressly as a ground in legislation dealing specifically with the provision of health care to young people, legislation that is aimed, among things, at making the law in this area more readily understood and more easily applied. Recommendation 22 makes it clear that any provision referring complaints to the Health Care Complaints Commission or to a health registration authority is not intended to affect any other ground of liability that might arise from breaches of the recommended legislation. In turn, Recommendation 23 provides for a defence to practitioners who make an honest but reasonable mistake in their assessment of a young person's competence.

Breach of a statutory duty?

9.24 If, following on from this report, legislation is enacted to regulate the assessment of young people's competence and the responsibilities of practitioners to obtain a valid consent, then civil liability may possibly arise from a failure to comply with the legislation. A practitioner in this situation may be liable in tort for a breach of a statutory duty. To establish liability on this ground, it would need to be shown that, in enacting the legislation, the legislature created a duty intended to protect a specified class of people, and the rights of a person within that class had been infringed.²² Crucial to establishing a statutory duty is proof that Parliament intended to protect a specified class of people and intended to create a private right of action for breach of the duty.²³ Parliament's intention can be most readily shown by an express provision in the legislation creating a private right of action, but this is not essential to establishing a statutory duty. The legislation as a whole must be considered, including the policies that underlie it. The tort of breach of a statutory duty has traditionally arisen from breaches of legislation relating to industrial safety, where it has been found that a private right of action arises from breach of a legislative provision

22. Law Book Company, *Laws of Australia*, vol 33 (at 3 August 2007) [33.5.140].

23. The other three elements of this tort are: that the plaintiff was a person within the class of persons intended to be protected, the defendant was a person whose conduct fell within the statutory prescription; that the obligation imposed by the statute was breached; and that the plaintiff suffered damage as a result of the breach. See Law Book Company, *Laws of Australia*, vol 33 (at 3 August 2007) [33.5.160]; *Downs v Williams* (1971) 126 CLR 61, 75 (Windeyer J).

prescribing a specific precaution for the safety of others in matters where a person owes a duty of care under the general law of negligence.²⁴ Factors which may indicate that there was no intention to create a statutory duty include the provision of a remedy other than a tortious remedy, the availability of an alternative to provide compensation, and the provision of a penalty. Once established, a breach of a statutory duty requires proof of damage by way of personal injury or damage to economic or property interests. Damage to other interests, such as outraged feelings or privacy, is not compensable.²⁵

9.25 In the context of our proposed legislation, there are certainly grounds for arguing that tortious liability could arise from its breach on the basis of a breach of a statutory duty. The legislation could be described as creating an obligation on practitioners to provide a service to young people only after obtaining a consent in a manner prescribed by the legislation and that the aim of these provisions is to protect young people as a specified class of people. A private right of action could be found to lie against practitioners who breach their obligations under the recommended legislation in situations where they otherwise owe a duty of care under general negligence law. On the other hand, the existence of alternative remedies or complaint mechanisms, such as referral to the Health Care Complaints Commission or professional body, may argue against the existence of a private right of action, although as noted in paragraph 9.13, the focus of these complaint processes is not so much compensating the complainant as protecting the health and safety of the public by ensuring that practitioners comply with an expected standard of professional conduct. In short, while there are grounds for arguing that tortious liability will arise from breach of the recommended legislation, this will depend on whether or not the courts are willing to ascribe a legislative intention to do so, assuming that the legislation does not itself contain an express provision to this effect. We have decided against going so far as to recommend express provision in the legislation for the creation of a statutory duty, the breach of which may give rise to a cause of action. There may be very limited practical benefit in such an action in situations where there has been no physical injury caused by the breach, but more injury to feelings.

24. See *O'Connor v SP Bray* (1937) 56 CLR 464.

25. See *JD Bell (Calool) Pty Ltd v Shortland County Council* (1991) 74 LGRA 398, 401; *Pickering v Liverpool Daily Post and Echo Newspapers* [1991] 2 AC 370. See Law Book Company, *Laws of Australia*, vol 33 (at 1 August 2007) [33.5.260].

Appendices

- Appendix A: Submissions received
- Appendix B: Consultations
- Appendix C: Public forum

APPENDIX A: SUBMISSIONS RECEIVED

Youth Justice Coalition, 10 January 2004

Androgen Insensitivity Syndrome Support Group Australia, 26 August 2004

Dr Stephania Siedlecky AM, 29 August 2004

Faculty of Nursing, Midwifery & Health, University of Technology, 29 August 2004

National Children's and Youth Law Centre, 31 August 2004

Shopfront Youth Legal Centre, 31 August 2004

NSW Commission for Children and Young People, 13 September 2004

Doctors Reform Society, 14 September 2004

Redfern Legal Centre, 28 September 2004

Youth Action Policy Association, 27 October 2004

NSW Council for Intellectual Disability, 21 December 2004

Mr George Tomossy, 8 April 2005

Australian Dental Association (NSW Branch), 26 June 2008

APPENDIX B: CONSULTATIONS

Youth Advisory Council, 13 August 2004

Youth Action and Policy Association, 6 October 2004

Dr S Towns, Department of Adolescent Medicine, Children's Hospital at Westmead, 15 August 2006

Dr M Kang, Department of General Practice, University of Sydney, 15 August 2006

Dr J Starling, Ms M English, Ms K Munro, Ms D Rose, Dr J Tubby, Ms M Pinter, Dr D Dossiter, Department of Psychological Medicine, The Children's Hospital at Westmead, 6 September 2006

Clin/Prof David Bennett, Head, Centre for the Advancement of Adolescent Medicine, 6 September 2006

Dr S Trethewie, Department of Palliative Care, Sydney Children's Hospital at Randwick, 22 September 2006

Department of Pain and Palliative Care, Children's Hospital at Westmead, 9 October 2006

New South Wales Youth Health Council, 17 October 2006

Australian Medical Association (Dr Chooung-Liew Young and Dr M Grickrunah), 19 October 2006

Ms Joanna Kelly (NSW Department of Health), Ms Glenn Juiger (Office of the NSW Privacy Commissioner), Mr Duncan McInnes (NSW Parents Council), Ms Michelle Bouuer (NSW Council of Social Services), 9 November 2006

Associate Professor Marilyn Walton, 10 January 2007

Dr N Olbourne and Ms P Garcia, Australian Society of Plastic Surgeons, 7 February 2007

NSW Guardianship Tribunal (Diane Robinson, President, Esther Cho, legal officer), 21 September 2007

NSW Health Care Complaints Commission, 28 February 2008

Public Forum: Minors' Consent to Medical Treatment

Monday 27 November 2006
NSW Parliament House
Convened jointly by The Division
of Law, Macquarie University and
The Law Reform Commission of NSW



PROGRAMME

- 8:30 - 9:00 Registration**
9:00 Opening of Forum: The Hon James Wood QC, NSW Law Reform Commission
- 9:15 - 10:45 Minors' Consent to Medical Treatment and the Law**
This session will explore the role of legal systems in regulating minors' capacity to consent to medical treatment, drawing upon comparative approaches from other jurisdictions.
Chair: Michael Tilbury, NSW Law Reform Commission
Speaker: Derek Morgan, Faculty of Law, Queensland University of Technology
"International Developments on the Law on Minors' Consent to Medical Treatment"
Discussants: David Worswick, School of Law, Flinders University
 Michael Fasher, Royal Australian College of General Practitioners, NSW & ACT Faculty
 Michelle Taylor - a young person's perspective
Discussion
- 10:45 - 11:15 Morning Tea**
- 11:15 - 12:30 Special Treatments: Special Dilemmas**
Chair: Gillian Calvert, NSW Commissioner for Children and Young People
This session will examine different special treatment categories in consent to treatment legislation relating to minors. It will address the rationale for setting limits on minors' capacity to consent to different types of treatment, outline possible inconsistencies and alternative approaches.
Professor Richard Chisholm: Commentary on *Re Kevin* and *Re Alex*
Issue 1: Palliative Care - Mary Chiarella, Centre for Health Services Management, University of Technology Sydney
Issue 2: Bone Marrow Transplantation - Tracey O'Brien, Cord & Marrow Transplant Program, Centre for Children's Cancer and Blood Disorders, Sydney Children's Hospital
Issue 3: Genetic Testing - Fiona Richards, Dept. of Clinical Genetics, Children's Hospital at Westmead
Discussion
- 12:30 - 13:30 Lunch**
- 13:30 - 14:45 Minors with Special Needs**
This session will examine areas where minors may have special needs in the context of law reform on the area of minors' consent to medical treatment.
Chair: Deborah Frew, NSW Health
Issue 1: Street Kids - Melissa Kang, Department of General Practice, Children's Hospital at Westmead
Issue 2: Minors in Detention Settings - Robyn Rosina, Justice Health NSW
Issue 3: Aboriginal Health - James Ward, Aboriginal Health and Medical Research Council
Discussant: Jane Sanders, The Shopfront Youth Legal Centre
Discussion
- 14:45 - 15:10 Afternoon Tea**
- 15:10 - 16:30 Making Decisions: Guardianship and the Courts, Capacity and Consent**
This session will examine the role of tribunals and the courts in resolving problems related to minors' decision-making capacity and conflicts between families, healthcare providers and minors.
Chair: Diane Robinson, NSW Guardianship Tribunal
Speaker: Cameron Stewart, Division of Law, Macquarie University
Discussants: John Devereux, School of Law, University of Queensland
 David Dossetor, Area Director, Mental Health, Children's Hospital at Westmead
 Kerryn Boland, Children's Guardian for NSW
Discussion
- 16:30 - 16:45 Closing Remarks:** Rosalind Croucher, Dean, Division of Law, Macquarie University
Conclusion

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<i>AG, Re</i> [2007] NSWGT 1 (5 February 2007)	3.33, 3.34
<i>Alex, Re</i> (2004) 180 FLR 89; 31 Fam LR 503.....	4.20, 8.8, 8.9
<i>Auckland Healthcare Services Ltd v Liu</i> (unreported, High Court, Auckland, 11 July 1996, M812/96)	5.33
<i>Axon v Secretary of State for Health and Family Planning Association</i> [2006] QB 539; [2006] 2 WLR 1130	2.10, 2.13, 2.49, 4.12, 4.21
<i>B (A Minor) (Wardship: Medical Treatment), In re</i> [1981] 1 WLR 1421	2.55
<i>B, Re (Wardship: Abortion)</i> [1991] 2 FLR 426	2.58
<i>B v British Columbia (Director of Child, Family and Community Service)</i> [2005] BCSC 573	5.24
<i>BH, Application for consent to special medical treatment</i> (unreported, NSW Guardianship Tribunal, March 2005)	8.55
<i>Birkett v Central Sydney Area Health Service</i> (Unreported, NSW Court of Appeal, Priestly, Clarke JJA and Abadee AJA, 18 November 1996).....	7.12
<i>Bridgett v Coyney</i> (1827) 1 Man & Ry KB 211	9.6
<i>C (Adult: Refusal of Medical Treatment), Re</i> [1994] 1 WLR 290.....	1.7
<i>C (A Child) (Immunisation: Parental Rights), Re</i> [2003] EWCA Civ 1148	6.17
<i>C (A Minor) (Medical Treatment), Re</i> [1998] Lloyd's Rep Med 1.....	2.55
<i>C, Re</i> [1997] 2 FLR 180	4.48
<i>C & F, Re (Children)</i> [2003] EWHC1376.....	6.17
<i>Chatterton v Gerson</i> [1981] 1 QB 432.....	1.7, 1.10, 1.12
<i>CJ, Application for consent to special medical treatment</i> (unreported, NSW Guardianship Tribunal, March 2001)	8.26
<i>Cowell v Corrective Services Commission of NSW</i> (1988) 13 NSWLR 714	9.6
<i>CU (Next friend of) v McGonigle</i> [2003] ABCA 66.....	2.59
<i>Director General, New South Wales Department of Community Services v Y</i> [1999] NSWSC 644	2.46, 2.56, 4.18, 4.47, 4.48
<i>Downs v Williams</i> (1971) 126 CLR 61	9.24
<i>E (A Minor) (Wardship: Medical Treatment), Re</i> [1993] 1 FLR 386	2.53
<i>Elizabeth, Re</i> (1989) 13 Fam LR 47.....	4.31, 8.7
<i>Elm, Re</i> (2006) 69 NSWLR 145,	4.23, 7.8, 7.12
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