

CONSENT TO HEALTH CARE OF YOUNG PEOPLE

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Report No 51

**Volume One
The Law and the Need for Reform**

Queensland Law Reform Commission
December 1996

The short citation for this Report is QLRC R51.
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ISBN: 0 7424 7546 0

Printed by: Watson Ferguson & Company

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Previous Queensland Law Reform Commission publications on this reference:

Information Paper	<i>Consent by Young People to Medical Treatment</i>	(MP2, May 1993)
Research Paper	<i>Circumcision of Male Infants</i>	(MP6, December 1993)
Research Paper	<i>Female Genital Mutilation</i>	(MP7, December 1993)
Draft Report	<i>Female Genital Mutilation</i>	(WP42, July 1994)
Report	<i>Female Genital Mutilation</i>	(R47, September 1994)
Discussion Paper	<i>Consent to Medical Treatment of Young People</i>	(WP44, May 1995)
Miscellaneous Paper	<i>Medical Examinations in Cases of Suspected Child Abuse</i>	(MP17, June 1996)

This Report is in three volumes:

Volume 1: The Law and the Need for Reform

Volume 2: The Commission's Legislative Scheme for Consent to Health Care of Young People

Volume 3: Summary of the Commission's Report

To: The Honourable Denver Beanland MLA
Attorney-General and Minister for Justice

In accordance with section 15 of the *Law Reform Commission Act 1968*, the Commission is pleased to present its report on *Consent to Health Care of Young People*.

The Report is accompanied by preliminary draft legislation prepared by the Office of the Queensland Parliamentary Counsel. The Commission hopes to be involved in any further development of the Draft Bill before it is introduced into Parliament.



The Honourable Justice P de Jersey
Chairperson



Mr P M McDermott
Deputy Chairperson



Mr W G Briscoe
Member



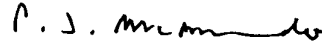
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PREFACE

This Reference covers a diverse range of sensitive and often controversial issues. It has evoked strong opinions on the steps that should or should not be taken to address particular problems relating to consent to health care of young people. Nevertheless, the Commission has been guided throughout this project by a philosophical understanding which has been soundly supported by the responses to the Discussion Paper¹ and by the extensive consultations undertaken following the release of the Discussion Paper. That understanding is that the law should not be an impediment to young people's access to appropriate health care in Queensland. In the context of the Reference, the health needs of young Queenslanders have been the Commission's principal concern.

The Commission believes that, whenever possible, parents have and should retain a vital role in the health care of their children and its recommendations for reform contained in this Report reflect that belief. However, that role should always be subject to what is in the best interests of the child - and there will be circumstances where what the parents want for the child and what the child needs are two different things. There will also be situations where the child needs treatment but is unwilling to be treated if his or her parents are involved in the decision-making processes relating to the treatment. At that point the risks to the child of not being treated and what is perceived by many as a right in the parents to control the health care of the child, may clash. The Commission has attempted to identify those types of situations in this Report and to ensure, to the maximum degree possible, that the vital role of parents and the needs of young people are both reflected in its recommendations.

Currently, the health needs of young Queenslanders appear to be of little significance in the context of the common law and in the limited statute law relating to consent to health care. The results of the current situation are outlined in Volume One of this Report.

The Commission has also acknowledged the psychological and health advantages to young people of their being involved in decision-making affecting their health, irrespective of their ability at law to consent to or refuse health care. Although it would be inappropriate to dictate by statute that all health care providers and/or parents should involve young people in the decision-making process relating to the health of those young people, the involvement of young people should nevertheless be encouraged in relevant community and professional education programs and in treatment situations.

The Commission has also been concerned that its recommendations should recognise the autonomy of the individual. This is a concept which underlies the

¹ Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995).

(ii)

legal requirement for consent to health care. That requirement is intended to ensure protection for the patient against unauthorised interference with his or her right to bodily integrity. The right in each person to bodily integrity is the right in an individual to choose what occurs with respect to his or her own person. The right to bodily integrity also extends to young people although where the young person is not legally competent to consent, others, such as his or her parents, may consent on the young person's behalf in certain circumstances.²

The Commission acknowledges the role parents generally play in the health care of their children and, in particular, the role of decision-maker assumed by parents when a child is too young or otherwise not legally competent to make decisions or a particular decision in relation to his or her own health. During the course of the consultation meetings and from the submissions received in response to the Discussion Paper there was wide acknowledgment of the significance of the parental role in the health care of children. However, there was also recognition of instances where due, for example, to family circumstances or to the seriousness or sensitivities attaching to the health problem being experienced by a young person, parents are unavailable, unable or unwilling to assist their child. At that point the health needs of the young person should become the paramount concern of other people with an interest in the young person.

The position of the many homeless young people in Queensland who have little or no contact with their parents highlights the need to ensure that the law does not hinder their access to appropriate health care. A number of submissions pointed out that homelessness amongst young people is the exception rather than the rule and that the Commission's recommendations should reflect the typical family situation rather than the unusual or the "dysfunctional" family. The fundamental issues relating to the need for treatment and the requirement of consent are currently no different for young people residing in a family situation than for young people who are homeless. The Commission's preliminary recommendations in the Discussion Paper did not distinguish between such young people and the recommendations in this Report apply to young people irrespective of their family or living conditions or arrangements. What the plight of homeless young people highlights, however, is that where parental support is not readily available, other accessible and acceptable mechanisms need to be in place to ensure the delivery of appropriate health care.

Young people living in a family situation may, on occasion, be in much the same position as homeless young people vis à vis their ability to access appropriate health care - particularly if young people are unable to communicate with parents about a particular, perhaps sensitive, health concern.

Further, there are many young people in Queensland who are not competent to

² See Ch 5 of this Report.

(iii)

consent to their own health care and who are in the care of someone who is not legally authorised to make decisions about their health care. These may include young people being cared for in residential facilities or boarding schools, or by relatives or friends.

There is no general statutory provision in Queensland enabling a person other than a parent or a court-appointed person to consent to a young person's health care.³ Young people who are not in the care of a person with authority to consent to their health care are among the most vulnerable people in our community - primarily because they may very well lack the most natural advocate that most people have during their childhood and youth - a parent. The Commission is concerned that these young people should not be denied the opportunity given to other young people to access appropriate health care when required.

Incidental to ensuring that Queensland law does not hinder young people's access to appropriate health care, is the issue of the current uncertain criminal and civil liability for assault and/or battery faced by health care providers when presented with a young patient in a variety of contexts. According to numerous respondents to the Discussion Paper and views expressed in the consultation meetings, the current lack of protection from liability in cases where the health care provider is dealing with a young person with all due care and attention and in the best interests of the young person, actually deters some health care providers from treating young people without the consent or involvement of the young person's parents or without appropriate Court authorisation. This is despite the fact that the young person may otherwise be competent at law to consent to his or her own health care or may be suffering from a condition which, if left untreated, may have serious consequences for the health and/or well-being of the young person. The Commission believes that in appropriate cases no criminal or civil liability for assault or battery should attach to a health care provider who treats a young person if the health care is in the best interests of the young person.

Although the health care provider's potential criminal or civil liability for assault and battery is secondary to the Commission's concern that, generally, a valid consent be obtained before proceeding with the treatment of young people, the Commission recognises that the willingness of health care providers to treat young people is fundamental to young people's ability to access health care. Hence, an aim of the Commission has been to reduce the incidence of health care providers refusing to treat young people on the basis of the health care providers' real or perceived fear of litigation.

³

In all cases other than an emergency, a person who, without court approval, consents to the health care of a young person not his or her child, could be liable as an accessory to the assault of the young person - as the consent would not necessarily have been a valid consent. See 15-17 of this Report for a discussion of the need for consent and Ch 2 for a discussion of the various consequences that can flow from providing health care without a valid consent.

(iv)

A secondary, but important aim of the scheme is to protect vulnerable young people from inappropriate or exploitative health care.

A further basis of any scheme relating to the health care of young people should be that it be simple to read, understand and enforce. If health care providers are not confident in their understanding of the provisions in the scheme which directly affect them, such as the provisions which protect their actions, they are less likely to treat young people in circumstances where they would currently, and reasonably, fear liability. The Commission's preferred scheme as set out in the Discussion Paper was necessarily more complex than the scheme constituted by the Commission's final recommendations, which are set out in Volume Two of this Report. In the Discussion Paper the Commission needed to consider all appropriate options for reform known to the Commission at that time.

A number of the respondents to the Discussion Paper and participants at meetings held during the consultation process emphasised the need for simplicity and readability - and the Commission has endeavoured to do this to the extent possible given the natural complexity of this area of the law and the need to protect the interests of all concerned.

The Commission acknowledges that the problems facing young people's access to appropriate health care are not confined to, nor are they primarily due to, the existing law. The law does currently hinder young people's access to appropriate health care but, to a greater extent, so do entrenched personal and organisational attitudes towards young people, or towards the types of problems experienced by many young people - such as sexual health problems, sexuality problems, alcohol and drug related problems and psychological and psychiatric problems. The Commission has therefore felt compelled to make a number of recommendations which are not directly within the terms of the Commission's reference but which nevertheless may have a significant impact on young people's access to appropriate health care. For example, the Commission has recommended a comprehensive and ongoing education program for all key players concerning the proposed legislation scheme.⁴

A number of issues covered by the Report are the subject of strongly held views by various groups within the community. It is unlikely that a broad consensus of opinion will ever be achieved in relation to the resolution of some of these issues. For example, some parents and organisations are adamant that parents should always be informed before their children are treated or advised on matters involving sexual activity such as contraception and sexually transmitted diseases - so that young people can be guided, warned, counselled or disciplined by their parents. There are others, however, who are of the view that young people who fail to be advised or treated in relation to such matters may suffer greatly and that a

⁴ See 359-360 of this Report.

(v)

requirement of parental involvement may contribute to the failure to be properly treated.

The Commission is of the view that the treatment of a young person who is unable to consent to his or her own health care should always be provided on the basis that the treatment is in the young person's best interests and not on the basis of the religious, cultural or moral beliefs of others - no matter how strongly those beliefs are held. Similarly, for a young person who is able to consent to or refuse health care on his or her own behalf, his or her decision concerning the health care should not be overridden or interfered with on the basis of the religious, cultural or moral beliefs of others - particularly if the health care is in the young person's best interests.

The Commission believes that the proposed scheme, if enacted, would go some significant way towards addressing the needs of a most vulnerable group in our community.

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CHAPTER 1

INTRODUCTION

1. TERMS OF REFERENCE

This reference is part of a wider reference given to the Commission by the Attorney-General in its Fourth Programme of work.⁵ The full terms of the reference are set out in item 4 of the Programme, namely:

Examine the rights relating to consent to medical procedures by:-

- (a) children;*
- (b) intellectually disabled adults (including consent to sterilisation).*

The Commission has divided the reference into two major parts. The first part concerns consent to health care of young people.⁶ The second part concerns consent to health care of adults with a decision-making disability.⁷

This Report deals specifically with general legislation on consent to health care of young people. The Commission seeks to address the question of what general principles regarding consent should apply in relation to the provision of health care to young people and what, if any, changes to the law relating to consent should be made to ensure that the law does not hinder young people's access to appropriate health care. Other, more specific, aspects of the first part of the reference have either been completed or may be dealt with at a future time by the Commission.⁸

⁵ Fourth Programme dated September 1990.

⁶ The Commission prefers to use the term "young person" rather than "child" throughout this Report. The term "child" is inappropriate for many of the situations the Commission has dealt with during the course of this reference. Although people under the age of 18 are children or "minors" in the eyes of the law (see *Law Reform Act 1995* (Qld) s17) many of the "children" to whom the Commission's recommendations apply are in fact young adults.

None of the submissions received in response to the Discussion Paper commented on the use of the term of "young person".

⁷ The latter part is dealt with, in a broader context, by the Commission in its Report *Assisted and Substituted Decisions* (R49, June 1996).

⁸ The Commission has already published: a Research Paper *Female Genital Mutilation* (MP7, December 1993); a Draft Report *Female Genital Mutilation* (WP42, July 1994); a Report *Female Genital Mutilation* (R47, September 1994); a Research Paper *Circumcision of Male Infants* (MP6, December 1993); and a Research Paper *Medical Examinations in Cases of Suspected Child Abuse* (MP17, June 1996). These papers were preceded by a general Information Paper *Consent by Young People to Medical Treatment* (MP2, May 1993). The content and publication dates of any future papers have yet to be determined.

This Report considers, in particular, the ability of young people to consent to, or to refuse, health care and the ability of parents⁹ and others to consent to, or to refuse, health care on behalf of young people.

2. MATTERS EXCLUDED FROM REFERENCE

(a) Health care requiring court or tribunal authorisation

The Commission has drawn a distinction between the consent required for health care to which young people and/or parents have traditionally had the power to consent, and consent for that health care which the Courts or legislatures have said requires special consent, such as that of a Court or tribunal.

For example, the High Court of Australia in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)*¹⁰ held that parents cannot consent, without prior Court approval, to non-therapeutic sterilisation procedures for young people who lack competence to make their own decisions.¹¹

As a result of the decision in *Marion's case*, approval of a court exercising *parens patriae* jurisdiction¹² or the Family Court of Australia or, in certain circumstances in other jurisdictions, the approval of a State or Territory Guardianship body,¹³ is currently required before such a procedure can be performed. In the absence of

⁹ Throughout the Report the Commission refers to the responsibilities and role of parents in the health care of their children. Unless otherwise stated, by the term "parent" the Commission is referring to natural and adoptive parents as well as a guardian appointed by operation of law, or a guardian appointed by deed or by will to care for the testator's children upon the testator's death (see *Children's Services Act 1965* (Qld) s90), or a guardian appointed by order of the Family Court of Australia or by the Supreme Court of Queensland pursuant to care and protection proceedings. Note, however, the Commission's recommended definition of "parent" in Ch 15 of this Report and in clause 21 of the draft legislation in Ch 17 of this Report.

¹⁰ (1992) 175 CLR 218.

¹¹ Although the majority of the High Court in *Marion's case* did not favour use of the terms "therapeutic" and "non-therapeutic" because of their uncertainty, they recognised (at 250) the necessity of making the distinction. Brennan J defined treatment as "therapeutic" when it is administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder, provided the treatment is appropriate for and proportionate to the purpose for which it is administered (at 269). "Non-therapeutic" medical treatment is descriptive of treatment which is inappropriate or disproportionate having regard to the cosmetic deformity, pathological condition or psychiatric disorder for which the treatment is administered and of treatment which is administered chiefly for other purposes (Brennan J at 269).

¹² For a discussion on *parens patriae* jurisdiction see 94-95 of this Report.

¹³ Queensland is the only Australian jurisdiction without a comprehensive Guardianship Tribunal. See Queensland Law Reform Commission, *Report Assisted and Substituted Decisions* (R49, June 1996). Note, *P v P* (1994) 181 CLR 583 in which it was held that the Family Court can authorise sterilisation of a child of a marriage even where the carrying out of such a procedure would be contrary to the *Guardianship Act 1987* (NSW).

such approval those involved in performing the procedure may be civilly and/or criminally liable for assault and/or battery of the young person.¹⁴

Although the High Court of Australia has not stated what, if any, other procedures would require prior court authorisation, it is at least likely that a number of other types of procedures fulfil the same criteria as sterilisation, that is, non-therapeutic procedures involving:

- invasive, irreversible and major surgery;
- a significant risk of making the wrong decision either as to a young person's present or future capacity to consent or about what are the best interests of a young person who cannot consent; and
- particularly grave consequences if a wrong decision is made.

Such procedures may include, for example, gender reassignment¹⁵ and serious procedures performed for purely cultural reasons.¹⁶

This Report does not examine in detail the common law relating to health care requiring court or tribunal authorisation.¹⁷

¹⁴ The Family Law Council (*Sterilisation and Other Medical Procedures on Children* November 1994) and the Law Reform Commission of Western Australia (*Report on Consent to Sterilisation of Minors* Project No 77 Part 11 October 1994) have both reported on the issue of sterilisation of young people. It is possible that Commonwealth legislation will be considered to govern the practice - particularly in light of the recommendations of the Family Law Council. In relation to medical procedures other than sterilisation, the Family Law Council simply claimed that the *Family Law Act 1975* (Cth) is adequate to cope with those procedures for which court authorisation may be sought. No additional legislation was considered necessary in view of the Australian cases to date. There was no discussion as to the types of procedures other than sterilisation for which court approval is required.

The Law Reform Commission of Western Australia acknowledged that the future direction of the law in this regard will largely depend on what action is taken by the Commonwealth. That Commission would prefer that the Commonwealth not legislate in this area and that all sterilisation decisions be made by the Western Australian Guardianship and Administration Board. It also concluded that sterilisation should not be permitted except with the permission of the appropriate decision-making body. The Western Australian Law Reform Commission did not consider approval requirements for medical procedures other than sterilisation.

¹⁵ The Family Court has given its approval for a 14 year old child to undergo gender reassignment by the construction of male sexual organs. At birth, the child had been diagnosed as a female child with masculinisation of the genitalia. The child had undergone genital reconstruction to give her a feminine appearance but received inadequate hormone replacement treatment. Recurrent masculinisation of the child's physical structures had occurred with a change in mental behaviour and attitude. The child wanted to undergo the reassignment procedure but in this case the Court held that the child was not mature enough to understand the nature and consequences of the procedure. As the procedure would require invasive, irreversible and major surgery, the child's parents could not consent - and Family Court approval was required: *Re A* (1993) 16 Fam LR 715.

¹⁶ See this Commission's Report *Female Genital Mutilation* (R47, September 1994) for a discussion of a serious procedure performed for essentially cultural reasons.

¹⁷ But see the Commission's recommendations restricting a young person's capacity to consent to a sterilisation at 248-250 and 263 of this Report.

(b) Health care of fetuses

The Commission has decided to restrict its consideration to young people from their birth to 18 years of age. Although health care, including surgery, for fetuses is becoming more common,¹⁸ there are very strongly held community views and basic philosophical differences concerning the "rights" of the foetus versus the "rights" of the mother/parents.¹⁹ Further, the issues involved in the health care of fetuses, in particular, the possible conflict between the right of the expectant mother to the inviolability of her own body and the "physical condition" of the foetus, are quite distinct from those raised in relation to consent to health care of young people (being from birth to 18 years of age). In the latter case, health care of the young person does not involve interference with the bodily integrity of any other person in order to effect the treatment. No submissions received by the Commission in response to the Discussion Paper commented on this issue.

(c) Participation in research projects

The Commission is also of the view that consent to participation in medical research should not be covered in this reference as the research may not relate specifically to the treatment of the young person. Some interest in issues relating to participation by young people in medical research was expressed in the submissions to the Discussion Paper. However, similar issues will arise in relation to participation of adults in research projects.²⁰ It may be appropriate for a separate project to be undertaken at a future date on participation in medical research.

¹⁸ For example, a foetus can now successfully undergo complex surgery such as a heart operation within the womb, and can be treated for a number of conditions which, if left unchecked, could pose a threat to the viability of the foetus or lead to abnormalities at birth.

¹⁹ If the mother refuses to permit medical intervention to assist her foetus, the foetus may die or be seriously disabled. If someone else is able to consent to the treatment of the foetus, obviously there will be a conflict between the rights of the mother to the inviolability of her own body and the rights (if any) of the unborn foetus. See Haberfield L, "Pregnant Women: Judicial Intervention and the Right of Pregnant Women to Refuse Medical Treatment" (1995) 2 *James Cook University Law Review* 1. See also Reed H, "A Pregnant Woman's Rights Versus a Fetus' Rights: What is the Australian Position?" (1996) 4(2) *Journal of Law and Medicine* 165.

²⁰ In relation to participation in research projects by adults with a decision-making disability, see Queensland Law Reform Commission, *Report Assisted and Substituted Decisions* (R49, June 1996) Volume 1 at 388.

(d) Tissue and blood donation by a competent young person

The *Transplantation and Anatomy Act 1979* (Qld) provides for the donation of tissue for transplantation by both “children”²¹ and “adults”.²² The right to consent to the removal of tissue from a child is conferred on a parent of the child.²³

The Act differentiates between the removal of tissue from a child who is capable of understanding the nature and effect of the removal and the nature and effect of the transplantation and a child who, by reason of his or her age, is incapable of understanding. If a child is capable of so understanding, then there can be no removal of tissue, unless both the child and one of his or her parents agree.²⁴

Tissue donation by a child is more restricted than tissue donation by an adult in two significant respects:

- (a) Donation by a child is limited to regenerative tissue only,²⁵ whereas an adult may also consent to the removal of non-regenerative tissue.²⁶
- (b) Tissue removed from a child may only be transplanted to the body of a brother, sister or parent of the child,²⁷ whereas an adult may consent to the removal of tissue for the purpose of transplantation to any living person.²⁸

The requirement of parental consent means that a young person who wished to donate regenerative tissue to a sibling could not do so if his or her parents opposed the tissue donation.

²¹ *Transplantation and Anatomy Act 1979* (Qld) ss12A-12E.

²² *Id* ss9-12. An “adult” is a person who has attained the age of 18 years and who is of sound mind: see ss10, 11.

²³ *Id* s12B.

²⁴ *Id* s12C. If the child is not, by reason of his or her age, capable of so understanding, s12D(1) of the Act provides (in effect) that, in addition to the consent of a parent, three medical practitioners must certify that:

- (a) the child was not capable, by reason of his or her age, of so understanding; and
- (b) the brother, sister or parent of the child, in the medical practitioner’s opinion, is likely to die unless the tissue is transplanted; and
- (c) the risk to the child, in the medical practitioner’s opinion, is minimal.

²⁵ *Id* s12B. “Regenerative tissue” is defined in s4(1) of the Act to mean “tissue that, after injury or removal, is replaced in the body of a living person by natural processes of growth or repair”.

²⁶ *Id* s11. “Non-regenerative tissue” is defined in s4(1) of the Act to mean “tissue other than regenerative tissue”.

²⁷ *Id* s12B.

²⁸ *Id* ss10 (removal of regenerative tissue), 11 (removal of non-regenerative tissue). The main difference between the two provisions is that there is a cooling-off period of 24 hours between the giving of consent and the removal of non-regenerative (but not regenerative) tissue.

In this Report the Commission recommends that young people who are 12 years of age or older and who understand the nature and consequences of particular health care should be able to consent to their own health care.²⁹

This raises the question whether such young people should be in the same position as adults in relation to the donation of tissue or whether it is appropriate for some restrictions to remain in place until they turn 18. There are a number of possible options, which range from leaving the law in this respect as it stands, to conferring full adult rights of donation on young people when they are legally competent in relation to that donation.

The options considered by the Commission were:

- (a) to permit a young person to consent to the donation of regenerative tissue without parental consent to a brother, sister or parent (whereas presently while he or she can agree to the donation of that type of tissue, parental consent is also required);
- (b) to permit a young person to consent to the donation of regenerative and non-regenerative tissue to a brother, sister or parent (whereas presently only an adult can consent to the donation of non-regenerative tissue);
- (c) to permit a young person to consent to the donation of regenerative and non-regenerative tissue to any person (whereas presently tissue from a child can only be removed for transplantation to a brother, sister or parent of the child); and
- (d) not to deal with the issue of tissue donation by young people in this Report, but to leave it to a specific review of the *Transplantation and Anatomy Act 1979* (Qld).

The Commission is of the view that the purpose of tissue donation by young people is fundamentally different from the primary objective of this Report, which is to increase young people's access to appropriate health care. Tissue donation, by its nature, concerns the provision of a benefit to a third party, rather than health care of the young donor as such. For that reason, the Commission is in favour of option (d).

The *Transplantation and Anatomy Act 1979* (Qld) also provides for a parent to consent in writing to the removal of blood from a young person for the purpose of a blood transfusion or for use of the blood or any of its constituents for other therapeutic purposes or for other medical or scientific purposes if³⁰ -

²⁹ See Chs 11 and 12 of this Report.

³⁰ *Transplantation and Anatomy Act 1979* (Qld) ss 17, 18.

- (a) a medical practitioner advises that the removal is not likely to be prejudicial to the health of the child; and
- (b) the child agrees to the removal.

Accordingly, a competent young person is unable to donate blood unless one of his or her parents agrees to the donation.

The Commission is of the view, which is consistent with its position in relation to tissue donation by young people, that the issue of blood donation by young people, in particular, whether they should, if competent, be able to donate blood without the consent of a parent, does not concern the health of young people as such. For that reason, the Commission is of the view that any review of this issue would be better dealt with in the context of a specific review of the *Transplantation and Anatomy Act 1979* (Qld).

The Commission recommends that its legislative scheme should not make any changes to the law relating to tissue or blood donations by young people, but that those issues should be addressed in the context of a specific review of the *Transplantation and Anatomy Act 1979* (Qld).

3. PROGRESS OF REFERENCE

(a) 1993 Information Paper: Consent by Young People to Medical Treatment

In May and June 1993 advertisements were placed in *The Courier-Mail* calling for public submissions on Consent by Young People to Medical Treatment. An Information Paper³¹ outlining a wide range of issues was available to assist anyone interested in making a written or oral submission.

Approximately 300 copies of the Information Paper were distributed and approximately 160 oral and written submissions were received.³² The submissions contained reference to many concerns about the current law and practice relating to consent by young people to medical treatment.

³¹ Queensland Law Reform Commission, Information Paper *Consent by Young People to Medical Treatment* (MP2, May 1993).

³² A list of respondents to the Information Paper is found in Appendix 1 to this Report.

(b) 1995 Discussion Paper: Consent to Medical Treatment of Young People

Following analysis of the submissions received in response to the 1993 advertisements and Information Paper, various issues were identified which fell under the broad heading "Consent to Medical Treatment of Young People". Many of those issues were addressed in the Commission's Discussion Paper published in May 1995.³³

The Discussion Paper was prepared after initial consultations with a large number of individuals and organisations with a particular interest or expertise in the issues covered by the Paper. The assistance of those who made submissions and others who provided information and comments to the Commission in the preparation of that Paper is greatly appreciated.

The Discussion Paper was circulated and publicised throughout Queensland, including:

- press releases to all major regional newspapers, radio and television stations;
- advertising in *The Courier-Mail*, *The Sunday-Mail*, the *Morning Bulletin* (Rockhampton), the *Townsville Bulletin*, the *Cairns Post* and the *Gold Coast Bulletin*;
- radio and newspaper interviews;
- notices in P & C Association Newsletter;
- notice to each member of P & F Association;
- articles in Youth Affairs Network of Queensland Newsletter;
- notice to all members of Association of Independent Schools; and
- meetings organised with the assistance of Queensland's Regional Health Authorities.

The Commission also distributed copies of the Discussion Paper and summaries of the Discussion Paper to a large number of individuals and organisations whom the Commission considered might have a particular interest in the issues raised in the Discussion Paper. Over 1500 copies of the Discussion Paper and over 500 copies of the Summary of the Discussion Paper were distributed. Copies of a questionnaire designed for young people to complete either individually or as part of a group were also distributed.³⁴

For the consultations on the Discussion Paper, the Commission relied heavily on Regional Health Authorities (as they were then called; now referred to as Districts) of Queensland Health to identify interested people and organisations within the

³³ Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995).

³⁴ A copy of the Questionnaire is found in Appendix 2 to this Report.

respective regions to attend small interest group meetings. The Commission found small group meetings a very useful way to obtain feedback. The Commission is most grateful to the individuals in the various Districts of Queensland Health who organised and facilitated the meetings. The meetings were addressed by a member of the Commission and the Director of the Commission. Meetings included:³⁵

- Sunnybank
- Gold Coast (2)
- Cairns (3)
- Longreach (2)
- Townsville (2)
- Mt Isa (2)
- Hervey Bay
- Redcliffe
- Caboolture
- Nambour
- QEII Hospital (2)
- Upper Mt Gravatt
- Royal Children's Hospital (2)
- Rockhampton (2)
- Mackay
- Toowoomba
- Ipswich
- Mooloolaba
- Brisbane (2)

Over 80 written and oral submissions were received in response to the Discussion Paper.³⁶ Those submissions have been most helpful to the Commission in the preparation of this Report and the Commission greatly appreciates the assistance given to it by all respondents.

³⁵ Details of the consultation meetings are set out in Appendix 3 to this Report.

³⁶ A list of respondents to the Discussion Paper is set out in Appendix 4 to this Report.

- (c) **1993 Research Paper:** **Female Genital Mutilation**³⁷
 1994 Draft Report: **Female Genital Mutilation**³⁸
 1994 Report: **Female Genital Mutilation**³⁹

An issue that was raised by a number of respondents to the Information Paper was the cultural practice of what is commonly referred to as Female Genital Mutilation (FGM). This issue was regarded by the Commission as a discrete subject that should be dealt with as a separate project within the broad reference of Consent to Medical Treatment of Young People.

FGM is a term used to describe a variety of ritual practices performed primarily on girls and young women in certain communities throughout the world. The practices range from a cut to a female's genitals to the removal of a genital organ.

A Research Paper on FGM was produced to assist the Commission in understanding the issues surrounding FGM and in an attempt by the Commission to contribute researched information to the public discussion on FGM. The Research Paper was circulated to individuals and organisations with an interest or expertise in the issues raised, to verify the accuracy and significance of the information contained in the Research Paper, and to seek suggestions as to the most appropriate approach to adopt.

The Research Paper was not released as a public document and the media were not specifically approached at the outset of this project because of the Commission's concern with the adverse effect an uninformed public debate could have on particular communities and individuals within Queensland and throughout Australia.

At the time the Commission's Research Paper was published in December 1993, FGM became a topic of intense media coverage, largely because of a widely publicised Victorian Magistrates Court case involving two young girls who had been the subject of FGM (albeit prior to coming to Australia), and the release of a Discussion Paper on FGM by the Family Law Council in January 1994.

Over 50 submissions were received in response to the Commission's Research Paper, primarily from individuals and organisations with a strong interest, expertise or experience in the relevant issues.

³⁷ Queensland Law Reform Commission, Research Paper *Female Genital Mutilation* (MP7, December 1993).

³⁸ Queensland Law Reform Commission, Draft Report *Female Genital Mutilation* (WP42, July 1994).

³⁹ Queensland Law Reform Commission, Report *Female Genital Mutilation* (R47, September 1994).

In July 1994 the Commission published and publicised a Draft Report on FGM. The Draft Report contained a number of preliminary recommendations for reform which were made after a review of submissions to the Research Paper, consultations with relevant individuals and organisations and an extensive literature review.

The Commission received over 30 submissions in response to the Draft Report, again primarily from organisations and individuals with a particular interest or expertise in the matter. The Commission also met with and received submissions from women and men from different African, Middle Eastern and Asian countries residing in Queensland and Victoria who have had experiences with or a knowledge of FGM.

The Commission's Final Report on FGM was delivered to the Attorney-General in September 1994 and was tabled in Parliament on 18 October 1994. Shortly after, the then Attorney-General announced that the Government would criminalise certain activities amounting to FGM.

In its Report the Commission expressed the view that FGM of young people is a practice totally unacceptable to the Australian community, and that prevention or elimination of the practice should be the aim of any reform. The Commission believes that this may in part be achieved by the introduction of a clear statutory prohibition against the practice. However, overseas experience has shown that legislation prohibiting FGM without more is ineffective in reducing or eliminating the practice. Education in a culturally sensitive manner of men and women affected by the practice has proven far more effective. The Commission therefore recommended that education be the primary focus of reform, and that commencement of a specific prohibition against the practice await the implementation of appropriate education programs.

The Commission recommended that such education programs be developed and implemented by Queensland Health, either independently or in conjunction with relevant interstate and Commonwealth departments, to commence following the introduction of legislation. The Commission recommended that a specific division of the Code was necessary to allow for the following:

- a clear definition of the practice, to include all degrees of the procedure, from a ritual nicking to complete infibulation;
- a penalty system specifically designed to suit the unique nature of the offence, providing for a maximum term of five years imprisonment and allowing such matters as the cultural beliefs of an individual to be taken into account in determining any penalty; and
- definition of the exceptions to the prohibition (which is required, as some forms of the practice may need to be performed for medical reasons).

The prohibition would extend to persons performing the procedure interstate on a child normally resident in Queensland.

The Commission also made a number of ancillary recommendations concerning child protection strategies, Commonwealth funding for, and involvement in, overseas educative efforts, and laws prohibiting discrimination against persons affected by the practice.

The Commission's recommendations have yet to be implemented in Queensland, although an inter-departmental committee was convened to consider the recommendations.⁴⁰ The Queensland Bureau of Ethnic Affairs has also conducted a one day seminar since the publication of the Commission's Report to consider the appropriate approach to adopt in relation to FGM in Queensland.

The Commission understands that at a Commonwealth level the Commission's recommendations were being considered by the previous Government as a possible basis for Commonwealth legislation and education programs. The present Government has not, to the Commission's knowledge, expressed a policy in this area.

The Commission is maintaining a watching brief on the issues relating to FGM and has accumulated a considerable library of relevant and up-to-date information and opinions on FGM. The Commission will be able to contribute to any renewed discussions on the need for reform.

(d) 1994 Research Paper: Circumcision of Male Infants⁴¹

A further issue raised by a number of the respondents to the Information Paper was the circumcision of male infants. Again, the Commission considered that this was a topic discrete enough to be dealt with separately from other issues in the reference on Consent to Medical Treatment of Young People.

The Commission published a Research Paper on *Circumcision of Male Infants* to assist the Commission in understanding the issues and arguments on the topic. The Paper was circulated to individuals and organisations with an interest or expertise in the issues raised, to verify the accuracy and significance of the information contained in the Paper, and to seek suggestions as to the most appropriate, if any, reforms to recommend.

⁴⁰ A report on certain questions relating to possible amendments of the *Criminal Code* (Qld) did not consider FGM (Criminal Code Advisory Working Group *Report to the Attorney-General* July 1996). The Queensland Law Reform Commission has made a submission on that Report highlighting the Commission's recommendations for reform of the *Criminal Code* (Qld) to take into account FGM: letter to the Attorney General dated 11 September 1996.

⁴¹ Queensland Law Reform Commission, Research Paper *Circumcision of Male Infants* (MP6, December 1993).

As with the Commission's Research Paper on *Female Genital Mutilation*, the Commission decided not to release the Research Paper as a public document and the media were not specifically approached at the outset of the project, primarily because of the Commission's concern with the effect an uninformed public debate could have on particular communities within Australia that have strongly held beliefs relating to the circumcision of infant males.

The Commission was surprised by the level of community and professional interest in, and the disparity of views existing on, this topic. Proponents of infant male circumcision base their opinions on preventative health or on religious/customary grounds. Opponents of infant male circumcision base their opinions on human rights, protection of bodily integrity and health grounds.

Over 50 submissions were received in response to the Research Paper. Those submissions further highlighted the wide disparity of opinion on the practice of circumcision. They also, however, highlighted a universal concern for the health and the cultural and religious well-being of young people.

The Commission's decision to proceed with a separate project on infant male circumcision was motivated by an overriding concern for the health and well-being of children who undergo the procedure on the consent of others.

The debate on infant male circumcision has been ongoing.⁴² The Australian Medical Association is currently reviewing its policy on infant male circumcision.⁴³

The Commission has not, to date, made any specific recommendations about consent to circumcision procedures. However, as a form of treatment, any circumcision procedure performed on a young person would be subject to the Commission's proposed legislative scheme relating to consent as outlined in this Report.

⁴² Since the publication of the Commission's Research Paper, the Australian College of Paediatrics has re-evaluated its policy on neonatal male circumcision to acknowledge possible health benefits - particularly in relation to reduction in the risk of local penile inflammatory conditions, penile cancer, and urinary tract infection (although studies claiming reduction in the risk of sexually transmitted disease (especially HIV) and of cancer of the cervix in partners of circumcised males have methodological problems which could influence findings and these problems would be difficult to overcome). The Australasian Association of Paediatric Surgeons informed the College that it is its view that routine male circumcision should not be performed prior to the age of 6 months. It believes that "Neonatal male circumcision has no medical indication. It is a traumatic procedure performed without anaesthesia to remove a normal functional and protective prepuce". The College's statement appears to have adopted a number of the possible reforms outlined in the Commission's Research Paper, including that "informed discussion with parents regarding the possible health benefits of routine male circumcision and the risks associated with the operation is essential. Up-to-date, unbiased written material summarising the evidence in plain English should be widely available to parents. If the operation is to be performed, the medical attendant should ensure this is done by a competent operator, using appropriate anaesthetic techniques and under medical conditions that minimise the hazards. In the majority of cases, parents will decide for or against a routine male circumcision on family, social, aesthetic and religious grounds rather than on medical ones. In all cases the medical attendant should avoid exaggeration of either risks or benefits of this." The Australian College of Paediatrics, Position Statement *Routine Circumcision of Normal Male Infants and Boys* (May 1996).

⁴³ As at the date of publication of this Report the Australian Medical Association is still considering its policy.

The Commission may revisit this issue after completion of the current Report. If it eventuates that the Commission produces nothing further on the issue, then it feels that it has at least contributed to an informed public debate on an issue of concern to many people.

(e) 1996 Research Paper: Medical Examinations in Cases of Suspected Child Abuse⁴⁴

A further issue raised by a number of the respondents to the Information Paper was a particular problem concerning consent to the medical examination and treatment of victims of alleged child abuse. Upon an allegation being made to police, health care providers or social workers of physical, sexual or other abuse or neglect of a young person, it is common practice for a medical examination to be made of the young person. A physical examination may reveal evidence of the abuse to assist in the prosecution of the alleged perpetrator. A psychological or psychiatric examination may confirm suspicions and, in some cases, may provide the only indication or evidence of abuse having taken place. This is particularly so in cases of suspected sexual abuse.

An early examination may indicate physical injury, a sexually transmitted disease and/or psychological injury, and may suggest an appropriate course of treatment, including counselling, which may assist the young person to overcome or at least deal with the consequences of the abuse. However, where a parent or a guardian of a person who is too young or immature to be able to consent to his or her own medical examination, refuses consent to the examination taking place, it appears that the current law in Queensland may actually hinder the investigation of the alleged offence.

In the Research Paper the Commission made a number of preliminary recommendations, including an expanded provision to enable the examination and treatment of young people suspected of having being abused, without the consent of parents or against their refusal. If a young person refuses a medical examination relating to suspected child abuse, after having the reasons for such an examination explained to him or her, then such an examination should not proceed without an appropriate court order. The Commission also agreed with a number of proposals for reform made by the Department of Families, Youth and Community Care, including, for example, the development of a formal protocol with Queensland Health on the obtaining of consent to medical examinations from young people.

⁴⁴ Queensland Law Reform Commission, Research Paper *Medical Examinations in Cases of Suspected Child Abuse* (MP17, June 1996).

4. THE NEED FOR CONSENT

Subject to certain exceptions - for example, situations of emergency,⁴⁵ self-defence, jostling in a crowd or the normal incidents of contact sport - any voluntary touching by one person of another person is unlawful unless the other person, or a person authorised to consent on that other person's behalf, has consented to that touching. In the absence of consent, even the slightest degree of physical contact may give rise to a civil claim for damages for trespass to the person or to a criminal charge for assault and/or battery.⁴⁶

This general rule also applies to physical contact whilst providing health care to any person unless there is a specific statutory provision to the contrary. The intention or motives of the health care provider are irrelevant; it is the act of touching in the absence of a valid consent which forms the basis for potential liability. The requirement of consent is intended to ensure protection for the patient against unauthorised interference with his or her right to bodily integrity and for the health care provider against possible legal action.

The right in each person to bodily integrity is the right in an individual to choose what occurs with respect to his or her own person.⁴⁷ Cardozo J in *Schloendorff v Society of New York Hospital* described the principle as follows:⁴⁸

Every human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body; and a surgeon who performs an operation without his [or her] patient's consent commits an assault.

For a consent to be valid, the person giving it must have a sufficient degree of competence. The adult test for competency to consent to health care is whether or not the adult has a broad understanding of the nature of the decision.⁴⁹

⁴⁵ See 44-51 and 286-292 of this Report.

⁴⁶ *Criminal Code* (Qld) s245. The definition of "assault" in s245 includes "battery"; *Collins v Wilcock* [1984] 1 WLR 1172; *Horan v Ferguson* [1995] 2 Qd R 490. See 25 and 38-41 of this Report. For a discussion on consent in English law see Law Commission, Consultation Paper *Criminal Law: Consent in the Criminal Law* (No 139, 1995).

⁴⁷ *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 per Mason CJ and Dawson, Toohey and Gaudron JJ at 233.

⁴⁸ (1914) 105 NE 92 at 93.

⁴⁹ In *Chatterton v Gerson* [1981] QB 432 Bristow J said at 443:
In my judgment once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass ... In this case ... she was under no illusion as to the general nature of what an intrathecal injection of phenol solution nerve block would be, and in the case of each injection her consent was not unreal.

In Australia, for the consent of an adult to be sufficient to authorise interference with bodily integrity, it must also be a "real" consent.⁵⁰ For the purposes of an action for trespass to the person or of a criminal assault charge, a "real" consent is one that has not been obtained by fraud or by misrepresentation of the nature of the procedure.⁵¹ It is sufficient if the adult patient is informed in broad terms of the nature of the proposed treatment before giving consent. Failure on the part of a person providing treatment to supply information about possible alternative methods of treatment or to disclose the existence of side-effects or of risks associated with the treatment does not invalidate the consent.⁵² Fleming comments that:⁵³

Consent does not have to be 'informed' to be 'real'. The reason for this distinction lies less in doctrinal finesse⁵⁴ than in the perceived need for a more elastic and doctor-friendly standard. Besides, one is loath to equate a healing physician to a violent ruffian.⁵⁵

For adults with a decision-making disability, some legal procedures exist in Queensland for the appointment of substitute decision-makers. Decision-making for adults who do not have the capacity to make health care or other decisions has been examined in detail in the Commission's reference on *Assisted and Substituted Decisions*.⁵⁶

The right to bodily integrity also extends to young people, although where the young person is not legally competent to consent, others, such as his or her parents, may consent on the young person's behalf. Parental consent, when effective, is an exception to the need for personal consent to treatment.⁵⁷

Young people's competency to consent is examined in detail in Chapter 3 of this Report. Basically, their consent to health care is valid if they have sufficient understanding and intelligence to enable them to understand fully the nature and

⁵⁰ In some jurisdictions in the United States a patient's agreement to undergo treatment has been held not to be "real" consent unless the patient has been given sufficient information to allow an informed choice to be made. The concept of "informed consent" is applicable in Australia in relation to claims of negligence - see 24 and 240 of this Report.

⁵¹ *Chatterton v Gerson* [1981] QB 432 at 443; *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1984] QB 493 at 511.

⁵² *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553; *F v R* (1983) 33 SASR 189; *Rogers v Whitaker* (1992) 175 CLR 479. Of course, such a failure may indicate liability in negligence.

⁵³ Fleming JG, *The Law of Torts* (8th ed 1992) at 81.

⁵⁴ "Such as that the misapprehension relates to risk, not certainty, of injury."

⁵⁵ "Battery also lacks causation as a safety valve nor does it cover (non-invasive) advice".

⁵⁶ See the Commission's Report *Assisted and Substituted Decisions* (R49, June 1996).

⁵⁷ *Marion's case* (1992) 175 CLR 218 per Mason CJ and Dawson, Toohey and Gaudron JJ at 235.

consequences of what is proposed.⁵⁸ In the absence of requisite competency in a young person to consent to his or her own health care, the usual rule, established at common law, is that the young person's parents or legal guardian can consent on the young person's behalf, provided that in all cases the decision is made having regard to the young person's best interests.

5. HEALTH CARE TO BE COVERED BY THE COMMISSION'S SCHEME

In its Discussion Paper, the Commission referred to the term "treatment" to cover the type of procedures that it believed were encompassed by the terms of reference. However, the Commission now believes that term to be too narrow in that it connotes procedures used or adopted by a narrow range of health care providers such as medical practitioners and dentists. The Commission is concerned with care provided to young people by all those who profess to be in the business of improving or maintaining the health of others. Accordingly, the Commission has adopted the term "health care". The term "health care" was used by the Commission in its Report *Assisted and Substituted Decisions* in relation to health care decisions by or on behalf of adults with decision-making disabilities.⁵⁹ In the Discussion Paper the Commission invited comment on the definition of health care used in that Report:⁶⁰

- (1) "Health care" of an adult is any care, treatment, service or procedure -
 - (a) to maintain, diagnose or treat the adult's physical or mental condition; and
 - (b) carried out by, or under the supervision of, a health care provider.
- (2) However, "health care" does not include -
 - (a) the administration of a pharmaceutical drug if -
 - (i) a prescription is not needed to obtain the drug; and
 - (ii) the drug is normally self-administered; and
 - (iii) the administration is for a recommended purpose and at a recommended dosage level; and
 - (b) first aid treatment of the adult; and
 - (c) a non intrusive examination made for diagnostic purposes.

Most respondents to the Discussion Paper were in favour of such a broad definition of "health care".⁶¹ After further deliberation the Commission has adopted a definition of "health care", based upon, but broader than, the definition referred to above.

⁵⁸ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 per Lord Scarman at 189 (HL(E)).

⁵⁹ R49, June 1996.

⁶⁰ Discussion Paper at 8.

⁶¹ Submissions 3, 14, 34, 44 and 58.

For the purposes of this Report "health care" will be defined broadly, as follows:

"Health care" of a young person is any assessment, care, treatment, service or procedure to maintain, diagnose or treat the young person's physical or mental condition.⁶²

For the purposes of the Commission's legislative scheme some further refinement of the definition is proposed in Chapter 9 of this Report.

(a) The current regulation of health care

At present, medical practitioners and other health care providers may be exposed to liability for criminal assault, civil assault⁶³ or false imprisonment if the consent of a legally competent patient or other authorised person is not obtained prior to the provision of health care that involves physical contact.

The law is not certain as to when a young person achieves competence to consent to, or to refuse, health care. This uncertainty has contributed significantly to the apprehension some health care providers have towards treating or not treating young people in the absence of parental consent or against the wishes of parents.

Given their uncertain, yet potential, liability for treating without a valid consent, some health care providers refuse to advise or treat young people without parental involvement - with the consequence that some young people are being denied treatment required for their health and well-being. During the consultation meetings following the release of the Commission's Discussion Paper, it became apparent that this situation is a major concern to people working with young Queenslanders. It appears to be more of a problem in rural and isolated areas in Queensland where the choice of health care providers for young people is far more restricted than for young people living in urban areas.

The problem does not appear to be solely the result of fear by health care providers of potential litigation - it also appears to result from the attitude some health care providers have about treating young people without the knowledge or consent of parents or about treating young people for certain conditions. Those attitudes may

⁶² This definition is similar to the definition of "health care" adopted in the Commission's Report, *Assisted and Substituted Decisions* (R49, June 1996) at 57.

⁶³ The term "assault" is generally used in this Report to refer to both assault and battery. The definition of "assault" under s245 of the *Criminal Code* (Qld) includes battery.

need to be addressed on a professional and community level. The Commission's task is to make recommendations which will result in the removal of any legal barriers which may impede appropriate health care. It is possible that the removal of these legal barriers will influence health care providers who are currently unwilling to treat young people without parental involvement.⁶⁴

During Parliamentary debate upon the introduction of the South Australian *Consent to Medical and Dental Treatment Act 1985*, the Honourable Anne Levy noted the reason she first became interested in this issue:⁶⁵

A 17 year old girl who did not get on with her parents had left home and was living in a house with a group of people. She was employed and was fully self-supporting, self-sufficient, and obviously capable of managing her own affairs. She found that she had a lump in her breast. A biopsy revealed that the lump was non-malignant and there was no question of her life being threatened if nothing were done. However, the medical advice was that this lump should be removed but, because she was 17 years of age, the doctor to whom she went refused to operate on her without parental consent. She went to her parents, with whom she had had no contact for quite some time, to get their permission to have this lump removed from her breast. Her parents refused to give permission.

It is obvious from the consultation meetings and the submissions received in response to the Commission's Discussion Paper that the uncertainty in the current law in Queensland could give rise to a similar situation here.

⁶⁴ It is not the desire of the Commission to be seen to be interfering with the ability of health care providers and health care authorities to refuse to provide health care on medical, practical or economic grounds. See the English case of *R v Cambridge Health Authority, ex parte B* [1995] 1 WLR 898. In that case, a health authority had refused to commit £75,000 for the treatment of a 10 year old leukaemia patient with a very slim chance of success. The child's family went to court to challenge the health authority's decision. At first instance, Laws J held that the decision whether or not to treat should not have been purely medical, let alone financial. It should have been based upon what was best for the child. *The Times Newspaper* (11 March 1995 at 17) reports the judge as saying this was "not a medical choice but a human choice". The views of the parents were a factor that the authority had not considered but should have considered. So too was the child's "right to life". He implied that these were absolutes. He ruled the authority's decision unreasonable and therefore unlawful and said that it should reconsider the matter.

The decision of Laws J was reversed on the same day it was given by the Court of Appeal which was of the opinion that it is not for the courts to interfere with the way health authorities make medical judgments on funding. The Court of Appeal also acknowledged that it is inappropriate for the courts to interfere in medical decisions:

... the courts are not, contrary to what is sometimes believed, arbiters as to the merits of cases of this kind. Were we to express opinions as to the likelihood of the effectiveness of medical treatment, or as to the merits of medical judgment, then we should be straying far from the sphere which under our constitution is accorded to us. We have one function only, which is to rule upon the lawfulness of decisions. ([1995] 1 WLR 898 per Sir Thomas Bingham MR at 905).

⁶⁵ *Parliamentary Debates*, Legislative Council (SA), 13 February 1985 at 2448. The *Consent to Medical and Dental Treatment Act 1985* (SA) was repealed by the *Consent to Medical Treatment and Palliative Care Act 1995* (SA). See discussion at 168-179 of this Report.

(b) The significance of physical contact

There can be no criminal or civil liability⁶⁶ for battery and assault⁶⁷ unless there has been physical contact with the victim or a threat of imminent physical contact. Accordingly, health care that generally does not involve physical contact, such as hypnotherapy or counselling, is unlikely to attract criminal or civil liability for assault. There may, in certain limited circumstances, be liability for false imprisonment⁶⁸ and, as with health care involving physical contact, if the health care provider has breached a duty of care owed to the young person, the health care provider could be liable for negligence whether or not the health care involved physical contact with the young person.⁶⁹

6. HEALTH CARE PROVIDERS TO BE COVERED BY THE COMMISSION'S SCHEME

The doctor-patient relationship is not the only professional relationship concerned with addressing significant health related problems or concerns. Health care by nurses, dentists, counsellors, psychologists and numerous other health care providers also plays an important role in ensuring the physical and psychological health and well-being of people. Further, any person treating another may be criminally and/or civilly liable if the treatment involves physical contact with the patient and a valid consent has not been obtained either from the patient (if competent) or from another authorised person. Liability for unauthorised health care is not limited to medical practitioners. Moreover, the consequences to the patient of inappropriate or unauthorised health care may be as serious for health care provided by a non-traditional health care provider as for health care provided by, for example, a medical practitioner.

A number of respondents to the Discussion Paper commented on the use of the term "health care provider". Most of those respondents were in favour of the broad definition suggested in the Discussion Paper,⁷⁰ which would cover people who

⁶⁶ Battery and assault are crimes as well as torts. Under the law of torts they are two different forms of trespass to the person. See 38-41 of this Report.

⁶⁷ In Queensland, the definition of "assault" under s245 of the *Criminal Code* includes battery.

⁶⁸ See 38 and 41-43 of this Report.

⁶⁹ See 24 and 240 of this Report.

⁷⁰ Discussion Paper at 8. The suggested definition was a person who treats a young person for reward or who professes to be in the business of health care.

profess to be in the business of health care.⁷¹ However, one respondent noted that:⁷²

If ... the Commission is concerned only about "people who profess to be in the business of health-care", then it is ignoring groups such as [certain religious sects], with a great potential for the delivery to children of inappropriate psychological intervention for which no consent has been given.

However, if the provision of health care to young people, or for that matter adults, by members of particular health care professions is generally considered inappropriate, then the Government should consider imposing restrictions on their practice. It is not the function of the Commission to consider the appropriateness or inappropriateness of the health care provided by any individual or organisation.

The Commission's principal concern is that the law should not hinder a young person's access to appropriate health care. If the scheme proposed by the Commission were to place undue restrictions on who could or could not provide health care to a young person (whether upon the consent of the young person or a parent or other authorised person), then it is possible that some young people would be denied health care that may very well be to their benefit.

For the purposes of this Report a "health care provider" will be defined as a person who provides health care in the practice of a profession or in the ordinary course of business.

The Commission acknowledges that most people have reason to treat another person at some stage in their lives - whether it be by way of administering medication, dressing injuries or any of a multitude of other, in most cases, relatively minor procedures. The Commission has therefore made certain recommendations in relation to minor health care and emergency health care carried out by a person who is not a health care provider.⁷³

⁷¹ In the Commission's Report *Assisted and Substituted Decisions* (R49 June, 1996 Vol 2 Sched 2 to *Assisted and Substituted Decision Making Bill 1996*), the Commission defines "health care provider" as "a person who provides health care in the ordinary course of business or the practice of a profession".

⁷² Submission 3.

⁷³ See 286-292 and 299-301 of this Report.

7. THE COMMISSION'S LEGISLATIVE SCHEME

In Volume 2 of this Report the Commission sets out a proposed legislative scheme for the authorisation of health care of young people in Queensland. Draft legislation prepared by the Office of the Queensland Parliamentary Counsel is set out in Chapter 17.

The proposed scheme is more comprehensive than any current legislative scheme relating to the authorisation of health care for young people.⁷⁴ The proposed legislative scheme covers all touching health care and certain types of serious non-touching health care. It also covers all health care providers in their dealings with young people.

The general rules to apply within the scheme are that:

- (a) health care involving a touching will require a consent; and
- (b) health care not involving a touching will not require a consent.

The principal exceptions to these general rules are that:

- (a) for health care involving a touching, no consent will be required for minor health care; health care required without delay; or emergency health care; and
- (b) for certain serious health care not involving a touching, consent will nevertheless be a requirement.

The scheme restricts the health care to which even a competent young person will be able to consent⁷⁵ on the basis that young people should be protected from procedures that are unlikely to be for their benefit.

The consequences of providing health care to a young person without a valid consent from either the young person (if competent) or a parent, or without the authority of a court, will be criminal and/or civil, either under the current law or pursuant to penalties and/or a new civil cause of action created by the legislation.

⁷⁴ By comparison, it should be noted that the *Consent to Medical Treatment and Palliative Care Act 1995 (SA)*, which is currently the most comprehensive Australian legislation on consent to medical treatment of young people, makes no distinction between treatments involving a touching and treatments which do not. Further, the South Australian legislation contains no penalties in addition to those existing under the general law, for treating young people outside the South Australian scheme. The South Australian legislation only applies to medical practitioners and dentists. See 168-179 of this Report for a detailed discussion of the South Australian legislation.

⁷⁵ A young person under 16 years of age will not be able to provide a valid consent to his or her own sterilisation: see 248-250 of this Report.

The Commission's scheme is designed to recognise the maturing process young people go through from birth to adulthood. Parental responsibilities and young people's growing self determination are reflected in the three age groupings under the scheme: under 12 years of age (where basically, young people will not be capable of authorising or consenting to their own health care); 12 to 15 (inclusive), where young people will be able to consent to their own health care only if they understand the nature and consequences of the health care and only if the health care is in the best interests of their health and well-being (parents will also be able to consent to, but will not be able to refuse, health care over the young person's consent); and 16 and 17 year olds, where basically, if competent, only they can consent to or refuse health care.

CHAPTER 2

LIABILITY IN THE ABSENCE OF CONSENT

1. LIABILITY FOR HEALTH CARE WITHOUT CONSENT

If a health care provider carries out health care on a patient without a valid consent, the health care provider could be accountable for his or her actions in a number of respects:

- (a) criminal liability for assault and false imprisonment;
- (b) civil liability for trespass to the person; and/or
- (c) professional discipline.

A health care provider may also be liable to a patient for negligence, even though a valid consent to the health care has been obtained for the health care carried out.

In negligence, the plaintiff alleges that the defendant owed the plaintiff a duty of care, and by acting without reasonable care, breached that duty. It is well established that a health care provider owes a duty of care to a patient to exercise reasonable care and skill in the provision of professional advice and health care.⁷⁶ The standard of reasonable care required of a person exercising professional skill and judgment is that of the ordinary skilled person exercising and professing to have that special skill.⁷⁷

The duty of a health care provider in relation to the provision of advice and information to a patient includes a duty to warn the patient of a material risk inherent in the proposed health care.

Breach of a health care provider's duty of care to a patient does not vitiate consent. However, if a health care provider does not meet the required standard of skill in the health care of a patient, or if the health care provider fails to provide the relevant information, the health care provider may be liable to the patient in negligence if the patient suffers damage as a result.

Liability in negligence is outside the Commission's terms of reference.

⁷⁶ *Rogers v Whitaker* (1992) 175 CLR 479 at 483.

⁷⁷ Fleming JG, *The Law of Torts* (8th ed 1992) at 108.

2. CRIMINAL LIABILITY FOR ASSAULT AND FALSE IMPRISONMENT

(a) Assault

Health care providers treating or operating on their patients will, in most cases, have valid reasons for touching their patients. Rarely would the touching of a patient for professional reasons during a physical examination or treatment give rise to a prosecution against the practitioner for assault.⁷⁸ Usually the patient has impliedly or expressly consented to the touching.

Under the Queensland *Criminal Code*, an application of force to another without consent is an assault. It is proscribed unless authorised, justified or excused by law. Subsection 246(1) of the Code provides:

- (1) An assault is unlawful and constitutes an offence unless it is authorised or justified or excused by law.

A person can consent to what would otherwise be a simple assault, but cannot consent to more serious injuries such as grievous bodily harm being done to that person by another.⁷⁹

In most cases the consent to be touched will vitiate a charge of assault. In the context of the Queensland *Criminal Code* "consent" includes consent implied by law to the ordinary physical contact experienced in every day life.⁸⁰ It is unclear whether consent would be necessary for health care which is of a minor nature, such as

⁷⁸ "Assault" under the *Criminal Code* (Qld) is defined in such a way as to cover both assault (which involves the fear of a touching) and battery (which involves a touching). S245 of the *Criminal Code* (Qld) provides:

245.(1) A person who strikes, touches, or moves, or otherwise applies force of any kind to, the person of another, either directly or indirectly, without the other person's consent, or with the other person's consent if the consent is obtained by fraud, or who by any bodily act or gesture attempts or threatens to apply force of any kind to the person of another without the other person's consent, under such circumstances that the person making the attempt or threat has actually or apparently a present ability to effect the person's purpose, is said to assault that other person, and the act is called an "assault".

(2) In this section "applies force" includes the case of applying heat, light, electrical force, gas, odour, or any other substance or thing whatever if applied in such a degree as to cause injury or personal discomfort.

⁷⁹ See *R v Raabe* [1985] 1 Qd R 115 per Connolly J at 119. *R v Watson* [1987] 1 Qd R 440 per McPherson J at 444, with whose judgment Derrington J agreed.

⁸⁰ See *Horan v Ferguson* [1995] 2 Qd R 490. At common law, rather than assuming consent has been implied in certain situations, a general exception to the liability for "battery" has been recognised:

This exception has been said to be founded on implied consent ... Today this rationalisation can be regarded as artificial; and in particular, it is difficult to impute consent to those who, by reason of their youth or mental disorder, are unable to give their consent. For this reason, I consider it more appropriate to regard such cases as falling within a general exception embracing all physical contact which is generally acceptable in the ordinary conduct of every day life.

(*In re F (Mental Patient: Sterilisation)*) [1990] 2 AC 1 per Lord Goff at 72-73).

minor first aid procedures to relieve pain and discomfort or action taken to relieve other minor ailments.⁸¹

A health care provider may, notwithstanding the absence of a legally effective consent, have a defence to a charge of assault under section 24 of the *Criminal Code* (Qld). That section provides:

Mistake of fact. 24.(1) A person who does or omits to do an act under an honest and reasonable, but mistaken, belief in the existence of any state of things is not criminally responsible for the act or omission to any greater extent than if the real state of things had been such as the person believed to exist.

Thus, a health care provider who treated a young person under the honest and reasonable, but mistaken, belief that the young person was mature and intelligent enough to be able to provide a valid consent to treatment, would have a defence to a criminal action for assault.

Even in the absence of consent, in certain statutorily prescribed circumstances a health care provider may avoid criminal liability for treating, examining or operating on his or her patient. For example:

(i) Section 52 Medical Act 1939 (Qld)⁸²

Consent can be dispensed with in relation to surgical procedures to save or prolong a patient's life where the patient is considered by the medical practitioner to be incapable of consenting to the operation because of a mental disability. Section 52 of the *Medical Act 1939* (Qld) provides:

52. Operations when patient incapable of consenting. When a person who is in a hospital or institution is considered by the medical practitioner attending the person to require the performance of a surgical procedure to save or prolong the person's life and -

- (a) in the opinion of that medical practitioner, the person is not capable of consenting to the surgical procedure by reason of a mental disability; and
- (b) a relation of the person is not reasonably available to consent to the surgical procedure;

⁸¹ If not covered by the concept of implied consent, it may be covered by the principle of *de minimis non curat lex* (the law does not concern itself with trifles):

Courts of justice generally do not take trifling and immaterial matters into account, except in special circumstances, such as the trial of a right, or where personal character is involved.
(Jowitt, *The Dictionary of English Law* at 572).

⁸² The *Medical Act 1939* (Qld) is currently under review by Queensland Health. See Queensland Health, Draft Policy Paper *Review of Medical and Health Practitioner Registration Acts* (September 1996) at para 8.9.

the medical superintendent of the hospital or institution in which the person is or, if there is no such medical superintendent, the medical practitioner who is charged with the responsibility for medical care of persons in that hospital or institution may consent to the performance of the surgical procedure save where he or she is in either case the medical practitioner attending the person in question and the consent so given shall be sufficient authority for the performance of the surgical procedure.

Section 52 is restricted to surgical procedures in hospitals or institutions.

It is unclear from the wording of section 52 whether it is intended to apply in cases of emergency treatment.⁸³ It is also unclear whether an unconscious patient or a very young patient would be regarded as being incapable of consenting by reason of a "mental disability".

During the second reading speech of the *Medical Act Amendment Bill 1976* (Qld) the then Minister for Health stated in relation to the proposed section 52:⁸⁴

Before proceeding to carry out a surgical procedure it is necessary for a doctor to obtain the consent of the patient or, if the patient is a minor, the consent of the parent or legal guardian. In the case of an emergency such requirement may be waived if immediate action is necessary and the consent cannot be obtained. In fact a doctor would be failing in his duty if he did not act immediately, regardless of whether consent had been obtained or not. Sometimes, however, an occasion arises when an elective operation is necessary to prolong or save life. There is time to plan the operation but the patient himself is too confused owing to a psychiatric illness to give consent and no relative is available. In these circumstances it is proposed that the medical superintendent of the institution where the patient is an inmate give consent, provided he is not the doctor who will perform the operation.

Queensland Health has observed in relation to this passage:⁸⁵

[S]ection 52 was not intended to cover life-saving treatment given in emergency situations nor was it intended to apply to situations where the patient is unconscious.⁸⁶

⁸³ See 44-51 of this Report for a discussion on the common law of emergency.

⁸⁴ *Parliamentary Debates*, Legislative Assembly (Qld), 23 March 1976 at 2951. The *Parliamentary Debates* can be considered in determining the proper interpretation of legislative provisions: see s14B *Acts Interpretation Act 1954* (Qld).

⁸⁵ Queensland Health, *Discussion Paper Review of the Medical Act 1939* (September 1994) at 82.

⁸⁶ Queensland Health also observed in its Discussion Paper at 82:
The section suggests that a patient's relation has authority to provide consent to medical treatment on behalf of a patient who is incapable of consenting. However, where a patient is over the age of eighteen years, the consent of a relative is insufficient to make lawful what would otherwise be an assault.

(ii) **Section 282 *Criminal Code* (Qld)**

Criminal responsibility might also be avoided in relation to any "surgical operation" where the operation is for the patient's benefit.

Section 282 of the *Criminal Code* (Qld) provides:

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for the patient's benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case.

This provision could be used to excuse what would otherwise be an assault on a patient.⁸⁷ The words "having regard to the patient's state at the time and to all circumstances of the case" would indicate that the provision was intended to cover situations where the patient was unable to consent on his or her own behalf, and where there was no-one else available with authority to consent on the patient's behalf. It would also cover emergency situations where obtaining consent before treating the patient would be impracticable.⁸⁸

It does not matter that the person who performs a surgical operation is not qualified as a medical practitioner. The term "surgery" is defined in the Australian Concise Oxford Dictionary as "manual or instrumental treatment of injuries or disorders of the body", and this would presumably include the work of people such as nurses, dentists, and ambulance officers rendering first aid where manual treatment is involved and presumably anyone else performing surgical procedures on the patient so long as he or she uses reasonable skill and care in doing such an act.⁸⁹

The term "operation" has been defined as:⁹⁰

Surgical intervention upon a part of the body, usually performed with the use of instruments.

⁸⁷ For discussion on the meaning of this provision see O'Regan RS, "Surgery and Criminal Responsibility under the Queensland Criminal Code" (1990) 14 *Criminal Law Journal* 73.

⁸⁸ Fleming JG, *The Law of Torts* (8th ed 1992) at 83:
[A] doctor is privileged to amputate the gangrenous foot of an emergency patient who requires immediate surgery and is either unconscious or a child too young to give a valid consent and whose parents cannot be reached in time. [emphasis added]

⁸⁹ *Criminal Code* (Qld) s288. There would also be a duty imposed by reason of having control of a dangerous thing under s289 *Criminal Code* (Qld).

⁹⁰ *Medical Dictionary* (Butterworths, 2nd ed 1978).

To take advantage of section 282, the person who performed the surgery must have done so for the "benefit" of the patient. O'Regan QC has observed:⁹¹

The benefit may assume various forms. It may, for instance, be social, economic or therapeutic. Moreover, some operations, such as the removal of organs for transplant or the removal of blood for transfusion into others, benefit persons other than the patient. Experimental operations may advance science and benefit the wider community, but not those who submit to them. The section is incapable of application in many of these situations.

O'Regan has also suggested that it is doubtful whether "benefit" in this context would be given any wider meaning than "therapeutic" benefit.⁹²

Although section 282 makes no reference to the consent or dissent of the patient, the performance of the operation must be reasonable, having regard to the patient's state at the time and to all the circumstances of the case. A material circumstance would be whether the patient consented. O'Regan has stated:⁹³

It would be unreasonable to operate on an adult patient capable of an informed and rational choice without consent or on a person too young or ill to give consent without the approval of a parent or other person *in loco parentis*. It would be different where the parent or other person from whom consent was sought unreasonably refused to give it. If in those circumstances the operation was considered reasonably necessary to save life, prevent serious injury to health or relieve suffering, its performance would be reasonable, and protected by s282. Again, where emergency surgery is indicated it could be undertaken without the consent of others ... The autonomy of the patient should not lightly be disregarded, but it is also important that a doctor not be deterred by the risk of criminal prosecution from performing with reasonable care and skill an operation which he honestly and reasonably considers should be done for therapeutic reasons. However, the relevance of consent should be made explicit.⁹⁴

⁹¹ O'Regan RS, "Surgery and Criminal Responsibility under the Queensland Criminal Code" (1990) 14 *Criminal Law Journal* 73 at 75.

⁹² *Id* at 75-76.

⁹³ *Id* at 82-83.

⁹⁴ Such as in s51 of the Tasmanian *Criminal Code* which provides:

51.(1) It is lawful for a person to perform in good faith and with reasonable care and skill a surgical operation upon another person, with his consent and for his benefit, if the performance of such operation is reasonable, having regard to all the circumstances.

(2) In the case of a child too young to exercise a reasonable discretion in such a matter, such consent as aforesaid may be given by his parent or by any person having the care of such child.

(3) In the case of a person in such a condition as to be incapable of giving such consent as aforesaid, such operation may be performed without such consent.

O'Regan concluded that in its present form, section 282 gives inadequate protection to those who provide modern medical treatment.⁹⁵

(iii) Section 20 *Transplantation and Anatomy Act 1979* (Qld)

This provision protects medical practitioners from criminal liability where they give blood transfusions to persons under the age of 18 where a parent or person having authority to consent to the administration of the transfusion either fails or refuses to give consent.

A medical practitioner who administers a transfusion to a child without parental consent incurs no criminal liability if, in his or her opinion, this was necessary "to preserve the life of the child" and a second opinion to this effect is obtained.

Section 20 of the *Transplantation and Anatomy Act 1979* (Qld) provides:⁹⁶

(1) Where a blood transfusion is administered by a medical practitioner to a child, the medical practitioner or any person acting in aid of the medical practitioner and under the medical practitioner's supervision in administering such transfusion, shall not incur any criminal liability by reason only that the consent of a parent of the child or a person having authority to consent to the administration of the transfusion was refused or not obtained if -

(a) in the opinion of the medical practitioner a blood transfusion was necessary to preserve the life of the child; and

(b) either -

(i) upon and after in person examining the child, a second medical practitioner concurred in such opinion before the administration of the blood transfusion; or

(ii) the medical superintendent of a base hospital, being satisfied that a second medical practitioner is not available to examine the child and that a blood transfusion was necessary to preserve the life of the child, consented to the transfusion before it was administered (which consent may be obtained and given by any means of communication whatever).

(2) Where a blood transfusion is administered to a child in accordance with this section, the transfusion shall, for all purposes, be deemed to have been administered with the consent of a parent of the child or a person having authority to consent to the administration.

⁹⁵ O'Regan RS, "Surgery and Criminal Responsibility under the Queensland Criminal Code" (1990) 14 *Criminal Law Journal* 73 at 83.

⁹⁶ See 276-278 and 291-292 of this Report, where the Commission has recommended that this section be amended so as to enable a young person 16 or 17 years of age and competent to refuse a blood transfusion.

(3) Nothing in this section relieves a medical practitioner from liability in respect of the administration of a blood transfusion to a child, being a liability to which the medical practitioner would have been subject if the transfusion had been administered with the consent of a parent of the child or a person having authority to consent to the administration of the transfusion.

The purpose of the section is obviously to permit a transfusion to be given to a child, despite the refusal of a the child's parent or "person having authority to consent to the administration of the transfusion". It is not clear, however, whether the section would protect the medical practitioner from criminal liability in circumstances where it was a legally competent young person (rather than a parent) who refused the transfusion.

The words "person having authority to consent" in subsection 20(1) would not seem to include the young person to whom it is proposed to administer the transfusion.

Prior to the introduction of the *Transplantation and Anatomy Act 1979* (Qld), blood transfusions to children were dealt with in section 168B of the *Health Acts 1937-1979* (Qld).⁹⁷ Section 168B was framed in similar terms to subsection 20(1) of the *Transplantation and Anatomy Act 1979* (Qld), save that the section applied to persons under the age of twenty-one⁹⁸ and referred not to "a person having authority to consent to the administration of the transfusion", but to a "guardian".⁹⁹

The words "a person having authority to consent to the administration of the transfusion" were used in the similar provision in the draft legislation¹⁰⁰ appended to the Australian Law Reform Commission's Report *Human Tissue Transplants*.¹⁰¹ The *Transplantation and Anatomy Act 1979* (Qld) was based in part on the recommendations contained in that Report.¹⁰² The Australian Law Reform Commission's Report did not raise whether a young person

⁹⁷ This section was inserted by s79 of the *Health Acts Amendment Act 1959* (Qld).

⁹⁸ This was subsequently lowered to 18 years of age by the *Age of Majority Act 1974* (Qld) s8, Sch.

⁹⁹ Subsections 20(2) and (3) of the *Transplantation and Anatomy Act 1979* (Qld) reproduce sub-clauses 24(5) and (6) of the Draft *Transplantation and Anatomy Ordinance 1977* (ACT), which is appended to the Australian Law Reform Commission's Report *Human Tissue Transplants* (Report No 7, June 1977).

¹⁰⁰ Draft *Transplantation and Anatomy Ordinance 1977* (ACT) cl 24 (Administration of blood transfusions to children without parental consent).

¹⁰¹ Report No 7, June 1977.

¹⁰² *Parliamentary Debates*, Legislative Assembly (Qld), 6 December 1979 at 2407.

ought be able to consent to or refuse a transfusion, but simply recommended that.¹⁰³

the provisions of existing State and Federal legislation permitting transfusion to incompetents without **parental consent** should continue in force. [emphasis added]

Further, in the Second Reading Speech in relation to Queensland's *Transplantation and Anatomy Bill*, the then Minister for Health, Sir William Knox, commented:

I make it quite clear that no new legislation is being introduced dealing with children and blood. We are repeating what exists in present legislation, which is being repealed by this Bill. So there is no departure. Although it is mentioned in some detail in this Bill, it is simply a repetition of what exists in other legislation.

From those comments, it does not seem that the change in the wording of the provision from "guardian" in the *Health Acts 1937-1979* (Qld) to "person having authority to consent to the administration of the transfusion" in the *Transplantation and Anatomy Act 1979* (Qld) was intended to extend the class of people whose refusal could, by virtue of that provision, be overridden, by including the legally competent young person.

If this construction is correct, then there is at least no express protection from criminal liability for a medical practitioner who administers a transfusion to a legally competent young person who objects to the transfusion.

Although subsection 20(2) provides that a transfusion administered in accordance with section 20 is deemed to have been administered with the consent of a parent of the child, that would arguably only place the medical practitioner in the same position that he or she would be in under the common law if a young person were treated on the basis of a parental consent, but against the wishes of the young person.

It is still uncertain as to how the courts in Australia will resolve that conflict. The English courts have held that a parental consent would override a refusal by the young person.¹⁰⁴ In Australia, however, the High Court has expressed some reservations about those English decisions and the question remains to be resolved.¹⁰⁵

¹⁰³ Report No 7, June 1977 at 84.

¹⁰⁴ See 64-68 of this Report.

¹⁰⁵ See 73-74 of this Report.

(iv) Other provisions

A. *Health Act 1937 (Qld)*

The *Health Act 1937 (Qld)* enables medical practitioners to examine and treat certain persons without consent if necessary. For example:

- . A person suspected of suffering from a notifiable disease can be examined and treated against his or her will.¹⁰⁶
- . School children and others may be examined if suspected of being infected with a notifiable disease.¹⁰⁷
- . All pupils attending schools must submit to medical and dental inspections provided for by the Minister.¹⁰⁸
- . A child¹⁰⁹ who has presented or been presented at a hospital and is suspected of being maltreated or neglected so as to be subject or likely to be subject to unnecessary injury, suffering or danger can be subjected to such diagnostic procedures and tests as the prescribed medical officer considers necessary to determine his or her medical condition - notwithstanding the wishes of any parent, guardian or person having authority to consent to the child's treatment.¹¹⁰

¹⁰⁶ *Health Act 1937 (Qld)* s36.

¹⁰⁷ *Id* s47(4).

¹⁰⁸ *Id* s47(5), (6). The provisions of s47(5)-(12) of the *Health Act 1937* fall within Part 3 of the Act: *Prevention, Notification and Treatment of Disease or Disability* and, in particular, Division 2 of that Part: *Notifiable Diseases*, and have done so since 1937. Although subsections 47(5)-(12) do not specifically refer to notifiable diseases, they should be read in the context of the whole section and in the contexts of the Part and Division of the Act within which they appear. It could be strongly argued that the Minister's and Director General's powers under s47(5)-(12) are restricted to situations involving notifiable diseases. However, this is not the impression that a number of health care providers working in Queensland schools have of those provisions. The Commission has heard from a number of nurses working in primary and high schools about their confusion with these provisions. The confusion arises from a number of beliefs, such as, that everything a nurse does in his or her line of duty in a school is protected by the authority given to the nurse by the Minister or Director General. Thus, even if a valid consent is not obtained from the parent or child, and a touching is involved in the examination or treatment of the child, the nurse may believe that he or she would not be liable for the touching because he or she has an immunity from liability due to the nature of his or her relationship with the Minister.

It is not clear that this is the law. Unless the Minister gives a specific order to examine school children in a particular way, the nurse acting without a valid consent may be liable for assault. The health care provider must make a correct assessment of the young person's intelligence and maturity to be able to rely on the young person's consent solely.

¹⁰⁹ A "child" for the purposes of s76L is defined in s76M as meaning a person under or apparently under the age of 17 years.

¹¹⁰ *Health Act 1937 (Qld)* s76L. See Queensland Law Reform Commission, Research Paper *Medical Examinations in Cases of Suspected Child Abuse* (MP17, June 1996).

- Drug offenders convicted under the *Drugs Misuse Act 1986* (Qld) and detained for treatment under section 130B of the *Health Act 1939* (Qld), are to be examined at least every six months by a medical practitioner.¹¹¹

B. *Children's Services Act 1965* (Qld)¹¹²

Section 143 of the *Children's Services Act 1965* (Qld) provides:

- (1) For so long as the director is guardian of an infant the director shall be deemed to be guardian of the person and the estate of such infant.
- (2) While a child who, pursuant to the provisions of this Act, has been remanded into the temporary custody of the director remains so remanded the director may do all such acts and give all such consents in relation to such child as the director might lawfully do and give if the director were the guardian of such child.
- (3) It shall be lawful to submit an infant who is in the guardianship of the director or who, pursuant to this Act, is in the temporary custody of the director or of any other person (whether by way of remand or otherwise) to medical examinations and to therapeutic, palliative or preventive treatments (physical, psychiatric or psychological) if the consent of the director or, as the case may be, such person is first had and obtained.

Section 145 of the *Children's Services Act 1965* (Qld) provides that where a Court has ordered that a medical examination be made in relation to any person it is lawful to make the examination notwithstanding that the person or his or her parent or guardian has not consented to it.

For young people ordered to be admitted to the care and protection, or who are sought to be admitted to the care and control of the Director-General, the Childrens Court must order such medical examinations as appear necessary or desirable.¹¹³ Where a young person is admitted to the care and protection or care and control of the Director-General, the guardianship of the young person passes to the Director-General for the duration of the order.¹¹⁴

¹¹¹ *Health Act 1937* (Qld) s130C.

¹¹² This Act is currently under review by the Department of Families, Youth and Community Care.

¹¹³ *Children's Services Act 1965* (Qld) ss49(3) and 61(3).

¹¹⁴ *Id* ss55(1), 64(1).

C. *Corrective Services Act 1988 (Qld)*

The *Corrective Services Act 1988* (Qld) generally provides for corrective services with respect to people 17 years of age or over.¹¹⁵

- . A prisoner is required to submit to any examination or treatment authorised by section 50 of the Act.¹¹⁶ That section authorises a medical officer, for the purpose of any examination or treatment, to:
 - (a) carry out any medical test;
 - (b) take samples of a prisoner's blood and any other bodily substance;
 - (c) order a prisoner to provide a urine sample;
 - (d) perform any psychiatric or psychological examination or test or give any psychiatric or psychological treatment.
- . A prisoner must also submit to psychological assessments ordered by the Corrective Services Commission.¹¹⁷

D. *Criminal Code (Qld)*

Although not strictly relating to health care, it is of interest to note that subsection 259(3) of the *Criminal Code* (Qld) authorises a medical practitioner or his or her assistant to do the following things to a person in lawful custody upon a charge of committing an offence (prisoner):

- . examine the prisoner "including the orifices of the person's body";¹¹⁸
- . "take samples of the person's blood, saliva or hair";¹¹⁹

¹¹⁵ Young people who are under 17 years of age are dealt with under the *Juvenile Justice Act 1992* (Qld). See the definition of "child" in s5 of that Act. *Corrective Services Act 1988* (Qld) s38 provides that prisoners under the age of 18 years are to be kept apart from prisoners who are 18 years of age or older. Note also that the *Penalties and Sentences Act 1992* (Qld) s6(2) provides that that Act does not apply to a child within the meaning of the *Juvenile Justice Act 1992* (Qld), except to the extent allowed by the *Juvenile Justice Act 1992* (Qld).

¹¹⁶ *Corrective Services Act 1988* (Qld) s51.

¹¹⁷ Id s53(1).

¹¹⁸ *Criminal Code* (Qld) s259(3)(a)(i).

¹¹⁹ Id s259(3)(a)(ii).

- . "require the person to provide a sample of the person's urine";¹²⁰
- . "collect from his or her person, including the orifices of the person's body, any substance or thing if collecting the substance or thing would be unlikely to cause bodily harm to that person if the person co-operates therewith".¹²¹

The section also authorises a dentist or his or her assistant to do the following things to a prisoner:

- . "examine the mouth of the person";¹²²
- . "take samples of the person's saliva";¹²³
- . "take dental impressions from the person".¹²⁴

A person cannot do any of the above acts unless the prisoner consents in writing to the doing of the act and, where the prisoner is a young person, "consents in writing in the presence of a parent or guardian or an adult who is either a friend of the person in custody or does not have an interest in the matter in respect of which the charge is made".¹²⁵ Alternatively, an act can be performed without consent if a stipendiary magistrate approves the doing of the act.¹²⁶ In either case, the prisoner has the right to have two persons of his or her choice present while the act is being done.

Section 259 presumes that a "child"¹²⁷ can consent to such procedures, albeit in the presence of a parent or other adult. No competency test is applied.

¹²⁰ Id s259(3)(a)(iii).

¹²¹ Id s259(3)(a)(iv).

¹²² Id s259(3)(b)(i).

¹²³ Id s259(3)(b)(ii).

¹²⁴ Id s259(3)(b)(iii).

¹²⁵ Id s259(4)(a).

¹²⁶ Id s259(4)(b).

¹²⁷ People in Queensland can be criminally responsible for any act or omission from and including 10 years of age, although people under 15 years of age are not criminally responsible "unless it is proved that at the time of doing the act or making the omission, the person had capacity to know that the person ought not to do the act or make the omission": *Criminal Code* (Qld) s29. The Criminal Code Advisory Working Group in its *Report to the Attorney-General* (July 1996) recommended lowering the age at which young people, pursuant to the rebuttable presumption in section 29, are criminally responsible for their actions, from 15 years to 14 years. See *Criminal Law Amendment Bill 1996* (Qld) cl 12.

E. *Family Law Act 1975 (Cth)*

Subsection 69W(3) of the *Family Law Act 1975* (Cth) provides that an order requiring testing to determine the parentage of a person may be made in relation to "any other person, if the court is of the opinion that, if the parentage testing procedure were to be carried out in relation to the person, the information that could be obtained might assist in determining the parentage of the child".¹²⁸

F. *Juvenile Justice Act 1992 (Qld)*

This Act covers young people who have committed or who are alleged to have committed offences. It generally relates to people under the age of 17. When it refers to "medical treatment", it is referring to "a physical, psychiatric, psychological or dental examination or treatment" and "treatment" includes "therapeutic, palliative and preventative treatment".¹²⁹

The Queensland Corrective Services Commission is authorised "despite any other Act or law" to give consent to any medical treatment of a young person in its custody if:¹³⁰

- (a) the medical treatment requires the consent of a guardian of the child; and
- (b) the commission is unable to ascertain the whereabouts of a guardian of the child despite reasonable inquiries; and
- (c) it would be detrimental to the child's health to delay the medical treatment until the guardian's consent can be obtained.

Presumably such consent would be effective despite refusal of treatment by the young person, although some medical practitioners might feel ethically obliged to take into account an older child's views before proceeding with the treatment, despite the fact that the young person is in custody.¹³¹

¹²⁸ The equivalent to s69W(3) prior to the *Family Law Reform Act 1995* (Cth) was considered in *In the Marriage of F and R* (1992) 15 Fam LR 533. Compare with s11 *Status of Children Act 1978* (Qld) which provides that similar testing may be ordered by the Supreme Court of Queensland but can only be carried out with the consent of the person (if he has capacity to consent). In *Re Riley* [1996] 1 Qd R 209 it was held that the Supreme Court of Queensland has no power at common law to direct a person to provide bodily samples for testing.

¹²⁹ *Juvenile Justice Act 1992* (Qld) s5.

¹³⁰ Id s212 as amended by the *Juvenile Justice Legislation Amendment Act 1996* (Qld). The Commission may delegate to a chief executive of a department or to an officer of the Commission or the public service a power conferred on the Commission under the *Juvenile Justice Act 1992* (Qld): *Juvenile Justice Act 1992* (Qld) s9B(2).

¹³¹ The Australian Medical Association *Code of Ethics* February 1996 1.3(b) provides:
Respect your patient's right to choose their doctor freely, to accept or reject advice and to make their own decisions about treatment or procedures.

(b) False imprisonment

There will be circumstances in which the health care of a young person without an appropriate consent will amount to false imprisonment. False imprisonment is a crime in Queensland under section 355 of the *Criminal Code* (Qld) which provides:

S.355 Deprivation of Liberty. Any person who unlawfully confines or detains another in any place against his will, or otherwise unlawfully deprives another of his personal liberty, is guilty of a misdemeanour, and is liable to imprisonment for three years.

Consent is a defence to the crime of deprivation of liberty as the act of imprisonment must be against the will of the person being imprisoned. Nevertheless, the person does not need to be aware of the restraint.¹³² The state of mind of the health care provider is relevant only in that the imprisonment must be intentional; it is not relevant whether or not the imprisonment was considered by the health care practitioner to be for the patient's own good.¹³³

The relevance of false imprisonment to the provision of health care is discussed at 41-43 of this Report.

3. CIVIL LIABILITY FOR TRESPASS TO THE PERSON

The principal civil ground of action available to a person who has been the subject of health care without his or her consent, is for damages for trespass to the person. Trespass to the person comprises three separate torts: battery, assault and false imprisonment. Each of these may have relevance in the provision of health care. Each can be a crime or a civil wrong.

The institution of an action in tort would be primarily to recover damages suffered as a result of the wrong done to the plaintiff.

(a) Battery

To subject a patient to health care involving a touching without the patient or another authorised person consenting to what is about to be done is battery.

¹³² Lord Atkin in *Meering v Grahame-White Aviation Co* (1919) 122 LT Rep 44 at 53-54 noted:

[A] person can be imprisoned while he is asleep, while he is unconscious, or while he is a lunatic. So a man might in fact be imprisoned by having the key of a door turned against him so that he is imprisoned in a room in fact although he does not know that the key has been turned.

This view prevailed in the House of Lords in *Murray v Ministry of Defence* [1988] 2 All ER 521 and has been confirmed in Australia: see *Myer Stores Ltd v Soo* [1991] 2 VR 597 per O'Bryan J at 615.

¹³³ Wallace M, *Healthcare and the Law* (2nd ed 1995) at 89; *Australian Health and Medical Law Reporter* at 18-780.

Battery is committed when a person, intending or being in the position of foreseeing this result, does an act which directly and physically affects the person of another. There need be no intention to commit a battery - merely an intention to commit the requisite interference with the plaintiff's person. It is generally acknowledged that consent to the battery by the plaintiff is a defence to the action, the burden of establishing which rests on the defendant.¹³⁴ Mistake of fact or law is usually no defence - however reasonable the mistake (for example, mistake as to age, competency or maturity) may be. Thus, battery may operate as a tort of strict liability.

Although many incidents falling within the ambit of battery will be accompanied by hostility on the part of the defendant, a surgeon without hostility towards the plaintiff who exceeds the plaintiff's consent in the course of an operation nevertheless commits a battery.¹³⁵

In the 1988 English case of *T v T*, Wood J observed:¹³⁶

The incision made by the surgeon's scalpel need not be and probably is most unlikely to be hostile, but unless a defence or justification is established it must in my judgment fall within the definition of a trespass to the person.

Thus, unless there is actual consent or an implied consent, operative procedures at least will *prima facie* be acts of trespass to the person. To hold otherwise could lead to the proposition that all health care procedures may lawfully be performed without consent. As Grubb has observed:¹³⁷

¹³⁴ McHugh J in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 at 309-311:

the common law respects and preserves the autonomy of adult persons of sound mind with respect to their bodies. By doing so, the common law accepts that a person has rights of control and self-determination in respect of his or her body which other persons must respect. Those rights can only be altered with the consent of the person concerned. Thus, the legal requirement of consent to bodily interference protects the autonomy and dignity of the individual and limits the power of others to interfere with that person's body.

At common law, therefore, every surgical procedure is an assault unless it is authorised, justified or excused by law ...

In England, the onus is on the plaintiff to prove lack of consent. That view has the support of some academic writers in Australia, but it is opposed by other academic writers in Australia. It is opposed by Canadian authority. It is also opposed by Australian authority [*Hart v Herron* [1984] Aust. Torts R. 80-201; *Sibley v Milutinovic* [1990] Aust. Torts R. 81-013]. Notwithstanding the English view, I think that the onus is on the defendant to prove consent ... The essential element of the tort is an intentional or reckless, direct act of the defendant which makes or has the effect of causing contact with the body of the plaintiff. Consent may make the act lawful, but, if there is no evidence on the issue, the tort is made out. The contrary view is inconsistent with a person's right of bodily integrity.

¹³⁵ See *Boughey v The Queen* (1986) 161 CLR 10 where the High Court confirmed that intentional application of force to an unwilling victim need not be accompanied or motivated by positive hostility or hostile intent to be battery or assault.

¹³⁶ *T v T* [1988] 2 WLR 189 at 203.

¹³⁷ Grubb A, "Medical Law" *All ER Rev* (1988) 200 at 209.

This is an unattractive prospect because it lacks the core legal notion which seeks to protect the patient's autonomy in medical decision-making.

At common law, contact between people which conforms to accepted every day human behaviour does not amount to battery - at least where there is no indication that the contact would be resented.¹³⁸ Thus, it would not normally be a battery for someone to tap another on the shoulder to gain his or her attention or to touch someone whilst passing in a narrow passage.¹³⁹

In *T v T*, Wood J observed:¹⁴⁰

There are certain acts of physical contact which fall within a reasonable and generally acceptable band of conduct which may occur in the ordinary course of daily life and which will be the subject of a deemed consent in order to allow that ordinary daily life to continue (the exigencies of daily life) and that physical contact within that reasonable and acceptable band is no battery. However, when the physical act of contact does not fall within that band, there is the prima facie case of battery to which a defence or other justification must be raised ... [for example - children being subjected to reasonable punishment]. It would not seem to me that operative treatments or perhaps in some more serious cases medical treatments in hospital fall within the phrases 'exigencies of everyday life' or 'the ordinary conduct of daily life.' [emphasis added]

(b) Assault

An assault is committed if a person intentionally and directly causes another person to apprehend that he or she is going to commit a battery against that other person. Usually, the tort of assault and the tort of battery are committed in quick succession. This would normally be the situation arising in the context of treatment without appropriate consent.

Because the basis of assault is the apprehension of impending contact, the effect on the victim's mind is all important - not whether the defendant actually had the intention or means to follow it up. As Fleming states:¹⁴¹

¹³⁸ *Collins v Wilcock* [1984] 1 WLR 1172 at 1177, where Goff LJ states:
it is more common nowadays to treat (such cases) ... as falling within a general exception embracing all physical contact which is generally acceptable in the ordinary conduct of daily life.
See also *Horan v Ferguson* [1995] 2 Qd R 490.

¹³⁹ *Cole v Turner* (1704) 6 Mod 149; 87 ER 907. See also 15-17 of this Report.

¹⁴⁰ *T v T* [1988] 2 WLR 189 at 202, summarising the analysis made by Goff LJ in *Collins v Wilcock* [1984] 1 WLR 1172.

¹⁴¹ Fleming JG, *The Law of Torts* (8th ed 1992) at 26.

The intent required for the tort of assault is the desire to arouse apprehension of physical contact, not necessarily to inflict actual harm.... It is sufficient if the threat would have aroused an expectation of physical aggression in the mind of a reasonable person not afflicted with exaggerated fears or peculiar and abnormal timidity.

(c) False imprisonment

The tort of false imprisonment has been defined as "intentionally and without lawful justification subjecting another to a total restraint of movement by either actively causing his [or her] confinement or preventing him [or her] from exercising his [or her] privilege of leaving the place in which he [or she] is".¹⁴² The justification of the tort has been described by Lord Griffiths as follows:¹⁴³

The law attaches supreme importance to the liberty of the individual and if he suffers a wrongful interference with that liberty it should remain actionable even without proof of special damage.

Consent is also a defence to the tort of false imprisonment, as the act of imprisonment must be against the will of the person being imprisoned. Nevertheless, the person does not need to be aware of the restraint.¹⁴⁴ The state of mind of the health care provider is relevant only in that the imprisonment must be intentional; it is not relevant whether or not the imprisonment is considered by the health care provider to be for the patient's own good.¹⁴⁵

To establish a cause of action for false imprisonment it is necessary to prove only a restriction of personal liberty. Unlike battery and assault, false imprisonment does not require the threat or actual application of force.¹⁴⁶ Nor is it relevant that the restrained person lacked the capacity to consent to, or refuse, the deprivation of liberty.

False imprisonment may be relevant for health care providers in a number of situations. For example:

¹⁴² Id at 27. Detention may be lawful. See, for example, *Criminal Code* (Qld), *Quarantine Act 1908* (Qld), *Health Act 1937* (Qld), and *Mental Health Act 1974* (Qld).

¹⁴³ *Murray v Ministry of Defence* [1988] 2 All ER 521 at 529.

¹⁴⁴ Lord Atkin in *Meering v Grahame-White Aviation Co* (1919) 122 LT Rep 44 at 53, 54 noted:
[A] person can be imprisoned while he is asleep, while he is unconscious, or while he is a lunatic.
So a man might in fact be imprisoned by having the key of a door turned against him so that he is imprisoned in a room in fact although he does not know that the key has been turned.
This view prevailed in the House of Lords in *Murray v Ministry of Defence* [1988] 2 All ER 521 and has been confirmed in Australia - see *Myer Stores Ltd v Soo* [1991] 2 VR 597 per O'Bryan J at 615.

¹⁴⁵ Wallace M, *Healthcare and the Law*, (2nd ed 1995) at 89; *Australian Health and Medical Law Reporter* at 18-780.

¹⁴⁶ *Hart v Herron* (1984) Aust Torts Reports ¶80-201.

- **Young patient wishes to discharge himself or herself from hospital**

If a young person wishes to discharge himself or herself from hospital against the advice of the health care provider and/or the hospital, capacity is relevant. If the young person has sufficient capacity to consent to the health care being provided by the hospital, then it would be difficult to argue that the young person does not have capacity to consent to his or her discharge from the hospital. Accordingly, it would amount to false imprisonment and the crime of deprivation of liberty if the young person were held there against his or her will. The restraint need not be physical. It is enough that the young person submitted to the detention under the reasonable belief that he or she was not free to go, for example, because the hospital account has not been paid.

On the other hand, if the young person does not have capacity to consent to the health care and a parent's consent was obtained, then the young person can be detained at the hospital against his or her will, until the parent consents to the discharge.¹⁴⁷

- **Refusing to allow a young patient to leave the premises**

A verbal direction by a health care provider that a young person cannot leave until treatment is completed would amount to false imprisonment, provided that the young person believes that he or she has no choice but to submit.¹⁴⁸ It is the subjective belief of the patient that is relevant, not whether there is in fact a physical means of leaving.¹⁴⁹

- **Placing physical/chemical/mental restraints on a young person preventing them freedom of movement**

Restraint can be justified only if it is for the protection of the patient and/or others, and not just for the convenience of health care providers and staff.¹⁵⁰ In any other case, an action for false imprisonment will lie if a young person is physically, chemically or mentally restrained to a particular place, whether or not he or she is aware of it.¹⁵¹ It follows from this that a young patient who

¹⁴⁷ *Australian Health and Medical Law Reporter* at 18-770.

¹⁴⁸ *Watson v Marshall* (1971) 124 CLR 621.

¹⁴⁹ *Symes v Mahon* [1922] SASR 447.

¹⁵⁰ Wallace M, *Healthcare and the Law* (2nd ed 1995) at 89.

¹⁵¹ *Meering v Grahame-White Aviation Co Ltd* (1919) 122 LT Rep 44.

does not have the capacity to understand that he or she is being detained without the consent of a parent may still be the subject of false imprisonment.

In *Hart v Herron*¹⁵² a mentally ill adult patient brought a successful claim for false imprisonment when he was detained and given electroconvulsive treatment and deep sleep therapy without a valid consent, notwithstanding the fact that he had no memory of the imprisonment. This would apply equally to young patients who are subjected to such types of treatment without a valid consent from the young person or a parent.

Example

A young person seeking treatment for depression consults a psychologist who, as part of the treatment, hypnotises the young person without fully explaining the procedure or seeking to assess the young person's competence to consent. The young person may have an action against the psychologist for false imprisonment for the time he or she was hypnotised. It is unlikely that an action for assault and battery could be supported if there was no physical contact, or threatened physical contact, between the psychologist and the young patient.

4. PROFESSIONAL DISCIPLINE

A health care provider may also be the subject of disciplinary action by his or her professional organisation if he or she provides health care to a patient without the patient's consent or without other lawful authority. For example, registered medical practitioners are subject to the supervision of the Medical Assessment Tribunal established under the *Medical Act 1939* (Qld).¹⁵³ The Act regulates the circumstances in which a medical practitioner's right to practise may be restricted or suspended. An appropriate charge under the Act for treating a patient without consent may be that the medical practitioner has committed "misconduct in a professional respect".¹⁵⁴ Other professional bodies may have disciplinary

¹⁵² (1984) Aust Torts Reports ¶80-201.

¹⁵³ *Medical Act 1939* (Qld) s33.

¹⁵⁴ Id ss35, 35A. The Government's preferred policy is to retain registration boards, however, there have been proposals made to streamline the boards' functions in a number of respects: Queensland Health, Draft Policy Paper *Review of Medical and Health Practitioner Registration Acts* (September 1996) at 12-18.

procedures for members who treat patients or clients without a valid consent or otherwise without legal authority.¹⁵⁵

5. EXCEPTION TO REQUIREMENT FOR CONSENT: EMERGENCY HEALTH CARE

(a) Introduction

At common law a person will not be criminally or civilly liable for assault or battery for providing health care to a person whose injury or illness makes it impossible for him or her to be able to consent to or refuse the health care, if the person requires health care in an emergency situation. This rule will also apply in the situation of a young person who is unable to consent in those circumstances because he or she is still too young or immature. In an emergency situation, health care can be carried out without a valid consent. As McHugh J stated in *Marion's* case:¹⁵⁶

consent is not necessary ... where a surgical procedure or medical treatment must be performed in an emergency and the patient does not have the capacity to consent and no legally authorised representative is available to give consent on his or her behalf.

This exception to the general requirement for a valid consent would, for example, apply to a young person who had been knocked unconscious and sustained serious injuries in a car accident (and hence was physically incapable of giving consent) and whose parents were not present to give consent.

It appears that the exception only applies where immediate treatment is necessary in order to save a person's life or to prevent serious injury to a person's health. The exception is not limited to health care providers but can be relied on by any person who, for example, renders assistance to a person injured at the scene of an accident.

The basis for the exception has been the subject of debate. In the past, the exception was said to be based on the principle that a person gives his or her implied consent to all life-saving contacts¹⁵⁷ or that it came within the general, much broader, exception that a person who moves about in public impliedly consents to all bodily contact that is a normal part of everyday life, for example, jostling in a street

¹⁵⁵ The Codes of Ethics of a number of professional organisations which have contacted the Commission provide for disciplinary proceedings against members who it has been alleged have breached their respective codes.

¹⁵⁶ (1992) 175 CLR 218 at 310.

¹⁵⁷ *Mohr v Williams* 104 NW 12 (1905) (USA).

or on public transport.¹⁵⁸ Recently, in England and in Canada, it has been said to be founded upon the principle of necessity, that is, the principle which justifies action taken as a matter of necessity that would otherwise be unlawful.¹⁵⁹

According to Goff LJ in the English case of *In re F*,¹⁶⁰ the principle of necessity can only be relied on to justify the act of treating a person without his or her consent if the following two conditions are satisfied:¹⁶¹

- (i) there must be a necessity to act when it is not practicable to communicate with the assisted person; and
- (ii) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person.

In England, for people who are unable to provide a valid consent to health care, because of a decision-making disability other than age, the principle of necessity has been held to justify any type of "necessary" treatment, whether or not in an emergency type situation.¹⁶² That approach is not surprising, however, given that the House of Lords has held that the *parens patriae* jurisdiction in respect of adults of unsound mind is no longer vested in the courts.¹⁶³ If the principle of necessity did not extend to the non-emergency treatment of adults with a decision-making disability, they would have been in the position that no-one (not even the court) could consent to their treatment, and therefore no treatment could lawfully proceed.

There is, however, no decided case law which would suggest that the English approach to non-emergency health care represents the position in Queensland.

¹⁵⁸ *Wilson v Pringle* [1987] QB 237 at 252.

¹⁵⁹ *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 per Goff LJ at 74-77 and *Malette v Shulman* (1990) 67 DLR (4th) 321 at 328-329.

¹⁶⁰ [1990] 2 AC 1 at 75.

¹⁶¹ In the decision of *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 at 74 Goff LJ said:
... doubtless, in the case of a person of sound mind, there will ordinarily have to be an emergency before such action taken without consent can be lawful.

¹⁶² *Ibid.*

¹⁶³ It was held in *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 that as a result of the coming into force of the *Mental Health Act 1959* (UK) and the revocation on 1 November 1960 of the Warrant by which the jurisdiction of the Crown over the persons and property of those persons found to be of unsound mind had been assigned to the Lord Chancellor and the judges of the High Court, Chancery Division, the *parens patriae* jurisdiction with respect to adults of unsound mind no longer existed. See 94-95 of this Report for an explanation of the *parens patriae* jurisdiction.

(b) The meaning of "emergency"

Although there is no definitive authority on the meaning of the words "emergency health care", it is generally accepted that it refers to health care that is absolutely necessary or health care where time is of the essence, in the sense that it must reasonably appear that delay until such time as an effective consent can be obtained would subject the patient to a risk of either a serious bodily injury (or health problem) or death, which prompt action would avoid.¹⁶⁴

Health care that can be put off for a week or more will not amount to emergency health care. Treatment to save a limb should amount to emergency health care, but treatment for a broken limb may not. It is not clear whether the exception will even extend to cover treatment for the reduction of extreme pain.

As a common law concept the term "emergency" will be re-defined and moulded in the future according to the circumstances presenting themselves to the courts.

(c) Alleviation of future possible risk

Non-consensual health care provided to alleviate a future possible risk would not be considered to be health care reasonably required in the circumstances of the emergency. As Goff LJ observed in *In re F (Mental Patient: Sterilisation)*:¹⁶⁵

Where, for example, a surgeon performs an operation without his [or her] consent on a patient temporarily rendered unconscious in an accident, he [or she] should do no more than is reasonably required, in the best interests of the patient, before he [or she] recovers consciousness. I can see no practical difficulty arising from this requirement, which derives from the fact that the patient is expected before long to regain consciousness and can then be consulted about longer term measures.

Thus, in the New South Wales case of *Walker v Bradley*,¹⁶⁶ Kirkham DCJ found a gynaecologist to be liable in trespass on the basis that he had removed his patient's uterus without her consent when it was not absolutely necessary to do so.

The gynaecologist had performed the hysterectomy on his patient in circumstances where the patient had told the gynaecologist that he was only to remove her uterus if, on examination, he found that she had cancer. Although the gynaecologist found no cancer, he went ahead and removed the patient's uterus because he believed that the patient's uterus could cause her problems in the future.

¹⁶⁴ *Malette v Shulman* (1990) 67 DLR (4th) 321 at 328-329 and *Walker v Bradley*, (Unreported, District Court of New South Wales, Kirkham DCJ, 15 December 1993).

¹⁶⁵ [1990] 2 AC 1 at 77.

¹⁶⁶ Unreported, District Court of New South Wales, Kirkham DCJ, 15 December 1993.

However, in the Canadian case of *Marshall v Curry*¹⁶⁷ the alleviation of a future possible risk was held to be reasonable. A patient was under anaesthetic for a hernia repair when the surgeon noticed that the patient had a diseased left testicle. The surgeon went ahead and removed the diseased testicle without the patient's consent. If the operation had been postponed, the patient could have died from septicaemia. The court held that the operation was justified because it had been carried out to save the life and health of the patient.

(d) Refusal of emergency health care

Although there is no Queensland or Australian authority on point, it is arguable that the common law exception as to emergency cannot be used to override a patient's refusal of emergency health care (given just prior to, or at the time the emergency health care is required) where that patient has the legal capacity to refuse health care.¹⁶⁸ In the Canadian case of *Malette v Shulman*,¹⁶⁹ where the plaintiff was seriously injured in a car accident and was taken unconscious to hospital where she was given a blood transfusion, the Court observed:¹⁷⁰

A doctor is not free to disregard a patient's advance instructions any more than he would be free to disregard instructions given at the time of an emergency. The law does not prohibit a patient from withholding consent to emergency medical treatment, nor does the law prohibit a doctor from following his [or her] patient's instructions. While the law may disregard the absence of consent in limited emergency circumstances, it otherwise supports the right of competent adults to make decisions concerning their own health care by imposing civil liability on those who perform medical treatment without consent.

Similarly, it is arguable that the common law emergency exception cannot be used to override a patient's written unequivocal instructions to refuse certain emergency health care (given prior to and in anticipation of the need for emergency health care) - for example, a blood transfusion - where that patient has the legal capacity to refuse such health care. In *Malette v Shulman* the defendant doctor gave the plaintiff a blood transfusion even though he was aware that the plaintiff's purse contained a card which identified her as a Jehovah's Witness and requested on the basis of her religious convictions that she not be given a blood transfusion under any circumstances. The Court held that the Jehovah's Witness card imposed a

¹⁶⁷ [1933] 3 DLR 260.

¹⁶⁸ The principle of necessity does not apply unless it is "not practicable to communicate with the assisted person": see *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 per Goff LJ at 75. There is no direct Australian authority on this point and some commentators believe that the Australian courts are unlikely to uphold an action brought by an assisted person against a person who has carried out non-consensual life-saving treatment: see, for example, Wallace M, *Health Care and the Law* (2nd ed 1995) para [4.21] at 57.

¹⁶⁹ (1990) 67 DLR (4th) 321.

¹⁷⁰ *Id* at 330.

valid restriction on the emergency health care that could be provided to the plaintiff and precluded the defendant doctor from giving the plaintiff a blood transfusion. The defendant doctor was held liable for battery. In the course of its judgment, the court made the following comments:¹⁷¹

The fact that [the defendant doctor] had no opportunity to offer medical advice cannot nullify instructions plainly intended to govern in circumstances where such advice is not possible. Unless the [defendant] doctor had reason to believe that the instructions in the Jehovah's Witness card were not valid instructions in the sense that they did not truly represent the [plaintiff's] wishes, in my opinion he was obliged to honour them. He has no authorisation under the emergency doctrine to override the [plaintiff's] wishes. In my opinion, she was entitled to reject in advance of an emergency a medical procedure inimical to her religious values.

(e) Overriding refusal of parent

Although there is no relevant authority on the point, it is perhaps arguable that the common law emergency exception may operate to authorise a person to override the refusal by a parent (or parents) of a young person of health care for the young person where that refusal is not in the best interests of the young person. The basis for this argument is that, since a parent has no power to consent to health care on behalf of his or her child that is not in the child's best interests,¹⁷² a person should not be liable for assault or battery where emergency health care would be in the child's best interests.

(f) Statutory exceptions

In Queensland (and in all other Australian jurisdictions)¹⁷³ there are a number of statutory provisions which reinforce the general principle that consent to health care need not be sought in emergency situations. The provisions can only be relied on by particular types of health care providers and not, for example, by a non-qualified person who renders assistance to a person injured at the scene of an accident.

¹⁷¹ Id at 336-337.

¹⁷² See 90-91 of this Report.

¹⁷³ Relevant statutory provisions in other Australian jurisdictions include: *Emergency Medical Operations Act 1973* (NT) s3; *Transplantation and Anatomy Act 1978* (ACT) s23; *Human Tissue and Transplant Act 1982* (SA) s21; *Human Tissue Act 1982* (Vic) s24; *Human Tissue Act 1985* (Tas) s21; *Children (Care and Protection) Act 1987* (NSW) s20A; *Ambulance Services Act 1990* (NSW) s26; *Mental Health Act 1990* (NSW) ss186 and 201; *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s13.

Section 16 of the *Law Reform Act 1995* (Qld)¹⁷⁴ provides some legal protection for medical practitioners and nurses who voluntarily stop at the scene of an accident (for example, a car accident) to assist a person in need of emergency health care:

Liability at law shall not attach to a medical practitioner, nurse or other person prescribed under a regulation¹⁷⁵ in respect of an act done or omitted in the course of rendering medical care, aid or assistance to an injured person in circumstances of emergency -

- (a) at or near the scene of the incident or other occurrence constituting the emergency;
 - (b) while the injured person is being transported from the scene of the incident or other occurrence constituting the emergency to a hospital or other place at which adequate medical care is available;
- if -
- (c) the act is done or omitted in good faith and without gross negligence; and
 - (d) the services are performed without fee or reward or expectation of fee or reward.

The *Law Reform Act 1995* (Qld) does not define the words "circumstances of emergency". However, it is clear from reading the Parliamentary Debates on the *Voluntary Aid in Emergency Bill*¹⁷⁶ that the word "emergency" was intended to be construed according to the meaning given to it at common law, as described above.

Section 16 of the *Law Reform Act 1995* (Qld) will not protect medical practitioners or nurses unless their actions are done firstly, in good faith and without gross negligence and secondly, without fee or reward or expectation of fee or reward.

Subsection 10.5(5) of the *Police Service Administration Act 1990* (Qld) provides some legal protection for police officers who assist persons in emergency situations. That provision is in the following terms:

If an officer, staff member or recruit incurs liability in law for a tort committed ... in the course of rendering assistance, directly or indirectly, to a person suffering, or apparently suffering, from illness or injury in circumstances that the officer, staff member or recruit reasonably considers to constitute an emergency, and if the officer, staff member or recruit acted therein in good faith and without gross negligence, the

¹⁷⁴ The *Voluntary Aid in Emergency Act 1973* (Qld) s3, which contained the same provision, was repealed by the *Statute Law Revision Act 1995* (Qld) s5.

¹⁷⁵ As at the date of this Report, no regulation had been made to extend the legal protection offered by this section to anyone other than medical practitioners and nurses.

¹⁷⁶ See *Parliamentary Debates*, Legislative Assembly (Qld), 27 September 1973 at 717 and 12 October 1973 at 929. These Parliamentary Debates can be relied on to determine the proper interpretation of s16 of the *Law Reform Act 1995* (Qld); see *Acts Interpretation Act 1954* (Qld) ss14B(1), (3)(f) and (g).

Crown is to indemnify and keep indemnified the officer, staff member or recruit in respect of that liability.

Subsection 38(1) of the *Ambulance Service Act 1991* (Qld) provides that:

An authorised officer, in providing ambulance services, may take reasonable measures -

- (a) to protect persons from any danger or potential danger associated with an emergency situation; and
- (b) to protect persons trapped in a vehicle, receptacle, vessel or otherwise endangered; ...

An ambulance officer is specifically authorised to administer such basic life support and advanced life support procedures as are consistent with the training and qualifications of the ambulance officer.¹⁷⁷ The *Ambulance Service Act 1991* (Qld) also contains a similar indemnity provision to s10.5(5) of the *Police Service Administration Act 1990* (Qld).¹⁷⁸

A number of statutory provisions referred to earlier in this Chapter may also be relevant to the administration of health care in emergency situations.¹⁷⁹

(g) Conclusion

In all cases, whether it is at common law or under statute, there would appear to be protection from criminal and civil liability for assault and/or battery for persons administering health care to an injured person in an emergency situation. In an emergency there is usually no time for consent to be obtained and public policy should dictate that, provided the person does not act negligently or unreasonably in the circumstances, no liability should attach. This view gains momentum when it is considered that under the *Health Rights Commission Act 1991* (Qld)¹⁸⁰ services that are declared not to be health services for the purposes of the Act include "[s]ervices provided by the State Emergency Service and by volunteers in emergency situations, including first aid and life support services, for example services provided by lifesavers, coastal rescue groups, teachers, teachers' aides and school administrative staff".

¹⁷⁷ *Ambulance Service Act 1991* (Qld) s38(2)(h).

¹⁷⁸ *Id* s39.

¹⁷⁹ See the discussion of the *Medical Act 1939* (Qld) s52, the *Transplantation and Anatomy Act 1979* (Qld) s20 (also discussed at 289 of this Report) and the *Criminal Code* (Qld) s282.

¹⁸⁰ *Health Rights Commission Act 1991* (Qld) Sch1 Pt 2 s4.

The Commission does not intend that its scheme codify the common law on emergencies. There should continue to be no consent requirement in emergency situations. The patient's life and well-being will depend upon speedy health care - and this will in many cases override the requirement for consent.¹⁸¹

¹⁸¹ See Ch 13 of this Report for the Commission's recommendations in relation to emergency health care.

CHAPTER 3

LEGAL COMPETENCE TO CONSENT TO HEALTH CARE

1. INTRODUCTION

In New South Wales and South Australia, a young person's capacity to consent to his or her own health care is regulated to some extent by statute.¹⁸² In all other Australian jurisdictions, including Queensland, the common law still applies and is virtually the sole source of the law which recognises the capacity of young people,¹⁸³ parents and others to consent to the health care of young people.

There have been very few relevant cases in Australia. However, English decisions, in particular the House of Lords decision in *Gillick v West Norfolk and Wisbech Area Health Authority*¹⁸⁴ (*Gillick's case*), have often been referred to by commentators on Australian law as being authoritative statements.¹⁸⁵ In 1992 the High Court of Australia endorsed the principles enunciated in *Gillick's case*.¹⁸⁶

¹⁸² See Ch 8 of this Report.

¹⁸³ Note *Mental Health Act 1974* (Qld) s17(2) which provides for the informal admission to any relevant hospital of a person 16 years of age or older who is in need of treatment for mental illness "notwithstanding any right to custody or control of that patient vested in any person". A review of the Act has suggested that alternate consent mechanisms should be used to enable voluntary treatment of young people wherever possible (Queensland Health, *Green Paper Review of the Mental Health Act 1974* (October 1994) at 41). There have been no further publications relating to this review. Also, the *Status of Children Act 1978* (Qld) s11(2A) provides that the consent of a person aged 16 and above to a medical test to determine paternity shall be as effective as if the person was of full age.

¹⁸⁴ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112 (HL(E)).

¹⁸⁵ See, for example, Gamble H, "Re-examining Children's Consent to Medical Treatment" (1992) 27 *Australian Journal of Social Issues* 194.

¹⁸⁶ *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218. The Australian courts have been prepared to extend the application of the test of capacity to consent formulated in *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 to a wider range of cases than those involving health care. The Supreme Court of the Northern Territory in *Re Adoption of J (An Infant)* (1990) 102 FLR 152 applied the *Gillick* test in determining a 16 year old mother's capacity to consent to adoption of her child. In *J v Lieschke* (1987) 162 CLR 447 at 452 Deane J referred to *Gillick's case* in relation to a young person's capacity to instruct a duty solicitor to intervene in proceedings arising out of the *Child Welfare Act 1939* (NSW). The Supreme Court of Victoria in *Hinch v Director of Public Prosecutions* [1996] 1 VR 683 has applied *Marion's case* and *Gillick's case* in relation to the capacity of an 8 year old to consent to the publication of his name as a victim of sexual abuse.

2. THE LAW IN QUEENSLAND

(a) *Gillick v West Norfolk and Wisbech Area Health Authority (Gillick's case)*

(i) Facts

In *Gillick's* case the Department of Health and Social Security issued to area health authorities in England and Wales a notice dealing with the organisation and development of a family planning service. The notice stated that family planning clinic sessions should be available to people irrespective of their age. It emphasised that attempts should be made to persuade young people under the age of sixteen who attended clinics to involve parents or guardians. The notice said that it would be most unusual to provide contraceptive advice and treatment without parental consent, but that in exceptional cases it was for a doctor, exercising clinical judgment, to decide whether contraceptive advice or treatment should be provided.

Mrs Gillick, the mother of five girls under the age of sixteen, wrote to her local area health authority seeking an assurance from the authority that no contraceptive advice or treatment would be given to any of her children under the age of sixteen without her knowledge and consent. The authority refused to give Mrs Gillick such an assurance.

Mrs Gillick then commenced an action for declarations that the notice gave advice which was unlawful and wrong and which adversely affected the welfare of the Gillick children and her right as parent and custodian of the children, and/or her ability to properly and effectively discharge her duties as such parent and custodian. She claimed that the notice advised doctors either to commit offences, as principals, of causing or encouraging unlawful sexual intercourse with a girl under sixteen, or to commit offences of being an accessory to unlawful sexual intercourse with a girl under the age of sixteen.

Legislation in the United Kingdom stated that a young person who had attained the age of 16 years was able to consent to "surgical, medical or dental treatment" as if he or she were an adult.¹⁸⁷ The Court in *Gillick's* case was therefore primarily concerned with young people up to and including 15 years of age.

¹⁸⁷ *Family Law Reform Act 1969* (UK) s8. See 179-181 of this Report.

(ii) First instance

At first instance Woolf J dismissed Mrs Gillick's action.¹⁸⁸ Woolf J held that by providing contraceptives the doctor may not be encouraging sexual intercourse. He or she may merely be recognising that, whether or not contraceptives were prescribed, intercourse would take place and the provision of contraceptives would merely protect the girl from unwanted pregnancy or disease. The doctor could not therefore be said to be an accessory before the fact. Nor could the prescription of contraceptives be said to be aiding or abetting an offence, as contraceptives were "not so much 'the instrument for a crime or anything essential to its commission' but a palliative against the consequences of the crime".¹⁸⁹

As to the argument that the notice was inconsistent with the rights of the parents of the child and the ability of the parents to properly and effectively discharge their duties as parents to supervise the physical and moral welfare of their children, Woolf J held that interference with parental rights would only occur if the doctor's actions amounted to a trespass. He stated that the fact that a child is under the age of sixteen does not automatically mean that he or she cannot give consent to treatment. Woolf J noted:¹⁹⁰

In the absence of binding authority, the position seems to me to be as follows: the fact that a child is under the age of 16 does not mean automatically that she [or he] cannot give consent to any treatment. Whether or not a child is capable of giving the necessary consent will depend upon the child's maturity and understanding and the nature of the consent which is required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent if given can be properly and fairly described as a true consent. If the child is not capable of giving consent, then her [or his] parents can do so on the child's behalf. If what is involved is some treatment of a minor nature, and the child is of normal intelligence and approaching 16, it will be easier to show that the child is capable of giving the necessary consent; otherwise if the implications of the treatment are long-term. Taking an extreme case, I would have thought it unlikely that a child under the age of 16 will ever be regarded by the courts as being capable of giving consent to sterilisation.

¹⁸⁸ *Gillick v West Norfolk and Wisbech Area Health Authority* [1984] 1 QB 581 (QB:Div Ct).

¹⁸⁹ *Id* at 595.

¹⁹⁰ *Id* at 596.

Woolf J¹⁹¹ was influenced by the judgment of Addy J in the Ontario High Court case of *Johnston v Wellesley Hospital*¹⁹² and in particular the passage quoted from Nathan, *Medical Negligence* (1957):¹⁹³

The next question which requires consideration is whether a consent was required from the parents or guardian of the plaintiff previous to the medical procedure being undertaken by the doctor, or, more specifically, whether the plaintiff, being an infant, was capable at law of giving his [or her] consent to the treatment, for, if he [or she] was capable at law of giving his [or her] consent and did in fact give it, there would, of course, be no necessity of obtaining any parental consent. The question of consent, of course, is very relevant to the case because, if there was no legal consent, the treatment administered by the doctor would constitute an actionable assault, ... and liability, in so far as the doctor at least is concerned, would flow automatically in the circumstances of the present case. There is, of course, no question here of this being an emergency treatment of the kind which would justify a doctor acting without consent in order to preserve life or to prevent a serious impairment of the patient's health. Treatment could easily have been postponed to obtain parental consent, if required. Also, parental consent could easily have been obtained between the time of the original visit and interview and that of the actual treatment.

There is no doubt that the plaintiff in fact consented to receiving treatment ... he specifically requested it ...

Although the common law imposes very strict limitations on the capacity of persons under 21 years of age to hold, or rather to divest themselves of, property or to enter into contracts concerning matters other than necessities, it would be ridiculous in this day and age, where the voting age is being reduced generally to 18 years, to state that a person of 20 years of age, who is obviously intelligent and as fully capable of understanding the possible consequences of a medical or surgical procedure as an adult, would, at law, be incapable of consenting thereto. But, regardless of modern trend, I can find nothing in any of the old reported cases, except where infants of tender age or young children were involved, where the Courts have found that a person under 21 years of age was legally incapable of consenting to medical treatment. If a person under 21 years were unable to consent to medical treatment, he [or she] would also be incapable of consenting to other types of bodily interference. A proposition purporting to establish that any bodily interference acquiesced in by a youth of 20 years would nevertheless constitute an assault would be absurd. If such were the case, sexual intercourse with a girl under 21 years would constitute rape. Until the minimum age of consent to sexual acts was fixed at 14 years by a statute, the Courts often held that infants were capable of consenting at a considerably earlier age than 14 years.

¹⁹¹ As was Lord Scarman in the House of Lords: [1986] 1 AC 112 at 189.

¹⁹² (1970) 17 DLR (3d) 139.

¹⁹³ Written at the time when the age of majority was 21. In Queensland, the age of majority is 18: *Law Reform Act 1995* (Qld) s17.

I feel that the law on this point is well expressed in the volume on *Medical Negligence* (1957), by Lord Nathan, page 176: "It is suggested that the most satisfactory solution of the problem is to rule that an infant who is capable of appreciating fully the nature and consequences of a particular operation or of a particular treatment can give an effective consent thereto, and in such cases the consent of the guardian is unnecessary; but that where the infant is without that capacity, any apparent consent by him or her will be a nullity, the sole right to consent being vested in the guardian."

(iii) Court of Appeal

The Court of Appeal¹⁹⁴ reversed Woolf J's findings by using a statutory survey which looked at a number of Acts dealing with children in order to discern the relationship between parents and children.¹⁹⁵ From this examination the Court reached three conclusions:¹⁹⁶

- (1) That a child's guardian has a collection of rights in relation to a child.... The court held that these rights could not be transferred...
- (2) That there was an age below which the law stated that a child was incapable of consenting or making decisions with respect to his [or her] upbringing. As the criminal law had declared sixteen to be that age for the purpose of sexual intercourse with a girl, it followed that a doctor who provided contraception or abortion treatment to a girl under sixteen without parental consent did so illegally.
- (3) Accordingly, the memorandum, which suggested that it was legal for a doctor to provide contraceptive treatment to a girl under sixteen without the consent of her parents, was incorrect.

(iv) The House of Lords

The majority of the House of Lords¹⁹⁷ adopted the view that parental rights exist "only so long as they are needed for the protection of the person and property of the child".¹⁹⁸ Thus, it would be wrong to say that a young person remains under parental control until a particular age. The leading speeches were delivered by Lord Scarman and Lord Fraser. Although they adopted different conceptual approaches to the significance of the patient's and the

¹⁹⁴ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112 at 118.

¹⁹⁵ Devereux J, "The Capacity of a Child in Australia to Consent to Medical Treatment - Gillick Revisited?" (1991) 11 *Oxford Journal of Legal Studies* 283 at 291. See also Gerber P and Rahemtula A, "Who has the Right to Advise Children on Birth Control" (1986) 144 *The Medical Journal of Australia* 419.

¹⁹⁶ Devereux J, "The Capacity of a Child in Australia to Consent to Medical Treatment - Gillick Revisited?" (1991) 11 *Oxford Journal of Legal Studies* 283 at 291.

¹⁹⁷ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112.

¹⁹⁸ *Id* per Lord Scarman at 184.

doctor's opinion, they both agreed on the diminishing nature of parental control over decisions for medical treatment. Lord Scarman justified his position as follows:¹⁹⁹

The law relating to parent and child is concerned with the problems of the growth and maturity of the human personality. If the law should impose upon the process of 'growing up' fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change. If certainly be thought desirable, it is better that the rigid demarcations necessary to achieve it should be laid down by legislation after a full consideration of all the relevant factors than by the courts confined as they are by the forensic process to the evidence adduced by the parties and to whatever may properly fall within the judicial notice of judges. Unless and until Parliament should think fit to intervene, the courts should establish a principle flexible enough to enable justice to be achieved by its application to the particular circumstances proved by the evidence placed before them.

In Lord Scarman's opinion parental rights yield to the child's right to make his or her own decisions when he or she reaches a sufficient understanding and intelligence to be capable of making up his or her own mind on the matter requiring decision.²⁰⁰

as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances.

The issue for Lord Scarman was whether the young person had the capacity to consent. For Lord Fraser, the issue was whether the treatment was, in the opinion of the doctor, in the young person's best interests, having regard to the young person's understanding of what was involved and a number of other relevant considerations.²⁰¹ On Lord Fraser's analysis, a doctor faced with a request for advice or treatment from a young person under 16 years of age should seek to persuade him or her to agree to his or her parents being informed. If the young person did not agree to the parents being informed, the doctor would be justified in proceeding, but only if the doctor were satisfied of certain specific and precisely formulated matters.

¹⁹⁹ Id at 186.

²⁰⁰ Id at 188-189.

²⁰¹ Id at 174. Lord Fraser listed the following relevant considerations: that the doctor cannot persuade the young person to inform her parents or to allow the doctor to inform her parents that she is seeking contraceptive advice; that she is very likely to begin or to continue to have sexual intercourse with or without contraceptive treatment; and that unless she receives contraceptive advice or treatment, her physical or mental health or both are likely to suffer.

Lord Fraser emphasised:²⁰²

That result ought not to be regarded as a licence for doctors to disregard the wishes of parents on this matter whenever they find it convenient to do so. Any doctor who behaves in such a way would be failing to discharge his [or her] professional responsibilities, and I would expect him [or her] to be disciplined by his [or her] own professional body accordingly.

Thus, for Lord Scarman the patient is the final arbiter, provided the patient has sufficient capacity, but for Lord Fraser, the final arbiter is the doctor. Mental capacity is a necessary but not a sufficient condition.

(v) Issues unresolved by the House of Lords decision

A number of criticisms have been levelled at the House of Lords decision. For example, it has been claimed that:²⁰³

1. Very little indication of precisely what parental interest is infringed by giving a child advice (as distinct from treatment) is given, and more generally, it does little to clarify the scope of parental authority (as distinct from its duration). Woolf J thought parental "rights" would be infringed only if the conduct in question amounted to a trespass (which advice would not). In the House of Lords the case was decided on the public law issue that the Department of Health and Social Security advice was not erroneous in law - it sheds no light on the more specific issue of precisely what rights a parent does have in respect of his or her child. In particular, it remains unclear whether a parent could invoke the legal process to prevent a doctor (or other adviser) from merely giving advice to a child.
2. The decision does not indicate whether a legally competent young person is able to refuse health care which is considered by competent professionals to be in his or her best interests.
3. The decision does not elaborate on whether a legally competent young person's consent to health care excludes the Court's power to approve a treatment.
4. The decision does not elaborate on whether a doctor must independently assess what is in an immature young person's best

²⁰² Id at 174.

²⁰³ See, for example, Cretney SM, "Family Law" *All ER Rev* 1985 173 at 175. It was also suggested in that article that the decision ignores realities of everyday medical practice and that it is doubtful if many adults would satisfy the criteria - let alone young people.

interests before relying on parental consent to health care of the young person.

The House of Lords has not had a subsequent occasion to consider and further clarify the law relating to consent to health care of young people.²⁰⁴

(b) Secretary, Department of Health and Community Services v JWB and SMB (*Marion's case*)²⁰⁵

In *Marion's case* the parents of a 14 year old daughter with intellectual and physical disabilities applied to the Family Court for authority to have her sterilised by undergoing a hysterectomy and an ovariectomy. The trial judge referred the case to the Full Court of the Family Court where there was a difference of opinion between the judges as to whether Court authority was required before her parents could proceed with the sterilisation.²⁰⁶ The Secretary of the Northern Territory Department of Health and Community Services appealed to the High Court on the grounds that the guardian of a young person has no power to authorise the sterilisation of a young person, and that an application to a court for authorisation of such an operation was mandatory. The High Court considered and determined the law, but did not decide if the procedure should be performed on Marion.²⁰⁷ That decision was remitted to the Family Court for its determination.²⁰⁸

The High Court summarised the Australian common law in relation to the ability of young people to consent to health care:²⁰⁹

The common law in Australia has been uncertain as to whether minors under sixteen can consent to medical treatment in any circumstances.²¹⁰ However, the recent House

²⁰⁴ The English Court of Appeal has subsequently further considered the law relating to consent to health care of young people in the context of refusal of health care: see Ch 4 of this Report.

²⁰⁵ (1992) 175 CLR 218.

²⁰⁶ *Re Marion* (1990) 14 Fam LR 427 (Nicholson CJ, Strauss and McCall JJ).

²⁰⁷ Not her real name.

²⁰⁸ In *Re Marion* (No 2) (1992) 17 Fam LR 336 Nicholson CJ determined that sterilisation would be in Marion's best interests.

²⁰⁹ *Marion's case* (1992) 175 CLR 218 at 237.

²¹⁰ The reference cited in support of this view was an article by Dr John Devereux (now a member of this Commission): "The Capacity of a Child in Australia to Consent to Medical Treatment - Gillick Revisited?" (1991) 11 *Oxford Journal of Legal Studies* 283. Devereux noted various legislative provisions in Australia which attach some significance to the age of 16, but was reluctant to suggest that the common law in Australia had recognised that young people of 16 years to 18 years could consent to any medical treatment as if they were adults, even if that is the practical reality of the situation.

of Lords decision in *Gillick v West Norfolk A.H.A.*²¹¹ is of persuasive authority. The proposition endorsed by the majority in that case was that parental power to consent to medical treatment on behalf of a child diminishes gradually as the child's capacities and maturity grow and that this rate of development depends on the individual child. Lord Scarman said:²¹²

Parental rights ... do not wholly disappear until the age of majority ... But the common law has never treated such rights as sovereign or beyond review and control. Nor has our law ever treated the child as other than a person with capacities and rights recognised by law. The principle of the law ... is that parental rights are derived from the parental duty and exist only so long as they are needed for the protection of the person and property of the child.

A minor is, according to this principle, capable of giving informed consent when he or she 'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.²¹³

This approach, though lacking the certainty of a fixed age rule, accords with experience and with psychology.²¹⁴ It should be followed in this country as part of the common law.

Although the subject of this decision, Marion, would never have been capable of giving consent, the High Court's statement on the Australian common law relating to the competency of young people to consent to health care is the strongest judicial authority to date on this aspect of the law.

The High Court in *Marion's* case held that parents cannot consent, without prior court approval, to non-therapeutic sterilisation procedures for their children. The approval of a Court exercising *parens patriae* jurisdiction, the Family Court or, in certain circumstances in other jurisdictions, a State or Territory statutory Guardianship body,²¹⁵ is required before such a procedure can be performed. Although the High Court did not state what, if any, other procedures would require prior Court approval, it is likely that a number of other procedures fulfil the same criteria as sterilisation, that is, non-therapeutic procedures involving:

- . invasive, irreversible and major surgery;

²¹¹ [1986] AC 112.

²¹² *Id* at 183-184.

²¹³ *Id* at 189.

²¹⁴ The High Court noted:

The psychological model developed by Piaget ... one of the leading theorists in this area, suggests that the capacity to make an intelligent choice, involving the ability to consider different options and their consequences, generally appears in a child somewhere between the ages of eleven and fourteen. But again, even this is a generalisation. There is no guarantee that any particular child, at fourteen, is capable of giving informed consent nor that any particular ten year old cannot ...

²¹⁵ Queensland does not have such a statutory body. See Queensland Law Reform Commission, *Report Assisted and Substituted Decisions* (R49, June 1996).

- significant risk of making the wrong decision either as to a young person's present or future capacity to consent or about what are the best interests of a young person who cannot consent; and
- consequences of a wrong decision which are particularly grave.

Types of procedures other than sterilisation which are most likely to fall within the Family Court's jurisdiction include: termination of pregnancy;²¹⁶ the turning off of life support; removal of organs for transplantation; gender reassignment, and the like. The performance of a bone marrow harvest to collect bone marrow cells from a young person and peripheral blood collections to collect peripheral blood stem cells from a young person for transplantation to another have been held to be procedures for which Family Court approval is required.²¹⁷ Others are less clear. For example, an obstetrician seeking approval by the Court for a caesarean section in circumstances where the young mother would not consent to the procedure; applications in relation to the performance of cardiac surgery on children where parental consent has been refused,²¹⁸ and applications in relation to profoundly handicapped neonates.

²¹⁶ McHugh J in *Marion's case* (1992) 175 CLR 218 noted at 317:

No doubt in most cases of medical treatment or surgery, no conflict will arise between the interests of the parents and those of the child. In other cases, the risk of conflict may be so slight or theoretical that it can be disregarded. But in some cases - and claims that an abortion or sterilisation operation is in the best interest of a child are likely to be among them - a conflict between the interests of the parents and the child may arise. In such a case, the application of established and fundamental principle will deny the right of the parents to consent to the operation or treatment.

²¹⁷ See *GWW and GMW* (Unreported, Family Court of Australia HB 1447/1996, 21 January 1997) per Hannon J.

²¹⁸ *Re Michael* (1994) FLC ¶92-471 (Full Court of the Family Court of Australia).

CHAPTER 4

LEGAL COMPETENCE TO REFUSE HEALTH CARE

1. INTRODUCTION

In *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)*²¹⁹ the High Court endorsed the "principle of personal inviolability echoed in the well-known words of Cardozo J" in *Schloendorff v Society of New York Hospital*:²²⁰

Every human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body;

Lord Donaldson MR expressed a similar view in relation to an adult's right to refuse health care in *In re T (Adult: Refusal of Treatment)*:²²¹

An adult patient who ... suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered.... This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.

In developing a model for the consent to health care of young people, the question inevitably arises whether a young person's right to consent to health care should be accompanied by a right to refuse any or all proposed health care.

While the law in relation to the health care of adults has emphasised a right to bodily integrity,²²² the law in relation to the refusal of health care by young people has developed with a different focus.

There is limited Australian case law in relation to the capacity of young people to refuse health care. In *Marion's case*, the High Court made brief reference to two decisions of the English Court of Appeal²²³ which had dealt with that issue.

²¹⁹ (1992) 175 CLR 218 per Mason CJ and Dawson, Toohey and Gaudron JJ at 234 and per McHugh J at 310.

²²⁰ (1914) 105 NE 92 at 93.

²²¹ [1993] Fam 95 at 102. See also *Secretary of State for the Home Department v Robb* [1995] Fam 127 at 130 where the Court held in relation to the Home Office's duty to a hunger-striking prisoner "if an adult of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes even though they do not consider it to be in his best interest to do so" and *B v Croydon Health Authority* [1995] Fam 133 per Hoffmann LJ at 137 for a similar statement of the law.

²²² See *Marion's case* per Mason CJ and Dawson, Toohey and Gaudron JJ at 233.

²²³ *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64.

Accordingly, the Australian position is best examined following a consideration of those English decisions.

2. THE ENGLISH POSITION

(a) *Gillick v West Norfolk and Wisbech Area Health Authority (Gillick's case)*²²⁴

While *Gillick's* case is authority for the proposition that a young person who has achieved sufficient maturity and intelligence to understand what is involved in proposed health care can consent to that health care, the position as to refusal of health care by a young person is more complex.

This is largely as a result of the interpretations given in two decisions of the Court of Appeal²²⁵ of certain comments made by Lord Scarman in *Gillick's* case.

In *Gillick's* case Lord Scarman observed in relation to the nature of parental rights:²²⁶

... I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances.

(b) The Court of Appeal's interpretation of *Gillick's* case

The Court of Appeal subsequently interpreted Lord Scarman's comments in *Gillick's* case²²⁷ in a way that has removed any suggestion that a legally competent young person, under English law, has a right of refusal in relation to his or her health care.

²²⁴ [1986] AC 112. See 53-59 of this Report for a discussion of this case.

²²⁵ *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64.

²²⁶ [1986] AC 112 at 188-189.

²²⁷ *Ibid.*

(i) *In re R (A Minor) (Wardship: Consent to Treatment)*

In *In re R (A Minor) (Wardship: Consent to Treatment)*²²⁸ the Court had to decide whether R, who was then 15 years of age and had been made a ward, could be administered medication, including anti-psychotic drugs, against her wishes. The evidence was that R had intervals of lucidity, during which she objected to taking the drugs.

The Court held that R had not been *Gillick* competent and that, accordingly, her objection could be overruled by the Court. However, Lord Donaldson MR, who delivered the main judgment, went on to make much broader statements about the issues of consent and refusal generally.

In particular, Lord Donaldson MR construed Lord Scarman's statement in *Gillick's* case in a way that has significantly altered the direction in which the English law in this area has developed.²²⁹

A right of determination is wider than a right to consent. The parents can only have a right of determination if *either* the child has no right to consent, that is, is not a keyholder, or the parents hold a master key which could nullify the child's consent. I do not understand Lord Scarman to be saying that, if a child was "*Gillick* competent" ... the parents ceased to have an independent right of consent as contrasted with ceasing to have a right of determination, that is, a veto. In a case in which the "*Gillick* competent" child refuses treatment, but the parents consent, that consent *enables* treatment to be undertaken lawfully, but in no way determines that the child shall be so treated. In a case in which the positions are reversed, it is the child's consent which is the enabling factor and again the parents' refusal of consent is not determinative. [original emphasis]

By drawing a distinction between a right to consent to treatment and a right of determination or veto in respect of treatment, Lord Donaldson came to the conclusion that there are concurrent powers to consent vested in both the *Gillick* competent young person and his or her parents because both are, in his analysis, "keyholders". The effect of such concurrent powers of consent is as follows:²³⁰

If more than one body or person has a power to consent, only a failure to, or refusal of, consent by all having that power will create a veto.

A "*Gillick* competent" child or one over the age of 16 will have a power to consent, but this will be concurrent with that of a parent or guardian.

²²⁸ [1992] Fam 11.

²²⁹ *Id* at 23.

²³⁰ *Id* at 26.

This approach has been criticised by Bainham:²³¹

When in 1985 Lord Scarman said that the "parental right yields to the child's right to make his [or her] own decisions when he [or she] reaches a sufficient understanding and intelligence to be capable of making up his [or her] own mind on the matter requiring decision" ... most people took him at his word. There was some residual uncertainty about whether the so-called parental "right" remained in existence at all or was completely terminated in this event. But no one doubted that Lord Scarman was according priority to the competent child's wishes where these clashed with the parents' view - no one, that is, except apparently the Master of the Rolls. In *Re R (A Minor) (Wardship: Consent to Treatment)* ... Lord Donaldson of Lynton MR suggested that Lord Scarman did not mean this at all and, even if he did, he was wrong.

While Lord Donaldson eschewed the granting to parents of a power of veto (or as he would describe it, "a right of determination"), in practical terms, the parent would, on Lord Donaldson's analysis, have the right to overrule a young person's refusal of health care, thereby enabling medical treatment to be lawfully administered.

Bainham has further criticised this approach, pointing out that if a doctor is aware that a young person objects to treatment, but nevertheless chooses to treat on the consent of the parent, the practical effect is that the parent is exercising a power of veto.²³²

It [Lord Donaldson's analysis] can only work on the assumption that a doctor is dealing *solely* with the parent or *solely* with the child and is unaware of any disagreement between them. Where he *is* aware of a disagreement then, in the absence of judicial intervention, he *must* choose between the conflicting views. This is so where the parent is proposing action and the child is objecting, or conversely, where the child is in favour of action and the parent is objecting. If the doctor decides to proceed, or not to proceed, on the basis of the parent's view, he is in reality giving effect to a parental veto over the child's view. He is allowing the parent to "determine" the matter, and the suggested distinction between "determination" and "consent" falls apart. [original emphasis]

It might be argued that Bainham's concern about giving a parent an absolute right to override his or her child's purported refusal of treatment would not, in practical terms, pose any significant threat to the welfare of the child for two reasons:

²³¹ Bainham A, "The Judge and the Competent Minor" (1992) 108 *The Law Quarterly Review* 194 at 194.

²³² *Id* at 198.

- The parental right to consent to health care of a young person must be exercised in the best interests of the young person.²³³
- It has been suggested that a doctor is obliged to treat in accordance with his or her best clinical judgment.²³⁴

The combination of these factors might be thought to be a complete answer to the dilemma posited by Bainham, the argument being that the doctor would act on a consent - be it from a parent or a young person - only if the doctor considered the health care consented to to be consistent with his or her clinical judgment.

However, it is possible for there to be responsible, but differing, professional opinions as to whether a proposed treatment is in a young person's best interests. Douglas recognises that there is often no single view as to what treatment is in the interests of a patient:²³⁵

Does it make sense for Lord Donaldson to hold that any consent suffices for treatment, but only unanimous refusal can prevent it? It could be suggested that, since doctors recommend treatment in the patient's best interests, it is justifiable to override a refusal to such treatment.... But there are ... problems with this sanguine approach. First, we know that there are frequently two views on whether treatment is in the patient's interest - after all, the *Bolam* test of medical negligence²³⁶ is designed to recognise legitimate differences of medical opinion on precisely this matter. Second, we know that even where medical opinion seems agreed, another view can rightly be held - see *Re D (A Minor) (Wardship: Sterilisation)*.²³⁷

Lord Donaldson's analysis does not take into account the possibility that there may be a range of professional opinions as to what the most appropriate health care might be in a particular case. It is possible for a situation to arise where a young person and his or her parents hold different, but medically supported, views in respect of health care, both courses

²³³ Note the reference in *Gillick's* case per Lord Scarman at 184 to the fact that the "parental right must be exercised in accordance with the welfare principle". Bainham acknowledges that the court could override the wishes of parents where it considered this to be in the best interests of children, but does not refer to the limitation on a doctor's entitlement to treat: Bainham A, "The Judge and the Competent Minor" (1992) 108 *The Law Quarterly Review* 194 at 195.

²³⁴ Lord Donaldson suggested in *In re J (A Minor) (Child in Care: Medical Treatment)* [1993] Fam 15 at 27 that a doctor's fundamental duty, "subject to obtaining any necessary consent, is to treat the patient in accordance with his own best clinical judgment, notwithstanding that other practitioners ... may have formed a quite different judgment or that the court, acting on expert evidence, may disagree with him". On that basis, the Court of Appeal held that it would not, in the exercise of its inherent jurisdiction, order a doctor to treat a patient in a manner contrary to the doctor's clinical judgment and professional duty.

²³⁵ Douglas G, "The Retreat from *Gillick*" (1992) 55 *The Modern Law Review* 569 at 576.

²³⁶ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

²³⁷ [1976] Fam 185.

arguably being in the best interests of the young person. It would seem that it is to that scenario that Bainham's criticism is directed. Although, if the young person is legally competent, either the young person or the young person's parents can consent to the young person's health care, in practical terms, the parents will be accorded a power of veto if the doctor defers to their wishes when confronted by a conflict between the parents and the young person, either by treating, if the parents consent, or by refraining from treating, if they refuse treatment.²³⁸

An important consideration for Lord Donaldson in coming to the conclusion that a competent young person should not have the exclusive right to consent to, or to refuse, medical treatment was the untenable position in which a doctor treating a young person would be placed if the parental right to consent terminated once the young person was *Gillick* competent.²³⁹

If the position in law is that upon the achievement of "*Gillick* competence" there is a transfer of the right of consent from parents to child and there can never be a concurrent right in both, doctors would be faced with an intolerable dilemma, particularly when the child was nearing the age of 16, if the parents consented, but the child did not. On pain, if they got it wrong, of being sued for trespass to the person or possibly being charged with a criminal assault, they would have to determine as a matter of law in whom the right of consent resided at the particular time in relation to the particular treatment. I do not believe that that is the law.

However, the burden of making the correct decision is not necessarily any less just because there are concurrent powers of consent vested in the young person and his or her parents. On Lord Donaldson's own view, a doctor is entitled to treat a legally competent young person, who consents to such treatment, in the absence of parental consent or, indeed, over the refusal of the young person's parents. It is the young person's consent which is the enabling factor - the parents' refusal of consent is not determinative.²⁴⁰ One valid consent is sufficient to enable treatment to be lawfully administered.

In those circumstances, however, a health care provider still faces the burden of having to make a correct assessment of the young person's ability to understand to nature and consequences of the proposed health care. In the

²³⁸ It is unclear whether doctors in England, once presented with a valid consent, must determine whether the proposed treatment is also in the young person's best interests before treating the young person. There was no definitive statement to this effect in *Gillick's* case. See note 233 of this Report. Lord Scarman referred to the parents' obligation to act in accordance with the child's welfare (*Gillick's* case at 184). Lord Fraser referred to the doctor's ability to treat on the consent of the young person when such treatment is in his or her best interests (*Gillick's* case at 174). See Devereux J, "The Capacity of a Child in Australia to Consent to Medical Treatment - *Gillick* Revisited?" (1991) 11 *Oxford Journal of Legal Studies* 283 at 292-294.

²³⁹ *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 at 24.

²⁴⁰ *Id* per Lord Donaldson at 23.

absence of parental consent, the health care provider must, even on Lord Donaldson's view of the law, make that assessment and make it correctly. If the health care provider incorrectly forms the view that the young person is legally competent when he or she is not, then, in the absence of any parental consent, the health care provider may be liable for assault and/or battery if he or she proceeds to treat the young person.

The only possible way for a health care provider to avoid the dilemma posed by Lord Donaldson (even if the power to consent is vested in the parents and the young person) is for a health care provider only to treat the young person when he or she has the consent of both the young person and at least one parent so that there would always be a valid consent from someone. The difficulty is not alleviated by holding as a matter of law that parents have an independent right to consent until their teenager turns 18, for unless the health care provider as a matter of practice seeks the consent of a parent, the health care provider will not know whether he or she has the protection of that parental consent before proceeding to treat the young person.

For that reason, it does not seem that Lord Donaldson's concern about the health care provider's difficult decision regarding a young person's competency to consent is, of itself, a sufficient reason for holding that a young person does not upon maturity acquire an exclusive right to consent to his or her own health care, but has only a mere power to consent to health care, which is itself concurrent with a similar power vested in the young person's parents.

Lord Donaldson's approach also fails to accord any autonomy to the young person who, if he or she is Gillick competent, may well have a mature appreciation of the issues involved in refusing health care or a particular form of health care.

(ii) ***In re W (A Minor) (Medical Treatment: Court's Jurisdiction)***

In *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)*²⁴¹ the Court of Appeal again considered the question of refusal of health care by a young person. W, who was 16 years of age and suffering from anorexia nervosa, had been in the care of the local authority following the death of her parents. When W's condition deteriorated, the local authority sought to transfer her against her wishes to a specialised unit. In order to give effect to that transfer, the local authority sought leave to invoke the Court's inherent (*parens patriae*²⁴²) jurisdiction and sought leave to treat W without her

²⁴¹ [1993] Fam 64.

²⁴² See 94-95 of this Report for a discussion of the *parens patriae* jurisdiction.

consent. Accordingly, the issue before the Court was not whether a parent could override a young person's refusal of treatment, but whether the Court had such a power.²⁴³

Because W was 16 years of age, the decision of the Court of Appeal directly concerned section 8 of the *Family Law Reform Act 1969* (UK), which relevantly provides:

- (1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.
- (2) ...
- (3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

Lord Donaldson held in relation to section 8 of the *Family Law Reform Act 1969* (UK):²⁴⁴

The wording of subsection (1) shows quite clearly that it is addressed to the legal purpose and legal effect of consent to treatment, namely, to prevent such treatment constituting in law a trespass to the person, and that it does so by making the consent of a 16- or 17-year-old as effective as if he [or she] were "of full age." No question of "Gillick competence" in common law terms arises. The 16- or 17-year-old is conclusively presumed to be "Gillick competent" or, alternatively, the test of "Gillick competence" is bypassed and has no relevance.

That construction of the section was predictable as far as the simple right to consent was concerned. The problematic issue, however, (especially in light of the comments in *In re R*²⁴⁵ to the effect that the wishes of a legally competent young person could be overridden by a parent who consented to treatment) was always going to be whether subsection 8(1) conferred on a young person of sixteen years or over the same right to decide whether he or

²⁴³ *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 per Lord Donaldson MR at 76.

²⁴⁴ *Id* at 76-77.

²⁴⁵ *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11.

she would submit to treatment (that is, to exercise a power of veto over one's own treatment) that the young person would have if he or she were an adult.²⁴⁶

Although the question of parental rights was not in issue, Lord Donaldson again referred to Lord Scarman's speech in *Gillick's* case regarding the circumstances in which the parental right terminates and noted:²⁴⁷

If the parental right terminates, it would follow that, apart from the court, the only person competent to consent would be the child and a refusal of consent to treatment would indirectly constitute an effective veto on the treatment itself. I say "indirectly" because the veto would be imposed by the civil and criminal laws, rather than by the refusal of consent.

Lord Donaldson was saying in effect that, if the concurrent parental right to consent to health care of a young person were not to continue once a young person was legally competent, the young person would have autonomy (in his words "a power of veto") over his or her own health care for the reason that, apart from the court, no one but the young person would be able to consent to his or her health care. Lord Donaldson rejected the argument that the words "as effective as it would be if he were of full age", which appear in sub-subsection 8(1) of the *Family Law Reform Act 1969* (UK), meant that if W were of full age, her failure or refusal to give consent would be fully effective as a veto, as no one else would be in a position to consent.²⁴⁸ The effect of the rejection of that argument is that:²⁴⁹

No minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court. Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor.

As to the relationship between the decision of a legally competent young person and the exercise by the court of its *parens patriae* jurisdiction, Lord

²⁴⁶ *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 per Lord Donaldson at 77 where he noted, but rejected, the argument in favour of W having an exclusive right to consent to and to refuse treatment, that the words "as effective as it would be if he were of full age" in s8(1) of the *Family Law Reform Act 1969* (UK) might mean that a sixteen year old was put in exactly the same position as an adult with respect to treatment and therefore had the right of an adult to refuse treatment.

²⁴⁷ *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 at 76.

²⁴⁸ *Id* per Lord Donaldson at 77.

²⁴⁹ *Id* per Lord Donaldson at 84.

Donaldson held.²⁵⁰

There can therefore be no doubt that it [the court] has power to override the refusal of a minor, whether over the age of 16 or under that age but "*Gillick* competent".

(c) Limitations of *In re R* and *In re W*

The difficulty with the decisions in *In re R* and *In re W* is that, while both contain statements of law as to how disputes between a parent and a legally competent young person will be resolved, neither case involved such a dispute. Both decisions concerned the limits of the court's power, rather than the limits of parental power. Further, in *In re R*, R was held by the Court not to be "*Gillick* competent", while in *In re W*, the Court could probably have decided the case on a narrower basis by finding that W was not legally competent. While the Court did not overrule the finding of Thorpe J at first instance that W was of sufficient understanding to make an informed decision, the Court expressed its grave reservations about that finding. In particular, Lord Donaldson commented:²⁵¹

This appeal has been concerned with the treatment of anorexia nervosa. It is a peculiarity of this disease that the disease itself creates a wish not to be cured or only to be cured if and when the patient decides to cure himself or herself, which may well be too late.

(d) Summary of the English position

In summary, the relationship between the powers of consent vested variously in a young person, a young person's parents and the court would appear to be as follows:

- At 16 years of age, a young person can consent to his or her own surgical, medical or dental treatment.²⁵²
- Below that age, a young person can consent to his or her own health care if he or she is legally competent, that is, satisfies the test in *Gillick's* case.²⁵³
- In either case (that is, 16 years of age or older or under 16 but legally

²⁵⁰ Id at 81.

²⁵¹ Id at 83. Balcombe LJ made a similar comment at 84.

²⁵² Family Law Reform Act 1969 (UK) s8(1).

²⁵³ *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 per Lord Donaldson at 83-84.

competent), the consent of the young person cannot be overridden by those with parental responsibility, but can be overridden by the court.²⁵⁴

- Parents retain an independent right to consent to the health care of their children until they attain their majority at 18 years of age. Accordingly, a health care provider may lawfully treat a young person, even one over 16 years of age, if the person having parental authority consents to the health care.²⁵⁵ The parental power to consent must, however, be exercised in the best interests of the young person.²⁵⁶
- No young person has the power to refuse health care, so as to override a consent given by someone with parental responsibility or by the court.²⁵⁷ In this respect, legally competent young people (be they 16 or over, or below that age but *Gillick* competent) are in a different position from adults, upon whom no such limitation is imposed.²⁵⁸
- In all decisions, parents are constrained by the limitation that consent to health care of their child can only be validly given if the health care is in the best interests of the young person. It is unclear whether a health care provider must also determine whether the proposed health care is in the young person's best interests.²⁵⁹

3. THE AUSTRALIAN POSITION

In *Marion's* case²⁶⁰ the High Court made brief reference to the question of refusal of health care by young people.

²⁵⁴ Ibid.

²⁵⁵ *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 at 78 where Lord Donaldson uses his "flak jacket" analogy: "Anyone who gives him [the doctor] a flak jacket (that is, consent) may take it back, but the doctor only needs one and so long as he continues to have one he has the legal right to proceed". See also the comments of Balcombe LJ at 86.

²⁵⁶ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 per Lord Fraser at 173 and per Lord Scarman at 184.

²⁵⁷ *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 per Lord Donaldson at 84.

²⁵⁸ See *In re T (Adult: Refusal of Treatment)* [1993] Fam 95 at 102; *Secretary of State for the Home Department v Robb* [1995] Fam 127 at 130; and *B v Croydon Health Authority* [1995] Fam 133 at 137.

²⁵⁹ See note 238 of this Report.

²⁶⁰ (1992) 175 CLR 218.

In the joint judgment of Mason CJ and Dawson, Toohey and Gaudron JJ their Honours held that the *Gillick* approach should be followed in this country as part of the common law.²⁶¹ That comment was accompanied by the following footnote, which provides the best indication to date as to how the Court is likely to deal with the question of refusal of health care by a young person:²⁶²

As to the priority of parental rights and the capacity of a child to refuse medical treatment for mental illness, see *In re R. (A Minor)*, [1992] Fam 11, at pp. 22-23, per Lord Donaldson of Lymington MR. But see also the comment on Lord Donaldson's judgment by Bainham in "The Judge and the Competent Minor", *Law Quarterly Review*, vol. 108 (1992), 194.

Although their Honours made reference in *Marion's* case to *In re R*, there was no endorsement of its principles as such. Moreover, their Honours expressly referred to Bainham's criticism of the Court of Appeal's approach.

While it is clear that the majority of the High Court has endorsed the *Gillick* competence approach in relation to consent (as opposed to a fixed age rule), it is by no means clear that the High Court will adopt the English Court of Appeal's concept of concurrent powers of consent, with its inevitable implications for refusal.

Indeed, their Honours cited the principle for which *Gillick's* case is authority in the following terms, which would seem to be inconsistent with the Court of Appeal's approach:²⁶³

The proposition endorsed by the majority in that case [*Gillick*] was that **parental power to consent to medical treatment on behalf of a child diminishes gradually as the child's capacities and maturity grow and that this rate of development depends on the individual child.** [emphasis added]

Their Honours did not use Lord Scarman's terminology of the "parental right to determine", but rather, referred simply to the "parental power to consent". If the High Court does not draw Lord Donaldson's distinction between "determination" and "consent", it would seem difficult to sustain a view that a parental power of consent could remain, notwithstanding the young person's increase in maturity. It is arguable that the High Court was suggesting that, in those circumstances, the parental power to consent would diminish to the point of being lost altogether.

²⁶¹ Id at 237-238.

²⁶² Id at 238.

²⁶³ Id at 237.

Further, in *Marion's* case, McHugh J expressly criticised the decision of the Court of Appeal in *In re R*:²⁶⁴

[T]he parent's authority is at an end when the child gains sufficient intellectual and emotional maturity to make an informed decision on the matter in question. In so far as *Re R (A Minor) (Wardship: Consent to Treatment)* ... suggests the contrary, it is inconsistent with *Gillick*.

Accordingly, there should be no presumption that the Australian position with respect to refusal of health care by a young person will, or should, necessarily follow the English Court of Appeal decisions.²⁶⁵

Some hypothetical examples may highlight the uncertainty of the current Australian law in the situation where a competent young person refuses to undergo proposed treatment.

²⁶⁴ *Id* at 316-317.

²⁶⁵ Although the composition of the High Court has changed since the decision in *Marion's* case was handed down, that case did contain express and implied criticisms of *In re R*.

Example 1

A competent young person refuses further treatment for cancer: she has undergone a number of courses of treatment and, understanding the possible consequences of no further treatment - including the possibility of death - she refuses further treatment.

The parents of the young person agree that no further treatment should be given - their child has suffered enough.

The health care provider believes that another course of treatment has a sufficient chance of success to be considered to be in the young person's best interests.

The current law

It is most likely that the health care provider would have no authority to treat unless he or she obtained authorisation from either the Supreme Court of Queensland exercising its *parens patriae* jurisdiction or the Family Court of Australia exercising its welfare jurisdiction; or unless the Director-General of Families, Youth and Community Care consented to the treatment pursuant to a care and protection order made by the Childrens Court.²⁶⁶

²⁶⁶ See the discussion on s49 of the *Children's Services Act 1965* (Qld) in the Commission's Research Paper *Medical Examinations in Cases of Suspected Child Abuse* (MP17, June 1996).

Example 2

A competent young person refuses further treatment for cancer; she has undergone a number of courses of treatment and, understanding the possible consequences of no further treatment - including the possibility of death - she refuses further treatment.

The parents of the young person want their child to undergo further treatment - to give her one last chance to live.²⁶⁷

The health care provider believes that another course of treatment has a sufficient chance of success to be considered to be in the young person's best interests.

The current law

It is doubtful that the health care provider will have a sufficient authority from the parents to proceed with the treatment. To be protected from liability for assault the health care provider may prefer to obtain the authorisation of a court before proceeding with treatment.

Example 3

The parents of the young person disagree as to whether or not their child should undergo further treatment.

The current law

A court order may be the only way of resolving the conflict posed by the parents' disagreement.

²⁶⁷ An interstate example of another situation where there was a conflict between the wishes of a young woman and her parents has been brought to the Commission's attention. A 13 year old young woman, 20 weeks pregnant to her mother's boyfriend, wanted a termination performed. The mother wanted her to have the baby. The State Welfare Department was reluctant to commence care and protection proceedings over the young woman until the baby was born. Medical advice was that it would be very dangerous for the young woman to proceed with the pregnancy given her age and immature development. The medical practitioner who was considering performing the termination was, understandably, in a quandary.

4. THE ARGUMENTS IN FAVOUR OF CONFERRING UPON YOUNG PEOPLE A RIGHT TO REFUSE HEALTH CARE

(a) Right to autonomy

As noted above,²⁶⁸ the Court of Appeal held in *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* that the Court could overrule the decision of a legally competent young person. That decision has been criticised on the basis that it offends the principle of autonomy. Douglas notes in relation to that decision:²⁶⁹

By adopting the position it has, the Court of Appeal ... has firmly entrenched not welfare, but paternalism, as its guiding principle in wardship. For it must be emphasised that we are not talking about children who do not understand the implications of their decisions, but of children who have satisfied the stringent, not to say rigid, requirements laid down by Lord Scarman in *Gillick* before they can be said to be 'competent.' A court which recognised the spirit of the *Gillick* decision would have refused to go this far.

Once a young person has satisfied the test established in *Gillick's* case²⁷⁰ and can be described as legally competent, it can be argued that there is no logical reason for denying to that young person the right to decide whether he or she will receive health care and if so, what health care. Indeed, Balcombe LJ noted in *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* that:²⁷¹

In logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment.

From that perspective, the right to refuse health care could be said simply to derive from the fact that a young person has reached a certain level of decision-making capacity, in the same way that it does with a legally competent adult, who can choose whether or not to agree to health care.

²⁶⁸ At 68-71 of this Report.

²⁶⁹ Douglas G, "The Retreat from *Gillick*" (1992) 55 *The Modern Law Review* 569 at 573.

²⁷⁰ Some commentators have suggested that this is a more stringent test than is required of an adult patient: see, for example, Bainham A, "The Judge and the Competent Minor" (1992) 108 *The Law Quarterly Review* 194 at 200 and Devereux J, "The Capacity of a Child in Australia to Consent to Medical Treatment - *Gillick* Revisited?" (1991) 11 *Oxford Journal of Legal Studies* 283 at 292.

²⁷¹ [1993] Fam 64 at 88.

(b) Clinical advantage

In *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* Lord Donaldson MR touched upon an aspect of consent and refusal, which is important even in a "best interests" approach to the issue of consent and refusal:²⁷²

[Consent] has two purposes, the one clinical and the other legal. The clinical purpose stems from the fact that in many instances the co-operation of the patient and the patient's faith or at least confidence in the efficiency of the treatment is a major factor contributing to the treatment's success. Failure to obtain such consent will not only deprive the patient and the medical staff of this advantage, but will usually make it much more difficult to administer the treatment.

In many instances, there may be different medical options available to treat a particular illness. Arguably, if a young person does not have the capacity to refuse health care (or any particular form of it), the young person will have no capacity to choose one particular form of health care over any others, as that necessarily entails the rejection of other forms of health care and a refusal to submit to those other forms of health care.

For example, a young person suffering from tonsillitis might be offered the options of a tonsillectomy or a particular diet in combination with antibiotics to treat episodic bouts of infection. A choice of either form of treatment will necessarily involve the rejection of the other. It is not the case that refusal of treatment will necessarily involve the refusal of all forms of treatment. It is arguable that the concept of refusal is as fundamental to the right to choose between treatments, as it is to the right to refuse all forms of treatment.

5. THE ARGUMENT AGAINST CONFERRING A RIGHT TO REFUSE HEALTH CARE ON YOUNG PEOPLE

The principal argument against conferring on young people a right to refuse health care is that they may choose to exercise that right in a way which would not be beneficial to their health.

In coming to the conclusion in *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* that subsection 8(1) of the *Family Law Reform Act 1969* (UK) did not confer a right to refuse health care on young people of or over the age of 16, Lord Donaldson MR had regard to the background to the introduction of that legislation, as found in the *Report of the Committee on the Age of Majority*²⁷³ (the Latey

²⁷² Id at 76.

²⁷³ (1967) Cmnd 3342.

Committee Report). Lord Donaldson MR noted one particular mischief which the report had identified:²⁷⁴

[C]ases were occurring in which young people between 16 and 21 (the then age of majority) were living away from home and wished and needed urgent medical treatment which had not yet reached the emergency stage. Doctors were unable to treat them unless and until their parents had been traced and this could cause unnecessary suffering.

Despite a recommendation to the Latey Committee from all the professional bodies that gave evidence, except the Medical Protection Society, that young people should also be able to give an effective refusal, the Committee did not recommend an express right of refusal and the subsequent legislation based on the Latey Committee Report did not confer an express right of refusal.²⁷⁵ The legislation only conferred an express right to consent.²⁷⁶ Lord Donaldson MR seemed to be suggesting that the purpose of the legislation was only to enable young people to gain access to health care which they might otherwise be denied. If that was the purpose of the legislation, it is perhaps understandable why Lord Donaldson MR treated the issue of consent quite differently from the issue of refusal; consent is seen as something obviously for the benefit of young people.

Indeed, Leng²⁷⁷ suggests that the reason young people are granted substantial autonomy in relation to therapeutic treatment is that, generally, such treatment is beneficial.

Perhaps, however, what underpins the distinction drawn between the concepts of consent and refusal in Lord Donaldson's MR approach is the unarticulated view that the two concepts have quite distinct purposes (the purpose of consent almost always being beneficial), and that the level of maturity needed to appreciate what is involved in refusing health care is different from, and perhaps higher than, the level of maturity required in consenting to health care.

²⁷⁴ *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 at 77.

²⁷⁵ *Id* at 77-78.

²⁷⁶ See *Family Law Reform Act 1969* (UK) s8(1).

²⁷⁷ Leng R, "Consent and Offences against the Person: Law Commission Consultation Paper No. 134" [1994] *Criminal Law Review* 480 at 484.

6. RATIONALES FOR REFORM

The options for clarifying the law in relation to a young person's right of refusal will depend on the particular approach adopted: whether the primary purpose of a reform model is to confer on a legally competent young person the right to make all of his or her health care decisions (including the decision to refuse health care), or whether it is only to promote the young person's health by enhancing the young person's access to health care and by clarifying the circumstances in which a young person can provide a valid consent to health care.²⁷⁸

Under the former approach, the young person would be given the same right to refuse as to consent. Under the latter approach, the young person would be given a right to consent, but not a right to refuse.

²⁷⁸ See Bainham A, "The Judge and the Competent Minor" (1992) 108 *The Law Quarterly Review* 194 at 196.

CHAPTER 5

PARENTAL DUTIES AND RESPONSIBILITIES

1. THE CURRENT LEGAL POSITION

(a) Introduction

The law in relation to parental duties and responsibilities is complex for the reason that it is derived from a number of sources:

- *The common law*

Over time, laws are developed as a result of rulings made by judges in individual cases. This body of case law is referred to as the common law. These decisions may be made in areas that are not governed by any legislation (statute law), or alternatively, may be decisions that interpret a provision in legislation.

- *Commonwealth legislation*

The *Family Law Act 1975* (Cth) is a Commonwealth statute which applies in all States, except Western Australia, and in the Territories of Australia. It contains a number of provisions that impose duties and responsibilities on certain carers of young people. These are discussed below.

- *Queensland legislation*

There are also provisions in certain Queensland legislation (such as the *Children's Services Act 1965* (Qld) and the *Criminal Code* (Qld)) that impose duties on persons having the custody of a young person. These provisions are set out and discussed below.

The common law will often be used to interpret legislation which uses words or phrases which have through the development of the common law acquired a technical meaning.

(b) The common law

Parents have an extremely important role in protecting their children. That role has included protecting young people from their own immaturity. However, at least in

recent years, it has been recognised that parents do not have absolute control and authority over their children. Lord Denning MR has stated:²⁷⁹

[T]he legal right of a parent to the custody of a child ends at the 18th birthday: and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, and the more so the older he [or she] is. It starts with a right of control and ends with little more than advice.

The common law does not confer upon parents rights over their children; nor does it impose obligations upon children to involve parents in health care decisions. However, it does impose certain duties upon parents relating to the maintenance and support of their children.

The position at common law is that parents are the natural guardians and custodians of their child and as such have various duties, powers and responsibilities in relation to their child, including the power to consent to health care on behalf of their child. Under Queensland statute law (discussed below), certain other people with the care of young people also owe duties of care to those young people, including the duty to arrange for appropriate health care as required.²⁸⁰

In *Marion's* case,²⁸¹ Brennan J described the parental power as follows:²⁸²

The responsibilities and powers of parents extend to the physical, mental, moral, educational and general welfare of the child ... They extend to every aspect of the child's life. Limits on parental authority are imposed by the operation of the general law, by statutory limitations or by the independence which children are entitled to assert, without extra-familial pressure, as they mature. Within these limits, the parents' responsibilities and powers may be exercised for what they see as the welfare of their children.

In the same case, McHugh J acknowledged the suggestion that the rights and responsibilities of parents arise out of the duty of parents to support and maintain a child whom they have brought into the world.²⁸³ He cited ²⁸⁴ Blackstone's assertion that the duty:²⁸⁵

²⁷⁹ *Hewer v Bryant* [1970] 1 QB 357 at 369.

²⁸⁰ See, for example, *Children's Services Act 1965* (Qld) s40 set out at 85 of this Report.

²⁸¹ *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

²⁸² *Id* at 278.

²⁸³ *Id* at 312.

²⁸⁴ *Ibid*.

²⁸⁵ Blackstone, *Commentaries*, 17th ed. (1830), vol. 1, p. 452.

to provide for the maintenance of their children, is a principle of natural law; an obligation ... laid on them not only by nature herself, but by their own proper act, in bringing them into the world: for they would be in the highest manner injurious to their issue, if they only gave their children life, that they might afterwards see them perish. By begetting them, therefore, they have entered into a voluntary obligation, to endeavour, as far as in them lies, that the life which they have bestowed shall be supported and preserved.

The true basis for the parental power to consent to the health care of a child was identified by McHugh J as being the child's right of advancement. He explained the basis as follows:²⁸⁶

Both the interests of the child and the interests of society require that, wherever possible, a child should not be deprived of medical treatment that is for his or her benefit. Consequently, a just and rational legal system must make provision for the care of those who, by reason of infancy, lack the capacity to control and manage their own affairs. This means that the legal system must give a person or persons authority to act on behalf of children in respect of matters in which they are unable to act for themselves. In the case of children:²⁸⁷

"Apart from a public authority, the most obvious candidates are one or both of the child's parents and it is in such persons that English law, in keeping with most other societies, has vested such authority and responsibility."

The common law holds parents to be the most appropriate repository of such a power because, ordinarily, a parent of a child who is not capable of giving consent is in the best position to act in the best interests of the child.

McHugh J observed that if, as part of such parental obligations, parents were under a specific duty to seek health care for their children, then the power of parents to consent to that health care would be a necessary corollary of, and derive from, that duty.²⁸⁸ At least at common law, there appears to be no such duty on parents. However, over the last hundred years, legislation has been introduced that makes it an offence for parents, in certain circumstances, to fail to provide health care for their children.²⁸⁹

²⁸⁶ *Marion's case* (1992) 175 CLR 218 at 315.

²⁸⁷ Bromley and Lowe, *Family Law*, 7th ed. (1987) at p. 254.

²⁸⁸ *Marion's case* (1992) 175 CLR 218 at 315.

²⁸⁹ See, for example, *Children's Services Act 1965* (Qld) s69, which is set out in part at 85-86 of this Report.

However, McHugh J observed of this and similar legislation in other jurisdictions:²⁹⁰

[N]othing in the terms of this legislation nor in the implied duties which they impose give any ground for concluding that parents have a general power to consent to the medical treatment of their children. None of this legislation, for example, provides, even by implication, a duty to provide cosmetic surgery or treatment. At most, the legislation imposes a duty on parents not to neglect to provide necessary medical treatment for their child.

It follows that the duties that parents have towards their children cannot form the only basis for the power parents have to consent to health care.

(c) The *Family Law Act 1975* (Cth)

The position at common law referred to above is now entrenched in the *Family Law Act 1975* (Cth), which recognises the status of parents²⁹¹ of a child as having parental responsibility for the child, subject to any order of a court, until the child attains the age of eighteen.²⁹² The Act vests in parents all the duties and responsibilities ordinarily the incidents of parenthood at common law, apart from those matters specifically dealt with in the Act.

As the power of parents to consent to the health care of their children is not a matter subject to specific regulation under the Act, that power is included within this general grant of rights.²⁹³

(d) The *Children's Services Act 1965* (Qld)²⁹⁴

Section 40 of the *Children's Services Act 1965* (Qld) imposes certain duties upon the governing authority and person in charge of an institution having the custody of

²⁹⁰ *Marion's case* (1992) 175 CLR 218 at 313-314.

²⁹¹ "Parent" under the *Family Law Act 1975* includes an adoptive parent of a child (s60D) and a person whose spouse or *de facto*-partner has had a child by artificial conception procedures (s60H). Note that s31 of the *Family Law Reform Act 1995* (Cth), which came into effect on 11 June 1996, repealed Part VII of the *Family Law Act 1975* (Cth) (which was the Part that dealt with children) and inserted a new Part VII into the *Family Law Act 1975* (which also deals with children).

²⁹² See *Family Law Act 1975* s61C(1). Section 61B defines "parental responsibility" as meaning all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.

²⁹³ The power is a codification of the common law: see *Marion's case* per Mason CJ and Dawson, Toohey and Gaudron JJ at 235-236, Brennan J at 277-278, Deane J at 289-290 and McHugh J at 318. Note that s61C(1) is subject to any order of a court (see s61C(3)) and that it is possible for a parenting order (made under Division 6 of Part VII) to take away or diminish the parental responsibility of a parent, including the power to consent to health care (see s61D(2)).

²⁹⁴ Note that this Act is currently being reviewed by the Department of Families, Youth and Community Care.

a young person:²⁹⁵

The governing authority and person in charge of an institution (whether or not established or licensed under this Act) having in its, his or her custody a child shall -

- (a) provide such child with adequate food, clothing, lodging and care;
- (b) maintain every part of such institution at all times in a fit and proper state for the care of a child;
- (c) secure for such child adequate education and religious training of such a type and form as is approved by the director or, in the absence of such an approval as is in the best interests of such child;
- (d) ensure that such child receives adequate medical and dental treatment;
- (e) do, observe and carry out all acts, requirements and directions prescribed by this Act or by any order of the director in relation to the institution and the care of such child.

This provision applies to all relevant institutions. Although a duty to ensure that a young person receives health care is established by subsection (d), it does not appear that this overrides the requirement for there to be valid consent to the proposed health care. Unless there is an appropriate court order, an institution or individual who is not the parent of a young person who is not legally competent, but who cares for the young person, has no authority to consent to health care of the young person. If the health care proceeds without a valid consent, the health care provider may be criminally and civilly liable for assault and/or battery. The person purporting to provide a consent to the health care provider could also be liable as an accessory or party to any offence.

Section 69 of the *Children's Services Act 1965* (Qld), which creates offences in relation to the health of young people, is of more general application than section 40, and provides, in part:

- (1) A person having a child in his or her charge shall not ill-treat, neglect, abandon or expose the child in a manner likely to cause the child unnecessary suffering or to injure the child's physical or mental health nor suffer the child to be so ill-treated, neglected, abandoned or exposed.
- ...
- (3) A person having the charge of a child shall be deemed to have neglected the child in a manner likely to cause the child unnecessary suffering or to injure the child's health physical or mental, as the circumstances may indicate, if -

²⁹⁵ Section 8 of the Act defines "child" for the purposes of the Act as "a person under or apparently under the age of seventeen years".

- (a) being able to so provide from the person's own resources, the person fails to provide adequate food, clothing, medical treatment, lodging or care for such child; or
 - (b) being unable to so provide from the person's own resources, the person fails to take all lawful steps within the person's knowledge to procure the provision of adequate food, clothing, medical treatment, lodging and care for such child.
- (4) A person may be convicted of an offence against this section notwithstanding -
- (a) that suffering or injury to the health of the child in question or the likelihood of suffering or injury to the health of the child in question was avoided by the action of another person; or
 - (b) that the child in question has died.

(e) The *Criminal Code* (Qld)

Sections 285 and 286 of the Queensland *Criminal Code* (Qld) impose statutory duties on certain people, who may be punished under various provisions of the Code for their failure to fulfil those duties.²⁹⁶ The duties are, for practical purposes, the same as those imposed by the common law.

Section 285 provides:

It is the duty of every person having charge of another who is unable by reason of age, sickness, unsoundness of mind, detention, or any other cause, to withdraw from such charge, and who is unable to provide himself or herself with the **necessaries of life**, whether the charge is undertaken under a contract, or is imposed by law, or arises by reason of any act, whether lawful or unlawful, of the person who has such charge, to provide for that other person the necessaries of life: and the person is held to have caused any consequences which result to the life or health of the other person by reason of any omission to perform that duty. [emphasis added]

This provision would, for example, impose a duty on the person in charge of a boarding school to provide health care to boarders too young, or for any other reason unable, to do so themselves.

²⁹⁶ Two of the penalty provisions in the *Criminal Code* (Qld) are s324 (failure to supply necessaries) and s328 (negligent acts causing harm).

Whether one person has "charge" of another is a question of fact,²⁹⁷ except where the law imposes the charge.²⁹⁸ A person standing *in loco parentis* [in the place of a parent] to a young person would also be under a duty to provide the necessities of life for the young person. A person is said to be *in loco parentis* towards a young person where he or she assumes a moral obligation towards the young person of making such a provision for the young person as his or her parents would be bound in duty to make.²⁹⁹

A more specific duty to provide the necessities of life is imposed upon parents, and possibly others who have assumed responsibilities over young people, by section 286 of the *Criminal Code* which provides:³⁰⁰

Duty of head of family

It is the duty of every person who, as head of a family, has the charge of a child under the age of sixteen years, being a member of the person's household, to provide the necessities of life for such child; and the person is held to have caused any consequences which result to the life or health of the child by reason of any omission to perform that duty, whether the child is helpless or not.

It is unclear how this provision would apply to the situation of a parent who was respecting the wishes of a legally competent child to refuse medical treatment. It is also unclear why a limit of sixteen years was imposed on the duty.

²⁹⁷ *Bennet v Bennet* (1879) 10 Ch D 474 per Jessel MR at 477.

²⁹⁸ *R v Macdonald* [1904] St R Qd 151. Medical attention and remedies may be necessities. Unreasonable refusal to allow a surgical operation would be a failure to provide medical aid and would amount to a failure to provide the necessities of life *Oakey v Jackson* [1914] 1 KB 216 (parent's refusal to allow child to undergo operation to remove adenoids).

²⁹⁹ *Powys v Mansfield* (1837) 3 My & Cr 359; 40 ER 964. See 331-333 of this Report for a discussion on the concept of *in loco parentis*.

³⁰⁰ The *Criminal Law Amendment Bill 1996* (Qld) was introduced into Parliament on 4 December 1996. Cl 45 of that Bill proposes the replacement of the *Criminal Code* s286 with the following provision:

Duty of person who has care of child

- 286.(1) It is the duty of every person who has care of a child under 16 years to -
- (a) provide the necessities of life for the child; and
 - (b) take the precautions that are reasonable in all the circumstances to avoid danger to the child's life, health or safety; and
 - (c) take the action that is reasonable in all the circumstances to remove the child from any such danger;
- and he or she is held to have caused any consequences that result to the life and health of the child because of any omission to perform that duty, whether the child is helpless or not.
- (2) In this section -
- "person who has care of a child" includes a parent, foster parent, step parent, guardian or other adult in charge of the child, whether or not the person has lawful custody of the child.

This amendment was recommended by The Criminal Code Advisory Working Group in its *Report to the Attorney General* (July 1996) at 46-47.

Further, it is unclear whether section 31 of the *Criminal Code* would excuse from criminal liability for assault a person who was not a parent, but who nevertheless had "charge" of a young person, who purported to consent to health care for the young person, when the person had no authority to consent to the health care.

Section 31 of the *Criminal Code* provides, in part:

- (1) A person is not criminally responsible for an act or omission, if the person does or omits to do the act under any of the following circumstances, that is to say -
 - (a) **in execution of the law;** [emphasis added]

While it might be argued that the person who purported to consent to the young person's health care was doing so in execution of the duty imposed by section 286 of the *Criminal Code* (or, indeed, the duty imposed by section 285 of the *Criminal Code* or sections 40 or 69 of the *Children's Services Act 1965* (Qld)), the limited case law on section 31 suggests that its exculpatory effect is likely to be limited to excuse from liability only those persons who are public officials who might otherwise be liable for performing the duties of their offices.

In *Mackinlay v Wiley*³⁰¹ the Full Court of the Supreme Court of Western Australia held that an identical provision in the Western Australian *Criminal Code* did not exculpate the former editor of a student newspaper who had been convicted of publishing an obscene paper. It was argued for the appellant that he had acted in the manner required by the law governing his appointment.

In dismissing the appeal, Virtue SPJ held, in relation to section 31:³⁰²

Certainly, s. 31(1) has no application. This subsection confers on the hangman, the prison authorities, the bailiff and others **who are servants of the law and justice** and act in accordance with the demands of them that are made by their official position, to escape from ordinary criminal responsibility. It has no application in relation to those who are contractually or morally bound to carry out certain functions but whose obligations can in no sense be pleaded as an excuse for committing a criminal offence. [emphasis added]

Lavan J made a similar comment in relation to the scope of section 31:³⁰³

This section operates to exculpate those who **by reason of their official positions** are required to carry out certain functions which if performed without the protection of the law would render them liable to criminal prosecution. It has no application in the circumstances of the present case where the appellant was acting in the performance of an obligation voluntarily assumed and performed free of sanctions for their non-

³⁰¹ [1971] WAR 3.

³⁰² Id at 10.

³⁰³ Id at 18.

performance. [emphasis added]

Although the obligations imposed by sections 285 and 286 of the *Criminal Code* and by sections 40 and 69 of the *Children's Services Act 1965* (Qld) are not merely contractually or morally assumed, most of the persons to whom those obligations apply would not be "servants of the law and justice" or have "official positions".

Further, in *R v Slade*³⁰⁴ the Court held that section 31(1):³⁰⁵

can only apply where the act which would otherwise be criminal was necessary in the performance of the officer's duty so that it can truly said to be an act done under the compulsion of that duty.

However, the act in respect of which liability would attach in the case of a person purporting to consent to health care for a young person in the absence of any authority to do so (thereby becoming a party to a criminal assault) is not the act, the execution of which could be said to be required by any of the provisions mentioned above. The obligation required by those provisions is merely to provide the necessities of life or adequate medical treatment.

2. LIMITATIONS ON THE POWER OF A PARENT TO CONSENT

Several limitations are imposed by law upon the power of parents to consent to the health care of their children. They are as follows:

(a) No right to absolute control

In the nineteenth and early twentieth centuries the power of a parent to consent to the health care of a child was in certain circumstances clearly based upon the absolute right of control of a father over the person, education and conduct of his children. This was considered to be the natural right of a father.³⁰⁶

However, that control has been severely diminished over the past 150 years, not only with the vesting of significant, and often greater rights in the mother of a child, but, more importantly, with increasing recognition in legislation of the rights of young people as independent people. In particular, the emphasis on the welfare of the young person as an overriding consideration in disputes of any nature concerning a

³⁰⁴ [1995] 1 Qd R 390.

³⁰⁵ *Id* at 399.

³⁰⁶ *In re Taylor* (1876) 4 ChD 157 per Jessel MR at 159.

young person is inconsistent with complete control by a parent.³⁰⁷ As noted by the majority of the High Court in *Marion's case*.³⁰⁸

[T]he overriding criterion of the child's best interests is itself a limit on parental power.

McHugh J, in highlighting the point that a parent is no longer treated as having an absolute right of control over a child, referred to the proposition endorsed by the majority in the United Kingdom House of Lords decision of *Gillick v West Norfolk and Wisbech Area Health Authority (Gillick's case)*³⁰⁹ that a parent's power to consent to health care on behalf of a child diminishes gradually as the child's capacity and maturity grows. He concluded:³¹⁰

Modern case law makes it impossible, therefore, to assert that parents have a natural right of almost absolute control over the person, education, conduct and property of their children. Consequently, the power of parents to consent to medical treatment and surgical procedures in respect of their children can no longer be regarded as existing as an incident or corollary of such a right.

(b) The power must be exercised in the best interests of the young person

A parent has no authority to consent to health care of his or her child unless it is in the best interests of the child. This is because implicit in parental consent is understood to be the determination of what is best for the welfare of the child.³¹¹ If a parent purports to consent to health care that is not in the best interests of the child, the consent is of no effect and any person acting on such a consent would be guilty of assault if any physical interference were involved.³¹² Notably, what is in the best interests of a child is a matter to be determined objectively.³¹³

The best interests of the young person's health and well-being may be something other than the direct health consequences to the young person. For example, it may

³⁰⁷ Each of the child's parents is considered to have parental responsibility for the child: *Family Law Act 1975* (Cth) s61C(1). In Western Australia, the mother of a child whose parents have never married each other remains sole guardian of the child in the absence of an order to the contrary: *Family Court Act 1975* (WA) s35.

³⁰⁸ (1992) 175 CLR 218 at 240.

³⁰⁹ [1986] AC 112. See 56-58 of this Report.

³¹⁰ *Marion's case* (1992) 175 CLR 218 at 315.

³¹¹ *Id* at 240.

³¹² *Id* per McHugh J at 316. It is possible for legally competent adults to consent to health care which may not be in their best interests.

³¹³ See *Marion's case* (1992) 175 CLR 218 and the comments of McHugh J at 316 and of the majority at 240. The terms "in the best interests" and "for the welfare" are used interchangeably by the High Court in *Marion's case*.

be in the young person's best interests that an opportunity be given for the continuation of a relationship the young person has with another person which may outweigh the risk or discomfort of a surgical procedure performed on the young person for the direct health benefit of the other person.³¹⁴

(c) The power is exercised in the course of a fiduciary relationship

The power of a parent to consent to health care on behalf of a child is exercised in the course of a "fiduciary" relationship and is therefore restricted by the relevant principles concerning fiduciaries.

The accepted fiduciary relationships are sometimes referred to as relationships of trust and confidence or confidential relations. Mason J (as he then was) described the critical feature of these relationships as follows:³¹⁵

[T]he fiduciary undertakes or agrees to act for or on behalf of or in the interests of another person in the exercise of a power or discretion which will affect the interests of that other person in a legal or practical sense. The relationship between the parties is therefore one which gives the fiduciary a special opportunity to exercise the power or discretion to the detriment of that other person who is accordingly vulnerable to abuse by the fiduciary of his [or her] position.

Further:³¹⁶

It is partly because the fiduciary's exercise of the power or discretion can adversely affect the interests of the person to whom the duty is owed and because the latter is at the mercy of the former that the fiduciary comes under a duty to exercise his [or her] power or discretion in the interests of the person to whom it is owed ...

Some of the principles concerning fiduciaries may be applicable to the parent/child relationship. McHugh J in *Marion's* case³¹⁷ suggested, for example, that in principle, a parent can have no authority to act on behalf of his or her child where a conflict arises between the interests of the parent and the interests of the child.

³¹⁴ See *GWV and GMW* (Unreported, Family Court of Australia HB 1447/1996, 21 January 1997) per Hannon J at 13 and at 16 where a bone marrow transplant from the young person to an aunt was considered to be in the young person's best interests:

the psychological benefit to B of permitting the harvesting of the cells outweighs the minimal risks and consequences of the procedures and therefore it is in his best interests to permit him to participate as a donor.

³¹⁵ *Hospital Products Ltd v United States Surgical Corporation* (1984) 156 CLR 41 at 96-97.

³¹⁶ *Id* at 97.

³¹⁷ (1992) 175 CLR 218 at 317.

This may be relevant when, for example, the carrying out of, or failure to carry out, an operation or treatment affects the interests of the parents as well as those of the child. McHugh J noted:³¹⁸

No doubt in most cases of medical treatment or surgery, no conflict will arise between the interests of the parents and those of the child. In other cases, the risk of conflict may be so slight or theoretical that it can be disregarded. But in some cases - and claims that an abortion or sterilisation operation is in the best interest of a child are likely to be among them - a conflict between the interests of the parents and the child may arise. In such a case, the application of established and fundamental principle will deny the right of the parents to consent to the operation or treatment. If an operation or treatment is to be performed or carried out in such a case, only a court of general jurisdiction exercising the *parens patriae* jurisdiction or the Family Court acting under s64(1)(c) of the *Family Law Act 1975* (Cth)³¹⁹ can authorise the operation or treatment. In such a case, the consent of the court has the same effect in law as a valid consent given by a parent or a child with the requisite capacity.

It might be asserted that what is in the parents' or family's best interests would automatically be in the child's best interests. This does not always follow - in all cases the best interests of the young person must be considered and not merely presumed.

(d) Health care beyond parental authority

Non-therapeutic health care involving major, irreversible surgery that has serious consequences for the young person may be beyond a parent's power to consent - particularly if there is a significant risk of a wrong decision as to the young person's present or future capacity to consent to that treatment. In such cases, court or tribunal authority would be required before the surgery could lawfully proceed.³²⁰

In New South Wales and South Australia, there is legislation that prohibits certain health care for young people. In New South Wales, procedures that result in permanent infertility are prohibited where a young person is under 16 years of age, except where the health care is necessary to save the young person's life or to prevent serious damage to the young person's health, or where the New South Wales Supreme Court authorises the health care.³²¹ Where the young person is between 16 and 18 years of age and lacks capacity to consent to health care, similar provisions exist which prohibit the procedure unless it is authorised by the

³¹⁸ Ibid.

³¹⁹ See *Family Law Act 1975* (Cth) s67ZC as inserted by the *Family Law Reform Act 1995* (Cth).

³²⁰ *Marion's case* (1992) 175 CLR 218.

³²¹ *Children (Care and Protection) Act 1987* (NSW) s20B.

New South Wales Guardianship Board.³²²

In South Australia, if a young person of any age (including between 16 and 18 years of age) lacks capacity to consent due to mental incapacity, the authorisation of the South Australian Guardianship Board is required before a sterilisation or termination of pregnancy can be performed on the young person.³²³

This Report does not purport to examine this aspect of health care decision making for young people, other than in the context of what restrictions should be imposed on young people themselves consenting to such surgery or other procedures.³²⁴

(e) Assignability of authority to consent

It is apparent that parental authority to consent to the health care of children cannot be assigned by parents to others, without court approval. The authority is conferred on parents by the common law - it is not given to others who may nevertheless have an interest in the child.

Thus, although someone other than the young person's parents may be caring for the young person at a time when the young person requires health care, that other person will not automatically have the ability to provide a valid consent to the health care to the health care provider. Even if the young person's parents had indicated to the carer that the carer could make all decisions relating to health of the child, it does not seem that the parents would have the legal ability to assign their decision-making authority to the carer. Although it may be appropriate to appoint an agent to consent on the parent's behalf to particular health care (in which case the health care provider would be treating upon the consent of the parent but by way of direction from the parent's agent), it is less certain whether the parent would be able to appoint someone else to consent to as yet unknown health care for the young person. Thus, boarding schools that obtain a general consent from parents at the beginning of the school year may not lawfully be able to consent to health care not contemplated by the parents at the time the general consent was provided and not specifically included in that consent.

The Commission recognises this as a potentially significant limitation imposed by the law on young people's access to health care.³²⁵

³²² *Guardianship Act 1987* (NSW) Pt 5.

³²³ *Guardianship and Administration Act 1993* (SA) ss58, 61.

³²⁴ See the Commission's recommendation relating to a restriction in respect of sterilisation at 248-250 and 263 of this Report.

³²⁵ See the broad definition of "parent" recommended by the Commission in Ch 15 of this Report.

3. JURISDICTION OF THE COURTS IN RELATION TO YOUNG PEOPLE

Where the parent and young person both lack capacity to consent to health care for the young person, court authorisation is required before health care can proceed. The Family Court of Australia has a general supervisory jurisdiction in relation to the health care of children.³²⁶ State and Territory Supreme Courts have *parens patriae* powers, which would enable them to authorise health care in certain circumstances.

(a) *Parens patriae* jurisdiction of the Supreme Court of Queensland

The Supreme Court of Queensland is vested with a jurisdiction known as the *parens patriae* jurisdiction.³²⁷ That jurisdiction was described by Lord Esher MR in *R v Gyngall*³²⁸ as follows:³²⁹

The Court is placed in a position by reason of the prerogative of the Crown to act as supreme parent of children, and must exercise that jurisdiction in the manner in which a wise, affectionate, and careful parent would act for the welfare of the child.

Although the jurisdiction has been likened to a parental role, a court acting in its *parens patriae* jurisdiction has wider powers than those of a natural parent.³³⁰ In *Marion's case*³³¹ the majority of the High Court made the following observation in relation to the *parens patriae* jurisdiction:³³²

³²⁶ *Family Law Act 1975* (Cth) s67ZC. The provision applies to all children except those subject to prescribed child welfare laws by virtue of the referral of powers legislation: see note 337 of this Report. Section 67ZC provides, in effect, that the court has jurisdiction to make orders relating to the welfare of children and that, in doing so, the court must regard the best interests of the child as the paramount consideration. The Family Court of Australia can also exercise the cross-vested jurisdiction of the Supreme Courts and can supervise medical treatment and decisions in relation to children subject to prescribed child welfare laws: see *Jurisdiction of Courts (Cross-vesting) Act 1987* s4(2) in each State and *Jurisdiction of Courts (Cross-vesting) Act 1987* (Cth) s4(2).

³²⁷ See *Supreme Court Act 1867* (Qld) s22 and *Carseldine v The Director of the Department of Children's Services* (1974) 133 CLR 345 per McTiernan J at 350.

³²⁸ [1893] 2 QB 232.

³²⁹ *Id* at 241.

³³⁰ This view has attracted some criticism. See, for example, Eekelaar J, "The Eclipse of Parental Rights" (1986) 102 *The Law Quarterly Review* 4 at 8, where Eekelaar queries how the Crown, as *parens patriae*, can claim a right to intervene in the lives of minor children which it denies to those children's parents. See also Douglas G, "The Retreat from *Gillick*" (1992) 55 *The Modern Law Review* 569.

³³¹ (1992) 175 CLR 218.

³³² *Id* per Mason CJ and Dawson, Toohey and Gaudron JJ at 258-259. Brennan J in his dissenting judgment in *Marion's case* at 282 described the proposition that a court, in exercising its *parens patriae* jurisdiction, enjoys a wider power than parents or guardians possess in respect of the personal integrity of their children, as erroneous in law and disturbing in its

The more contemporary descriptions of the *parens patriae* jurisdiction over infants invariably accept that in theory there is no limitation upon the jurisdiction...

No doubt the jurisdiction over infants is for the most part supervisory in the sense that the courts are supervising the exercise of care and control of infants by parents and guardians. However, to say this is not to assert that the jurisdiction is essentially supervisory or that the courts are merely supervising or reviewing parental or guardian care and control. As already explained, the *parens patriae* jurisdiction springs from the direct responsibility of the Crown for those who cannot look after themselves; it includes infants as well as those of unsound mind. So the courts can exercise jurisdiction in cases where parents have no power to consent to an operation, as well as cases in which they have the power.

Accordingly, in the exercise of this jurisdiction, the court may override the wishes both of a young person's parents and of a legally competent young person.³³³

Application can be made to the Supreme Court of Queensland under its *parens patriae* jurisdiction by anyone with an interest in the welfare of a young person.³³⁴

It is possible for the *parens patriae* jurisdiction of the Supreme Court to be displaced by legislation. However, it will only be displaced if the legislation in question does so expressly or by necessary or inescapable implication.³³⁵

social implications.

³³³ *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 per Lord Donaldson MR at 25 and *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 per Lord Donaldson MR at 81. See also Ch 4 of this Report for a discussion of these cases in the context of the refusal of health care by a young person.

³³⁴ See, for example, *Re D (A minor) (Wardship: Sterilisation)* [1976] Fam 185, where an application in the equivalent jurisdiction in England was brought by a service provider. D had been born with Sotos syndrome. She reached puberty at the age of ten and her mother was concerned that she may be sexually assaulted and give birth to an abnormal child. When she was eleven years old, a consultant paediatrician agreed with her mother that she should be sterilised. D attended a school specialising in children who had learning difficulties and associated behavioural problems. She was of "dull normal" intelligence and had the understanding of a child of about nine or nine and a half years of age. It was common ground that she had sufficient intellectual capacity to marry in due course. Certain other professionals concerned with D's welfare did not believe that sterilisation, being permanent and irreversible, was in D's best interests. However, the doctor refused to postpone the operation. An educational psychologist attached to the education department of D's local authority applied to the court for an order to prevent the proposed procedure from being carried out.

See also *Re X (a minor)* [1975] 1 All ER 697, where an application was brought by the child's stepfather to prevent publication of a book about the child's father which contained material likely to be grossly psychologically damaging to the child.

³³⁵ *Carseldine v The Director of the Department of Children's Services* (1974) 133 CLR 345; *Johnson v The Director-General of Social Welfare (Victoria)* (1976) 135 CLR 92. In the United Kingdom, the *parens patriae* jurisdiction over adults with a mental or intellectual disability has been abolished, although it continues in respect of young people under the age of 18: *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1. See note 163 of this Report. This Commission has in its Report, *Assisted and Substituted Decisions* (R49, June 1996) recommended at 452 that the Supreme Court of Queensland's *parens patriae* jurisdiction over adults with a mental or intellectual disability not be abolished.

(b) Welfare jurisdiction of the Family Court of Australia

Section 67ZC of the *Family Law Act 1975* (Cth) confers a welfare jurisdiction on the Family Court of Australia. Section 67ZC³³⁶ of the Act provides:³³⁷

- (1) In addition to the jurisdiction that a court has under this Part in relation to children, the court also has jurisdiction to make orders relating to the welfare of children.
- (2) In deciding whether to make an order under subsection (1) in relation to a child, a court must regard the best interests of the child as the paramount consideration.

The original reference to "welfare" in the *Family Law Act 1975* (Cth) was inserted by the *Family Law Amendment Act 1983* (Cth).³³⁸ In *Marion's case*³³⁹ the majority of the High Court made the following observation in relation to the Family Court's jurisdiction to make orders with respect to the welfare of a child:

There was no independent reference to welfare and it is clear that, as the *Family Law Act* stood before 1983, there was no general power in the Family Court to make orders relating to the welfare of a child. Orders were confined to those concerning custody, guardianship, or access.

The 1983 amendment conferred on the Family Court a jurisdiction "similar to the *parens patriae* jurisdiction, without the formal incidents of one of the aspects of that jurisdiction, the jurisdiction to make a child a ward of court".³⁴⁰

³³⁶ The majority of the High Court in *Marion's case* (1992) 175 CLR 218 at 257 noted in relation to the then s64(1) (the nearest current provision being s67ZC) of the *Family Law Act 1975* (Cth):

The sub-section does not in terms confer jurisdiction on the Court but it confers power to make orders and presupposes jurisdiction.

³³⁷ This section applies to all children in Queensland except those who are the subject of prescribed child welfare laws. Subsection 3(2)(a) of the *Commonwealth Powers (Family Law - Children) Act 1990* (Qld) excluded from the matters referred to the Commonwealth Parliament:

the matter of the taking, or the making of provision for or in relation to authorising the taking, of action that would prevent or interfere with -

(a) a Minister, an officer of the State or any other person having or acquiring the custody, guardianship, care or control of children under a provision of an Act specified in schedule 1...

Although s67ZC is expressed to apply to all children, it is arguable that its scope may be limited by reference to other sections in Part VII of the Act, for example, s65H(1) (which provides that a parenting order must not be made in relation to a child who is or has been married or is in a *de facto* relationship) and s66V(1) (which provides that a child maintenance order does not apply to a child who marries or enters into a *de facto* relationship).

³³⁸ *Family Law Amendment Act 1983* (Cth) s29.

³³⁹ (1992) 175 CLR 218 at 255.

³⁴⁰ *Id* at 256.

Section 69C of the *Family Law Act 1975* (Cth) provides that (subject to express provisions dealing with who may institute particular kinds of proceedings in relation to young people) proceedings under that Act in relation to a child may be instituted by:

- (a) either or both of the child's parents;
- (b) the child;
- (c) a grandparent of the child; or
- (d) any other person concerned with the care, welfare or development of the child.

Accordingly, application may be made to the Family Court pursuant to section 69C to authorise particular health care that may be beyond the scope of a parent's power of consent.³⁴¹ This welfare jurisdiction could also be used to resolve other disputes in relation to the health care of young people.

It has also been held³⁴² that, in addition to the Family Court's welfare jurisdiction, it exercises the *parens patriae* jurisdiction of the State Supreme Courts by virtue of the cross-vesting legislation.³⁴³

(c) Relationship between the *parens patriae* jurisdiction of the Supreme Court of Queensland and the welfare jurisdiction of the Family Court of Australia

In *P v P*³⁴⁴ the majority of the High Court held that an order of the Family Court of Australia in its welfare jurisdiction authorising the health care of a young person without capacity to consent would override a State provision disallowing that health care.

In that case, the mother of a 16 year old intellectually disabled daughter ("L") applied to the Family Court for an order authorising the sterilisation of L. Neither parent intended to apply to the Guardianship Board established under the *Guardianship Act 1987* (NSW) for approval for the proposed surgery. That Act provides a comprehensive scheme for people 16 years and over who are incapable of consenting to health care, and prohibits the carrying out of a sterilisation unless authorisation is given by the Board. There was no evidence before the Family Court to suggest that the grounds for authorising a sterilisation under the *Guardianship Act*

³⁴¹ Id at 253, although the majority acknowledged it was costly for parents to fund court proceedings, that delay was likely to cause painful inconvenience and that the strictly adversarial process of the court was very often unsuitable for arriving at this kind of decision. See Ch 9 of this Report for a discussion of the ways in which the Family Court and others have attempted to address these concerns in Queensland.

³⁴² *Re Elizabeth* (1989) 96 FLR 248 at 258.

³⁴³ *Jurisdiction of Courts (Cross-vesting) Act 1987* (Cth) and the complementary State legislation.

³⁴⁴ (1994) 181 CLR 583.

1987 (NSW) would have been established (that is, that it was necessary either to save the life of L or to prevent serious damage to her health).³⁴⁵

It was in this context that the Court considered the relationship between the *parens patriae* jurisdiction of the Supreme Court of New South Wales and the welfare jurisdiction of the Family Court.³⁴⁶

Clearly enough, it was not the intention of the Parliament, in conferring general welfare jurisdiction upon the Family Court in respect of children of a marriage, to cover the field and thereby deprive the State Supreme Court of any *parens patriae* or guardianship jurisdiction in respect of such children. Equally clearly, however, it was not the intention of the Parliament to subordinate the jurisdiction conferred by it on the Family Court, being part of the judicial power of the Commonwealth, to that which was conferred by State law upon the State Supreme Court. The intent of the Parliament, confirmed by the subsequent cross-vesting legislation of 1987, was that both jurisdictions should exist concurrently.

The result, however, of concurrent jurisdictions is that conflicts may occur between the orders made by the courts in those jurisdictions. The High Court addressed that eventuality.³⁴⁷

In the case of a conflict between orders made by the Family Court in the exercise of the jurisdiction conferred by the *Family Law Act* and orders made by the Supreme Court of New South Wales in the exercise of its jurisdiction, the orders made by the Family Court would necessarily prevail. The State law, whether statutory or inherited, which conferred the relevant jurisdiction upon the Supreme Court would, to the extent that it purportedly gave legal efficacy to an order which was inconsistent with an order of the Family Court, be rendered invalid by s.109 of the Constitution for the reason that it was "to that extent" inconsistent with the provisions of the *Family Law Act* giving legal efficacy to the order made by the Family Court.

This means that an order made by the Supreme Court of Queensland in its *parens patriae* jurisdiction would also have to give way to a conflicting order of the Family Court made under the *Family Law Act 1975* (Cth).

However, the High Court held that the particular section of the *Guardianship Act 1987* (NSW) was not generally invalid in so far as it applied to children of a marriage.³⁴⁸

The invalidity under s. 109 is, like the inconsistency, confined to the purported operation of the State Act to prohibit treatment authorised by the Family Court in the exercise of the jurisdiction validly conferred upon it by the *Family Law Act*. As a practical matter,

³⁴⁵ Id per Mason CJ and Deane, Toohey and Gaudron JJ at 597-598.

³⁴⁶ Id at 604.

³⁴⁷ Id at 604-605.

³⁴⁸ Id at 606.

that invalidity will only be significant in a case where the Family Court exercises its jurisdiction to authorise **particular** medical treatment and then only in respect of **that treatment**. [emphasis added]

This means that State legislation would generally be valid and would be binding as far as State Courts were concerned. However, State legislation may, in a particular case, be held to be invalid, to the extent that it allowed the Supreme Court to make a particular order that was inconsistent with an order made by the Family Court in its welfare jurisdiction.

4. CONCLUSION

Australian law recognises the important role that parents play in the upbringing of their children. The Commission in no way wishes to derogate from the proper and appropriate exercise of parental responsibilities. However, the law views the exercise of such responsibilities as being proper only when they are in the best interests of the child. Parents do not possess untrammelled rights to do as they see fit in respect of their children.

CHAPTER 6

HEALTH CONCERNS OF YOUNG PEOPLE

1. INTRODUCTION

The law should not hinder a young person's access to the health care he or she requires to live as healthy a life as possible. Obviously, however, even if the law were clear, concise and conducive to a young person obtaining necessary health care, there would be other factors beyond the reach of the courts or the legislature that would influence whether or not the young person had access to necessary health care, such as:

- some health care providers may be reluctant to treat young people without parental involvement because of personal beliefs about the role of parents vis à vis their child's health and well-being, or fears about potential liability for assault based upon possibly misconceived interpretations of the law;
- some parents will seek to influence their child's decision whether or not to seek health care despite the wishes and/or best interests of the child. For example, parents may threaten to turn their child out of home if the child seeks contraceptive advice or treatment without the parents' permission;
- a young person may feel uncomfortable about approaching a health care provider for treatment through fear that the health care provider will involve the young person's parents;
- a young person may believe that he or she is unable to seek necessary health care if he or she does not personally have the ability to pay for the health care.

The scheme proposed by the Commission in this Report, including the education program³⁴⁹ that the Commission considers to be integral to the success of reform in this area, seeks to address such factors and encourage and facilitate necessary health care for young people.

³⁴⁹ See 359-360 of this Report.

2. HEALTH NEEDS OF YOUNG PEOPLE

Australia's young people generally enjoy good health by world standards, although there are a number of serious concerns, including the vulnerability of children and young people in general and the impact on their health of problems such as:³⁵⁰

child abuse and neglect; developmental, behavioural and emotional problems; health damaging behaviours, suicide and attempted suicide; and the late recognition and management of mental health problems and disorders.

There is also evidence of poorer health developing among Australian children in socio-economically disadvantaged families, children in families where no parent is employed, and children in single parent families.

Although improvements are occurring in health care for Aboriginal and Torres Strait Islander children and young people, it is apparent that their health status remains far below that of the general population.³⁵¹

Other groups identified by the Australian Health Ministers' Advisory Council as having special health needs include young Australians from non-English speaking backgrounds, particularly recent arrivals; those with disabilities; and those who are homeless.

The importance of addressing such health concerns in a timely and effective manner is that it is likely to result in a healthier adult population.³⁵²

while good health is important for everyone, attention to health during childhood and adolescence has the added dimension of being an investment in good health in adulthood. Childhood, adolescence and the teen years are times of rapid physical, intellectual, emotional and social development; illness, neglect, abuse and injury can impede developmental processes and have substantial effects, in some cases continuing into adulthood.

³⁵⁰ Australian Health Ministers' Advisory Council Working Party on Child and Youth Health, *The Health of Young Australians: A national policy for children and young people* (June 1995) at 3.

³⁵¹ Ibid, referring to Bhatia K and Anderson P, *An Overview of Aboriginal and Torres Strait Islander Health: Present Status and Future Trends* (Australian Institute of Health and Welfare, Canberra, 1995). A Queensland Government *Status Report on the Health of Queensland's Aboriginal and Torres Strait Islanders* (November 1996) concludes that the health of Aboriginal and Torres Strait Islander people remains substantially worse than that of any other section of the Queensland population. Infant deaths were two and a half times the Queensland rate in 1994. In remote communities many Aboriginal children display a failure to thrive. At 4 to 6 months of age, growth of some Cape York children slows down after they are weaned because they are not getting enough food. In young Aboriginal people up to the age of 14 perinatal conditions, infections, parasitic diseases and pneumonia account for the excess mortality of 2.6 times the overall Australian mortality rate of young people in that age group. At the time of publication of the Commission's Report, the Status Report was not publicly available. A summary of the Status Report is found in "State reveals black health crisis" *The Courier-Mail* (25 November 1996) at 1.

³⁵² Australian Health Ministers' Advisory Council Working Party on Child and Youth Health, *The Health of Young Australians: A national policy for children and young people* (June 1995) at 6.

Also, at a broader level:³⁵³

society has the responsibility to ensure and protect the right of children and young people to good health. As a signatory to the United Nations Convention on the Rights of the Child, Australia has formally recognised the rights of young Australians and its responsibilities as a nation to provide for their health and well-being.

Although this Convention has been ratified by Australia, the articles of the Convention have not been substantially implemented by Australian domestic law.³⁵⁴

³⁵³ Id at 7.

³⁵⁴ But see *Minister of State for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, which concerned the judicial review of decisions to refuse residency status to, and to deport the respondent, who had a number of young children and step-children in Australia. The High Court held that Australia's ratification of the United Nations Convention on the Rights of the Child (which provides, for example, by Article 3.1 that "[i]n all actions concerning children ... the best interests of the child shall be a primary consideration") gives rise to a legitimate expectation that the decision-makers exercising a statutory discretion will exercise that discretion in conformity with the terms of the Convention, even though the provisions of the Convention have not been incorporated into Australia's domestic laws. See, for example, Mason CJ and Deane J at 289-292. See, however, the joint Press Release of the then Attorney-General and the then Minister for Foreign Affairs of Australia of 10 May 1995 which sought to clarify the Government's position following the High Court's decision. The Ministers stated, in part:

The High Court reaffirmed in *Teoh* that provisions of treaties do not form part of Australian law unless they have been incorporated by legislation. At the same time, however, the Court developed a new way in which treaties could affect some administrative decisions. The High Court held that merely entering into a treaty could give rise to a legitimate expectation that government decision-makers would make decisions consistently with Australia's obligations under the treaty. It was not necessary for any legislation governing the decision to refer to the treaty. Indeed the provisions of the treaty could apply even where the person affected by the decision did not raise - or even know about - the treaty in question.... [T]he High Court decision gives little if any guidance on how decision-makers are to determine which of those treaty provisions will be relevant and to what decisions the provisions might be relevant, and because of the wide range and large number of decisions potentially affected by the decision, a great deal of uncertainty has been introduced into government activity. It is not in anybody's interests to allow such uncertainty to continue.

For that reason, the Government is taking action to restore the position to what it was understood to be prior to the *Teoh* case...

[The Government intends to legislate the following.] We state on behalf of the Government, that entering into an international treaty is not reason for raising any expectation that government decision-makers will act in accordance with the treaty if the relevant provisions of that treaty have not been enacted into domestic Australian law. It is not legitimate, for the purposes of applying Australian law, to expect that the provisions of a treaty not incorporated by legislation should be applied by decision makers. Any expectation that may arise does not provide a ground for review of a decision. This is so both for existing treaties and for future treaties that Australia may join.

On 28 June 1995, the *Administrative Decisions (Effect of International Instruments) Bill* 1995 ("the Bill") was introduced into the House of Representatives by the then Government and formally read for the first time. According to the Explanatory Memorandum to the Bill, the purpose of the Bill was to:

eliminate any expectation which might exist that administrative decisions, whether at the Commonwealth, State or Territory level, will be made in conformity with provisions of ratified but unimplemented treaties, or, that if a decision is to be made contrary to such provisions, an opportunity will be given for the affected person to make submissions on the issue. (The legitimate expectation principle established by the High Court in *Teoh*'s case is eliminated in section 5 of the Bill.)

The Bill was drafted so as to give it a retrospective operation. Section 2 of the Bill provided that the Act (once passed) would be taken to have commenced on 10 May 1995 (which was the date of the joint press release by the then Attorney-General and by the then Minister for Foreign Affairs).

The consequences of not being able to obtain health care may be serious for anyone - and possibly more serious for young people unfamiliar with symptoms or strategies for reducing the severity of the consequences. Of course, the consequences of non-treatment will vary with the illness. An untreated mild case of the chicken pox may have no adverse health consequence, apart from a prolonged suffering. However, certain untreated sexually transmitted diseases may lead to sterility and more serious complications. Untreated infections may lead to death.

Untreated psychiatric or psychological problems in adolescents may lead to serious psychiatric or psychological conditions or even to suicide.

Health problems and concerns vary in significance for young people:³⁵⁵

both in terms of the particular concern and in relation to the stage of development that the individual has reached. As the young person grows and develops, a range of health and health service issues will emerge, changing in importance as the young person matures.

The Australian Health Ministers' Advisory Council Working Party on Child and Youth Health has identified the following significant health issues existing in infancy and

The Bill was passed by the House of Representatives on 21 September 1995 and read for the first time in the Senate on 27 September 1995. As at 2 March 1996 (ie the date of the last Federal election), the Bill had still only been read in the Senate for the first time. With the change of government, the Bill has now lapsed and will need to be re-introduced into Parliament if it is to be enacted. During debate on the Bill in the House of Representatives (21 September 1995) the then opposition parties indicated that, whilst they supported the specific aim of the Bill, their proposals for reform of the treaty making process would in fact do away with the need for the Bill altogether.

It is likely that the current Government will in the near future require the passing of legislation before any new treaty is ratified. For an outline of the Government's proposal for treaty reform, see the comments made by the Hon Mr Ruddock (the member for Berowra) which are set out at pages 1443-1444 of *Hansard* for 21 September 1995 and the comments made by the Hon Mr Williams (the member for Tangney) which are set out at pages 1455-1456 of *Hansard* for 21 September 1995. The effect of such a requirement will be that a decision-maker will not be faced with the dilemma of whether or not to take into account the provisions of a treaty ratified (but not implemented) by the Australian Government.

It remains to be seen whether the legislation giving effect to the Government's policies on treaty reforms will also make it clear that a treaty already ratified (but not yet implemented) does not create a legitimate expectation that government decision-makers will make decisions that are consistent with Australia's obligations under that treaty.

A number of commentators have queried whether the joint press release on 10 May 1995 has the legal effect that it purports to have. See, for example, Burmester H, Acting Chief General Counsel in the Attorney-General's Department (Cth) in an address to the Australian Institute of Administrative Law on 18 May 1995 and Allars M in the postscript to her article "One Small Step for Legal Doctrine, One Giant Leap Towards Integrity in Government" (1995) 17 *Sydney Law Review* 205 at 239-241. Some commentators have suggested that the legitimate expectation principle established by the High Court in *Teoh's* case can only be changed by specific legislation. Other commentators have suggested that it may not be possible for a policy statement as general as the joint press release to overrule specific policy statements made at the time a treaty is ratified by the Australian Government.

Shortly before this Report was printed, a further joint statement was issued by the Minister for Foreign Affairs and the Attorney-General and Minister for Justice on the effect of *Teoh's* case (see *Commonwealth of Australia Gazette*, No S 69, 26 February 1997). This second statement - which is in similar terms to the joint press release of 10 May 1995 - applies to administrative decisions made from 25 February 1997. The earlier joint statement continues to apply to administrative decisions made in the period between 10 May 1995 and 25 February 1997. The second statement confirms the Government's intention to introduce legislation to provide that the executive act of entering into a treaty does not give rise to legitimate expectations in administrative law.

³⁵⁵ Australian Health Ministers' Advisory Council Working Party on Child and Youth Health, *The Health of Young Australians: A national health policy for children and young people* (June 1995) at 18.

early childhood: low birth weight, sudden infant death syndrome, nutritional problems, respiratory and gastro-intestinal illnesses, unintentional poisonings and injuries, developmental problems and child abuse and neglect.

In primary school years, concerns include: asthma, infections, accidental injury, and various forms of abuse and neglect, including violence at home and elsewhere.

In adolescence and teenage years, emotional health becomes a more dominant issue.³⁵⁶

Doubts and uncertainties surrounding the physical and emotional changes at puberty will arise. Relationships with their families, peers and communities will change. Young people experience increased self-consciousness at this time and often develop concerns about sexuality, personal appearance, especially acne, and body image. They may suffer from low self-esteem and social alienation, and some will become homeless. Mental health problems such as depression or schizophrenia may emerge for the first time.

In their late teens and early adulthood.³⁵⁷

Health-compromising behaviour and aggression, uncontained or impulsive means of resolving conflict or dealing with frustration and alienation, are mirrored in the health problems in this age group. Smoking and misuse of alcohol, including binge drinking, are widespread throughout the late teen years.³⁵⁸ By age 15, one-third of young people have experimented with smoking, and the rate is increasing in young females.

Gay and lesbian young people are particularly vulnerable to feelings of isolation and lack of self worth ...

Eating disorders are a particular health issue for young women. Many report that they are dissatisfied with their appearance and that they limit food intake to reduce weight. Anorexia nervosa and bulimia can be life-threatening and even minor eating disorders at this stage in development can lead to long-term problems such as osteoporosis ...

Injuries are a major health issue for this age group, particularly for young males, including fatal and non-fatal injuries sustained in traffic accidents, sporting activities, peer group violence or self-harming behaviour. Injuries causing permanent disability are frequently involved ...

Among young men 15 to 24 years old the rate of completed suicides has increased from 19 per 100,000 in 1982 to 27 per 100,000 in 1992. The rate of completed suicides is much less for girls and young women but evidence suggests that the rates of attempted suicide are increasing, particularly in young women of this age group ...

³⁵⁶ Id at 20.

³⁵⁷ Id at 20-21.

³⁵⁸ In a survey by the Australian Drug Foundation one third of year 8 and year 9 students in Melbourne surveyed reported at least one incident of blackout when they could not recall what happened after drinking: Australian Drug Foundation, *Preliminary Findings from the Alcohol and Education Project* (17 August 1995).

Young people, and in particular adolescents, appear to face attitudinal problems in having their health needs met. A study examining doctors' attitudes to adolescents³⁵⁹ suggested that adolescents are usually viewed by doctors as problematic and time-consuming, and that most doctors define teenage patients by negative characteristics which in turn could affect the therapeutic relationship.³⁶⁰ Many general practitioners were concerned by their deficient knowledge and competence in adolescent health, and cited a paucity of formal training in the area despite the fact that the extent of adolescent health problems was rising.

Other barriers to delivery of adolescent health care were seen to include problems of cost, communication and confidentiality. The study recommended a review of Medicare card policies to give young people easier access to their own card to overcome teenage concerns about cost and confidentiality.³⁶¹ Some doctors felt that cost, or not wanting bills to be sent to their parents, was preventing young people from attending altogether. The study also recommended the inclusion of adolescent health topics in medical education.

3. PARTICULAR TYPES OF HEALTH CARE

In the Discussion Paper the Commission expressed the view that access to appropriate health care should be facilitated as much as possible and that, while that health care should respect the moral, cultural or religious beliefs of the person being treated, it should not be hindered by moral, cultural or religious beliefs of others.³⁶² The Commission also expressed the view that, for the purposes of certainty and clarity, whatever legislative scheme was to be adopted, it should cover all types of health care other than those specifically excluded. Thus, it should cover treatment for common, uncontroversial conditions such as for the cold or influenza, as well as treatment for more controversial conditions such as sexually transmitted diseases.

The Discussion Paper asked a series of questions relating to the restrictions, if any, that should apply to a young person's ability to consent to health care for particular

³⁵⁹ Veit FCM, Sanci LA, Young DY and Bowes G, "Adolescent health care: perspectives of Victorian general practitioners" (1995) 163 *The Medical Journal of Australia* 16.

³⁶⁰ Ibid.

³⁶¹ See this Commission's recommendation in relation to the issue of Medicare cards to young people at 357-359 of this Report.

³⁶² Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995) at 107. See also Queensland Law Reform Commission, Report *Female Genital Mutilation* (R47, September 1994).

conditions.³⁶³ Health care for those conditions, particularly when performed on young people, is sometimes controversial and/or the subject of strong moral, religious and ethical debate. A number of respondents to the Discussion Paper commented on particular types of health care.

(a) Psychiatric and psychological advice, treatment and counselling and suicide prevention

The incidence and prevalence of psychological problems in adolescents indicate that young people may be in need of professional psychiatric or psychological assistance.

Without appropriate assistance, a young person's mental health and well-being may be at risk. The high incidence of psychological disorders among young Australians, at worst resulting in suicide, indicates that for a significant number of young people the assistance available to them during their times of need is either non-existent or inadequate.

Evidence presented to the National Inquiry into the Human Rights of People with Mental Illness³⁶⁴ (the Inquiry) indicated that approximately 15% of 15 to 20 year olds experience some form of mental health problem and that up to 5% of that group have serious psychiatric disorders which warrant specialist intervention.³⁶⁵

Research into the prevalence of mental disorders among Queensland children 10 and 11 years of age has indicated that 23% suffered from mental health problems and 14% fitted a diagnosis of mental disorders.³⁶⁶

Australian estimates indicate that 90% of all psychiatric disorders have their onset in adolescence or early adulthood and that 50% affect young people between 16 and 18.³⁶⁷

³⁶³ Discussion Paper at 111, 118 and 128.

³⁶⁴ Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness* (1993).

³⁶⁵ Id at 604 referring to Sawyer M, Meldrum D, Tonge B and Clark J, *Mental Health and Young People* (1991) at 14.

³⁶⁶ Id at 603 referring to Connell HM, Irvine L and Rodney J, "Psychiatric Disorder in Queensland Primary Schoolchildren" (1982) 18 *Australian Paediatric Journal* at 177-180.

³⁶⁷ Reiger D, "The NIMH Epidemiological Catchment Area Program: Historical Context, major objectives and study population characteristics" (1984) *Archives of General Psychiatry*.

It has been estimated that 75% of adults who commit suicide suffered from depression as teenagers.³⁶⁸

The prevalence of attempted suicide and suicide among young Australians highlights the need for ready access to appropriate health care services with as few legal or social impediments as possible.

(i) **Suicide statistics**³⁶⁹

Between 1982 and 1992 (11 years) as a proportion of total deaths, suicide in Australia increased from 1.5% in 1982 to 1.9% in 1992. 78% of the total number of deaths by suicide since 1982 have been male.³⁷⁰

Between 1982 and 1992, on an age and sex standardised basis, there was an increase in the suicide rate of 7.5%.³⁷¹ For males, the increase was 14%.³⁷² Males in the 15-24 year group had a considerably higher age specific suicide rate in rural areas than in urban areas.³⁷³ Between 1961 and the late 1980s in Australia, there was a 150% increase in the suicide rate of males in the 15-24 year group.³⁷⁴ Between 1979 and 1993 deaths by suicide among males increased by almost 50 per cent.³⁷⁵

³⁶⁸ *The Courier-Mail* (31 October 1994) at 7 referring to statements by George Patton, head of the Centre for Adolescent Health, Melbourne.

³⁶⁹ Statistics for this section have been taken primarily from Australian Bureau of Statistics, *Suicides Australia 1982-1992* (Cat No 3309.0 1994) and Queensland Health, *Suicide in Queensland 1990-1992 by Health Region* (1992). The Australian Bureau of Statistics defines suicide as "the act of voluntarily and deliberately taking one's own life". See *Suicides Australia 1982-1992* (Cat No 3309.0, Oct 1994) at 1. It should be noted, however, that there are cases where a coroner's inquest was unable to establish whether the injury causing death was accidental or was intentionally inflicted. In 1992 there were 190 such deaths in Australia and it is possible that some undetected suicides are included in this figure and that the number of suicides occurring in any period is understated.

³⁷⁰ Australian Bureau of Statistics, *Suicides Australia 1982-1992* (Cat No 3309.0, 1994) at 1.

³⁷¹ *Ibid.*

³⁷² *Id* at 2. For females, there was a downward trend over the same period of 15% below 1982.

³⁷³ 24 deaths per 100,000 in 1986 rising to 36 per 100,000 in 1988 and remaining at that level in subsequent years. Urban males in that age group had an age specific rate of 21 deaths per 100,000 in 1986 rising to 26 in 1988 and settling at 25 per 100,000 in 1990, 1991 and 1992.

³⁷⁴ Queensland Health, *Suicide in Queensland 1990-1992 by Health Region* (1992) at 3.

³⁷⁵ Commonwealth Department of Human Services and Health, *Youth Suicide in Australia: A Background Monograph* (1995) at 8.

The rate of suicide in Australia is amongst the highest in the world³⁷⁶ and deaths from suicide now outnumber those from motor vehicle accidents; in 1995, for example, deaths from suicide totalled 2,367 as against 2,029 deaths from motor vehicle accidents.³⁷⁷

This is a recent development and mainly reflects the effectiveness of endeavours in recent years to promote road safety through improved vehicle and road designs, driver training and other strategies. While deaths from motor vehicle accidents have declined in the period 1979-1994, deaths due to suicide continued to increase during the same period.³⁷⁸

The suicide rate in Queensland was consistently above the national average in all years between 1982 and 1992. In Queensland, suicide is the most frequent cause of adolescent death.³⁷⁹

Although suicide is rare for young people under the age of 15,³⁸⁰ in the age group 15-29 years, 34 males and 7 females per 100,000 population in Queensland committed suicide in the period 1990-1992. The most common age of suicides in Queensland is 21 years of age.³⁸¹ Aboriginal and Torres Strait Islander suicides are significantly younger.³⁸² Whereas most nations show increasing suicide rates with increasing age "[t]he Queensland and Australian 20-24 year male peak is highly unusual and concerning".³⁸³

The rate of attempted suicide in Australia has doubled since 1965 to about 130 per 100,000 population in the 12 to 15 year age group and about 350 per

³⁷⁶ Kosky RJ, Eshkevari HS and Kneebone G, *Breaking Out - Challenges in Adolescent Mental Health in Australia* (AGPS, 1992) at 92.

³⁷⁷ Australian Bureau of Statistics, *Causes of Death* (Cat No 3303.0, 1996) Table 2.

³⁷⁸ Australian Institute of Health and Welfare, *Injury Mortality Australia 1994* (Australian Injury Prevention Bulletin, Issue 13, October 1996) at 5 and 7.

³⁷⁹ Weber R, *Suicide Prevention at the Workplace* (paper presented to 1994 National Occupational Stress Conference, June 1994) at 5. Weber notes that an estimated 10,000 life years are lost in Australia every year due to teenage suicide. On the average, one teenager kills himself/herself every day. About one in every seven teenagers between 15 and 19 years old attempts suicide.

³⁸⁰ In 1990-1992 only 6 people below 15 years of age (all males, in 10-14 years age group) suicided: Queensland Health, *Suicide in Queensland 1990-1992 by Health Region* (1992) at 6.

³⁸¹ *Id* at 12.

³⁸² *Id* at 19.

³⁸³ *Id* at 12.

100,000 population in the 16-20 year age group.³⁸⁴

(ii) **Risk factors**

A variety of factors have been identified that tend to increase the risk that a person will commit suicide. Many of these factors relate to adolescents more so than to any other age group - factors such as:

- *Previous attempts.* People who have previously attempted suicide are up to seven times more likely to go through with a threat.³⁸⁵ The majority of young people who attempt suicide receive medical (as opposed to psychiatric or psychological) treatment only.³⁸⁶

They attend Accident and Emergency services and, because of limited resources and the reluctance of general hospitals to send young people to psychiatric hospitals ... most of these young people are just sent home ... And their cry for help which the suicide attempt represents goes unheard.

- *Alcoholism.* People with a history of alcohol abuse are 10 to 20 times more likely to suicide than people without such a history.³⁸⁷ Alcohol was involved in 39% of suicides in Queensland in the period 1990-1992.³⁸⁸ It has been suggested that the use of drugs and alcohol should not be viewed as a cause of youth suicide in itself, but rather as a symptom of more serious underlying problems.³⁸⁹
- *History of psychiatric illness.* Depression (not necessarily diagnosed) was mentioned in 32% of suicides in Queensland in the period 1990-1992. 18% of the suicide victims suffered from non-psychiatric illnesses at the time of the suicides, which may have been relevant to

³⁸⁴ Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness* (1993) at 638, quoting submission of Professor Bruce Tonge, Faculty of Child Psychiatry, Royal Australian and New Zealand College of Psychiatrists and Head of the Centre for Developmental Psychiatry, Monash University.

³⁸⁵ Weber R, *Suicide Prevention at the Workplace* (paper presented to 1994 National Occupational Stress Conference, June 1994) at 9. Also see Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness* (1993) at 638, quoting Professor Tonge who believes that the chance of such people attempting suicide again is increased at least five-fold.

³⁸⁶ Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness* (1993) at 638, quoting Professor Tonge.

³⁸⁷ Weber R, *Suicide Prevention at the Workplace* (paper presented to 1994 National Occupational Stress Conference, June 1994) at 10.

³⁸⁸ Queensland Health, *Suicide in Queensland 1990-1992 by Health Region* (1992) at 26-27.

³⁸⁹ Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness* (1993) at 640.

the suicides.³⁹⁰ A study of overseas and Australian research by the Commonwealth Department of Human Services and Health³⁹¹ suggests that up to 90 per cent of young people who suicide have evidence of psychiatric illness before their death, with depressive illnesses being the most common.

- *Ethnicity.* Research findings also indicate that Aboriginal and Torres Strait Islander young people are more likely to commit suicide than young people in the general population. For example, the suicide death rate in the total population of 15 to 29 year olds was 20.9 per 100,000 in 1990-92, compared with 39.4 per 100,000 for indigenous 15-29 year olds over the same period.³⁹²
- *Excessive stress.* Low self-esteem associated with youth homelessness is a factor in youth suicidal behaviour.³⁹³ Other stress inducing factors such as a change in significant relationships may be relevant. For the period 1990-1992 a reported previous change in significant relationships occurred in 13% of Queensland suicides. Of these relationship changes, 60% occurred within one month before the suicide, and 76% occurred within 3 months.³⁹⁴

Other factors include: risk-taking behaviour; pressure of societal role expectations (particularly in the case of young males); media coverage of other youth suicides; and poor education or leaving school early.³⁹⁵ It has been stressed, however, that there is no reliable way to predict which individuals will commit suicide.³⁹⁶

(iii) Difficulty in obtaining health care

A number of obstacles may affect a health care provider's ability to reach and assist suicidal adolescents. In general, there is ignorance about the prevalence of mental illness in adolescence, especially depression. Family

³⁹⁰ Queensland Health, *Suicide in Queensland 1990-1992 by Health Region* (1992) at 27-28.

³⁹¹ Commonwealth Department of Human Services and Health, *Youth Suicide in Australia: A Background Monograph* (1995) at 28.

³⁹² *Id* at 30.

³⁹³ See 130-136 of this Report for a discussion on the special needs of homeless young people.

³⁹⁴ Queensland Health, *Suicide in Queensland 1990-1992 by Health Region* (1992) at 28.

³⁹⁵ Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness* (1993) at 638.

³⁹⁶ *Ibid.*

members and teachers of young people are also often unaware of the extent of mental health problems experienced by adolescents.

There are other obstacles to confront. Within the community, family breakdown is common. Adolescents may not only have to negotiate parental separation, which is often traumatic, but they may have less effective advocacy for their problems by parents preoccupied with their own problems.

In the community there is a tendency to consider adolescent experiences such as emotional distress, depression, binge drinking and drug abuse as "normal" adolescent behaviour. This is usually far from the case and can result in troubled adolescents not gaining professional help when it is needed.

There is often extreme reluctance by both adolescents and their families to be associated with anything identifiable as "psychiatric or mental health" (due to prejudice against people who have mental illness).

Possibly as a result of any one or more of these factors, 24 hour crisis telephone services have been particularly popular among young people seeking assistance.³⁹⁷ One such service reports having received over 2 million calls from young people since opening in March 1991 with more than 421,000 of those calls representing real, immediate problems.³⁹⁸ The service receives on average 32,000 calls per week from young people throughout Australia. The service provides confidential counselling and referrals as well as information sheets on a range of topics (including suicide). Of the 1026 calls received relating to suicide in the 12 months ending August 1995 by the service, 53 per cent were from callers who had attempted suicide at least once and 27 per cent were from callers who expressed an immediate intention of significant self-harm.³⁹⁹

With regard to attempted suicide, there is sometimes a tendency to minimise the significance of the act, which may be perceived as manipulative or trivial. Thus, the suicidal adolescent may not be referred for psychiatric assessment when, in fact, it is always indicated.

³⁹⁷ Commonwealth Department of Human Services and Health, *Youth Suicide in Australia: A Background Monograph* (1995) at 37.

³⁹⁸ *Kids Help Line Infosheet 1: Kids Help Line* (October 1994).

³⁹⁹ *Kids Help Line Infosheet 2: Statistical Summary* (August 1995).

There have been cases where a person has suicided in order to punish those (usually friends or loved ones) who had ignored the cry for help.⁴⁰⁰

In an annotation on adolescent suicide,⁴⁰¹ Kosky drew these findings together and concluded that suicide ideation and attempts take place within a framework determined by two main parameters: symptomatic depression, and chronic family discord. The latter parameter refers to hostile arguing among family members leading to a persistent atmosphere of tension.

Kosky commented that symptomatic depression and family discord commonly interact. He also highlighted the importance of substance abuse as a potentiating factor in suicidal behaviour. Clearly, each of these issues provides a focus for intervention in the treatment and prevention of suicide in adolescence.

Groups of adolescents exist who are specifically "at risk" of suicide.

The circumstances surrounding these adolescents often make the issue of parental consent to health care difficult.

(iv) Health care provider's role in suicide prevention

Although the percentage of young people who visit health care providers prior to their suicide has not been well documented, it is generally believed that most young people have exhibited warning signs to family, friends, teachers and physicians, suggesting that health care providers and, in particular, medical practitioners, may have important opportunities to detect suicidal behaviour and intervene appropriately to prevent these tragedies.⁴⁰²

Community based research has shown that the majority of patients who suicide or attempt suicide consult a helping agency within the previous month, and up to half do so within the previous week.⁴⁰³ A focus on the early identification and treatment of depression may be the most effective means of preventing suicide in adolescents.

⁴⁰⁰ Keir N, *I Can't Face Tomorrow* (1986).

⁴⁰¹ Kosky RJ, "Annotation. Adolescent Suicide" (1989) *Australian Paediatric Journal* 25:257-8.

⁴⁰² Blumenthal SJ, "Youth Suicide: risk factors, assessment and treatment of adolescent and young adult suicidal patients" *Psychiatry Clin. North Am.* (1990) 100; 13:511-555. However, it has been observed that professionals and other workers have expressed concern about their lack of skills for working with young people at risk of suicide: Commonwealth Department of Human Services and Health, *Youth Suicide in Australia: A Background Monograph* (1995) at 38.

⁴⁰³ Hawton K and Bladestock E, "General Practice Aspects of Self Poisoning and Self Injury" *Psychol Med.* (1976) 6:571-5; Bancroft J, Skirmshire A, Casson J et al, "People Who Deliberately Poison or Injure Themselves, Their Problems and Contacts with Helping Agencies" *Psychol Med.* (1977) 7:259-303.

As mentioned earlier, many health care providers will evaluate suicidal young people in their offices during the weeks when these young people are contemplating whether to live or to die. Given that it can never be predicted with complete certainty who among adolescent and young adult patients will end their lives by suicide, if treatment is denied based upon a wrong or inconclusive diagnosis, the consequences may be disastrous.⁴⁰⁴

Due to the vital role played by health care providers in diagnosing and treating psychological and psychiatric disturbances in young people, it is apparent that as few as possible impediments to treatment should be imposed on "at risk" young people.

All submissions to the Commission's Discussion Paper that made reference to mental and psychological health concerns of young people expressed support for easily accessible health care for young people.

An association of psychologists, the administrators of a regional hospital, Queensland Health and the then Department of Family and Community Services (now the Department of Families, Youth and Community Care) were all in favour of minimum restrictions being imposed on young people's access to such health care.⁴⁰⁵ Queensland Health emphasised that early intervention precludes many "at risk" behaviours.

The submissions to the Information Paper also indicated a strong concern for the mental and psychological health of young people; the need for easily accessible treatment facilities was also recognised.

A paediatrician wrote:⁴⁰⁶

I think that for emotional or behavioural problems, children of any age should be able to seek advice, since the force responsible for the aberration is often the parents. Children in this situation often have a desperate need for counselling that may be denied because of fear of parental reactions to their viewpoint. It would be incumbent on the counsellor to seek to improve the relationship to the state where parents could be involved.

⁴⁰⁴ Blumenthal SJ, "Youth suicide: risk factors, assessment and treatment of adolescent and young adult suicidal patients" *Psychiatry Clin. North Am.* (1990) 100; 13:511-555, and Blumenthal SJ, "Suicide: a guide to risk factors, assessment and treatment of suicidal patients" *Med Clin North Am.* (1988) 72:937-971.

⁴⁰⁵ Submissions 16, 58, 62 and 79.

⁴⁰⁶ Information Paper Submission 1.

Similarly, a lay respondent wrote:⁴⁰⁷

It is suggested that young people should be able to seek counselling at any age without the approval of parents. In practical terms parents/guardians would be the people who would seek treatment for the young person. Further, in practical terms the assistance of the family support network may be needed to assist the young person through a crisis/crises.

A health care facility wrote:⁴⁰⁸

Again we are in favour of young people of any age being able to seek treatment without knowledge or approval of parents. With the ability to seek treatment it would be advisable that young people of any age could have access to a Medicare card. Young people who need treatment for drug abuse, eating disorders or sexuality issues often do not want to involve their parents in issues and should not be compelled to do so in order to receive treatment.

An association of professional counsellors wrote:⁴⁰⁹

We suggest young people of any age should be able to seek such treatment without the knowledge or approval of parents.

They did, however, express some reservations where the counselling is to take place in schools:

It is suggested that in schools, parents should be informed and consent gained before psychological assessment and/or counselling of young people is undertaken, unless there is a specific and valid reason that the young person may wish to exclude parents; e.g., child abuse.

On the other hand, a student wrote saying how valuable confidential counselling in school could be:⁴¹⁰

I believe that many would take advantage of counselling and clinics but would walk out if they knew that there was no confidentiality to parents or parental consent was needed. Many frustrated teenagers write to magazines such as Dolly to gain information only to be told to go to a clinic (such as a family planning clinic). Many do. They write to Dolly to bypass the parents and gain information. One step towards helping may be to have this kind of counselling in schools. As twelve years of age is quite young, parents know every move of the child therefore there is no confidentiality. However, if counselling was introduced into schools and with no parental consent the young person could gain knowledge without parents knowing.

⁴⁰⁷ Information Paper Submission 5.

⁴⁰⁸ Information Paper Submission 6.

⁴⁰⁹ Information Paper Submission 35.

⁴¹⁰ Information Paper Submission 106.

A family planning organisation wrote:⁴¹¹

Young people should be able to seek counselling without parental consent under the same criteria as applies to other forms of medical treatment. Counsellors already have an ethical obligation to ascertain whether parental involvement in the treatment would be appropriate, and to act accordingly.

An organisation with an interest in psychiatric and psychological health care recommended:⁴¹²

Young people 16 years of age or over to be treated as adults for the purpose of consent or refusal of consent to (psychiatric/psychological) treatment, although there should be mechanisms to help the adolescent to discuss with parents important decisions regarding such treatment and where possible get consent of parent in addition to the adolescent's (up to and including the age of 18).

Because of the potential risks of physical psychiatric treatments such as psychotropic medication, young people under the age of 16 should not be subjected to these treatments unless there is the full written consent from parents (if the child is old enough to understand information about the treatment then their consent should be obtained and if in conflict with the parents the child's consent should take priority).

Queensland Health, Youth Health Policy Unit noted:

Counselling is a very specialised health area, and parents cannot replace this role; they can offer support but cannot counsel. There needs to be input from the health professionals as to the suitability of counselling for particular individuals; in the interest of the young person's need at this time. The availability of counselling is a right and should not be dependent on adult sponsorship.

(v) Mental health patients

A particular concern relates to people under the age of 16 who are admitted as voluntary patients to psychiatric facilities in Queensland pursuant to section 17 of the *Mental Health Act 1974* (Qld). Subsection 17(2) provides:

In the case of a patient who has attained the age of 16 years arrangements referred to in subsection (1) may be made, carried out or determined notwithstanding any right to custody or control of that patient vested in any person.

⁴¹¹ Information Paper Submission 40.

⁴¹² Information Paper Submission 104.

As a legal academic wrote in response to the Information Paper:⁴¹³

I believe that under the provisions of subsection 17(2) of the *Mental Health Act* a young person of age 16 and over is able to seek and consent to treatment for mental illness as an informal patient notwithstanding any right to custody or control vested in another. This statutory recognition of the need for young people to have open and confidential access to mental health sources should extend to medical and dental services.

However, in relation to people under the age of 16, the situation is not clear.

A youth organisation wrote:⁴¹⁴

Subsection 17(2) of the *Mental Health Act (1974)* permits a person who has attained the age of 16 to seek and obtain psychiatric treatment without parental consent. For those under 16, presumably the principles outlined in the *Gillick* case would apply. Guidelines regarding psychiatric or psychological treatment should be consistent with those applied to other forms of treatment.

(vi) The Commission's view

The Commission is of the view that generally there should be no legal restrictions on the ability of young people to obtain psychiatric or psychological health care and health care for the purpose of suicide prevention. In the vast majority of cases, however, as there would be no physical contact involved in such health care, no liability (apart from negligence and possibly false imprisonment) could result from treating without a valid consent.

The Commission has, however, recommended in Chapter 9 of this Report that certain serious non-touching health care (which may well include some forms of psychiatric or psychological health care) should be administered only after obtaining a valid consent, either from a legally competent young person or from another authorised person.⁴¹⁵

⁴¹³ Information Paper Submission 23.

⁴¹⁴ Information Paper Submission 61. Also Information Paper Submission 82.

⁴¹⁵ See 208 of this Report and clause 8, clause 2 of schedule 1, and schedule 2 of the draft legislation in Ch 17 of this Report.

(b) Sexually transmitted diseases⁴¹⁶

Medical practitioners and medical superintendents of hospitals in Queensland are required to notify the Director-General of Health of cases of certain sexually transmitted diseases which medical practitioners have examined or treated.⁴¹⁷ A system of laboratory based notification has been in place in Queensland since 1988.⁴¹⁸

The sexually transmitted diseases currently notifiable in Queensland include: chancroid,⁴¹⁹ chlamydia,⁴²⁰ donovanosis,⁴²¹ genital herpes,⁴²² gonorrhoea,⁴²³ hepatitis B,⁴²⁴ hepatitis C,⁴²⁵ human immunodeficiency virus,⁴²⁶ lymphogranuloma venereum,⁴²⁷ and syphilis.⁴²⁸

⁴¹⁶ Statistical information referred to in this section is derived primarily from McCall B, "Surveillance of Sexually Transmitted Diseases in Queensland 1988 to 1993" (1995) 19 *Communicable Diseases Intelligence* 58; AIDS Medical Unit, Queensland Health, *HIV/AIDS Statistical Report Period Ending 31 December 1994*; Queensland Health, *Annual Report 1992/1993 Health in Perspective*; Queensland Health Communicable Diseases Branch, letter to Queensland Law Reform Commission dated 6 March 1996; and Commonwealth Department of Health and Family Services, Surveillance and Epidemiology Section, letter to Queensland Law Reform Commission received 3 April 1996.

⁴¹⁷ *Health Act 1937* (Qld) s32A. For a list of notifiable diseases see Notification and Schedule, *Queensland Government Gazette* (28 July 1990) at 1993-1994.

⁴¹⁸ The only exception is that initial episodes of genital herpes infection have been notified by the attending doctor rather than laboratories since 1991. See McCall B, "Surveillance of Sexually Transmitted Disease in Queensland 1988 to 1993" (1995) 19 *Communicable Diseases Intelligence* 58.

⁴¹⁹ An infection by the organism *Haemophilus ducreyi* which is relatively rare in Australia: McCall, note 418 at 58.

⁴²⁰ An infection by *chlamydia trachomatis* which is one of the most commonly reported sexually transmitted diseases in Australia: McCall, note 418 at 59.

⁴²¹ A progressive, destructive disease caused by *calymmatobacterium granulomatis* which is endemic among the indigenous population of Northern Australia: McCall, note 418 at 60.

⁴²² A common sexually transmitted disease caused by herpes simplex virus type 2: McCall, note 418 at 61.

⁴²³ A common sexually transmitted disease: McCall, note 418 at 62.

⁴²⁴ A virus infection transmissible through sexual intercourse and exposure to blood or bodily fluids: McCall, note 418 at 63.

⁴²⁵ A virus infection transmissible through blood and blood products with low transmission risk through sexual intercourse. Higher transmission risk through sexual intercourse if also infected with human immunodeficiency virus: McCall, note 418 at 64.

⁴²⁶ A virus infection transmissible through sexual intercourse and through bodily fluids. It may lead to Acquired Immune Deficiency Syndrome (AIDS): McCall, note 418 at 65.

⁴²⁷ A condition caused by serotypes L1, L2, L3 of *chlamydia trachomatis* usually found in the tropics: McCall, note 418 at 66.

⁴²⁸ Sexually transmitted disease caused by the spirochaete *treponema pallidum*: McCall, note 418 at 66.

The most common sexually transmitted diseases notified in Queensland in 1993 include chlamydia, genital herpes, gonorrhoea, hepatitis B, hepatitis C and syphilis. The highest rates of notification were in the 15-29 years age groups. Exceptions include hepatitis B and hepatitis C. For hepatitis B the highest rate of notification was in the 30-34 years age groups. For hepatitis C the highest rate of notification was in the 30-39 years age groups.

Notifications of HIV in Queensland as at 31 December 1995 (cumulative) totalled 2,129 (up from 1,873 in 1994) including 85 relating to people under the age of 20 years (8 in 1995). Of those 85, 23 notifications related to under 13 year olds and 62 related to 13 to 19 year olds.⁴²⁹

AIDS notifications in Queensland as at 31 December 1995 (cumulative) totalled 858 (up from 689 in December 1994) including 16 relating to people under the age of 20 years (including 2 in 1995). Eleven notifications related to under 13 year olds and 5 related to 13 to 19 year olds. It should be noted that a diagnosis of AIDS reflects an infection with HIV that occurred up to 10 years previously⁴³⁰ so that an HIV infection of a young person may not result in an AIDS diagnosis until he or she is an adult.

For a number of the notifiable diseases, the Queensland rates of notification exceed the Australia wide rates. For example, for chlamydia infection, the 1995 national rate was 35.4 per 100,000 population (down from 55.3 per 100,000 in 1994).⁴³¹ The 1995 rate for Queensland was 74.3 per 100,000 (down from 76.6 per 100,000 in 1994).⁴³² For gonorrhoea the national rate for 1995 was 18 cases per 100,000 (including a rate of 75 per 100,000 population in 20 to 24 year old males) and for Queensland it was 23.9 cases per 100,000 (including a rate of 97.5 cases per 100,000 population in 20 to 24 year old males). For hepatitis B (acute) the national rate for 1995 was 1.8 cases per 100,000 population and for Queensland it was 2 cases per 100,000 population. For syphilis, the 1995 national rate was 10 cases per 100,000 population (including a rate of 28.6 per 100,000 population in 15-19 year old females) and the Queensland rate was 10.9 cases per 100,000 population (including a rate of 57.3 cases per 100,000 population in 15 to 19 year old females).

It has been suggested that, given the limitations of the current Queensland reporting system for notifiable diseases, the statistics referred to above "probably reflect the

⁴²⁹ Figures are cumulative since 1984. Information obtained from AIDS Medical Unit, Queensland Health, 14 February 1996.

⁴³⁰ Aids Medical Unit, Queensland Health, *HIV/AIDS Statistical Report Period Ending 31 December 1994* at 2.

⁴³¹ Information in this paragraph obtained by letter from Surveillance and Epidemiology Section, Commonwealth Department of Health and Family Services dated 3 April 1996.

⁴³² Information in this paragraph obtained by letter from Communicable Diseases Branch, Queensland Health received 6 March 1996. Although as McCall notes, the higher rate in Queensland partially reflects differing notification practices and case definitions of the Australian States and Territories: McCall B, "Surveillance of Sexually Transmitted Diseases in Queensland 1988 to 1993" (1995) 19 *Communicable Diseases Intelligence* 58 at 59.

'tip of the iceberg' of sexually transmissible diseases in Queensland".⁴³³

The consequences to a person of not having a sexually transmitted disease treated are potentially very serious.

Chlamydia may result in serious complications including pelvic inflammatory disease, infertility, ectopic pregnancy and neonatal infections.

Genital herpes is characterised by recurring painful vesicular lesions on the genitalia and neonatal transmission of the virus is associated with high morbidity and mortality.

Gonorrhoea mainly affects the mucosal and glandular structures of the genital tract. Infection may involve the oropharynx, rectum and conjunctiva and the disease may spread to joints and skin.

Hepatitis B can result in chronic hepatitis, cirrhosis and hepatocellular carcinoma.

Syphilis affects primarily the skin or mucous membrane of the genitalia, later involving any organ or tissue and following a prolonged course over many years. If an infant contracts syphilis *in utero* the child suffers wasting, snuffles, rashes and inflammation of bones in the first few months of life, and in later childhood, inflammation of the cornea and deafness. Signs of syphilis may be absent in infancy yet appear in late childhood or adolescence.

McCall has summed up the available information on sexually transmitted diseases as at 1993 in Queensland as follows:⁴³⁴

The sexual health of the Queensland population has shown few encouraging signs of improvement during the last six years [1988-1993], with most STDs showing signs of recent or sustained increases in notification rates, possibly not all attributable to increased, efficient surveillance and laboratory notification mechanisms.... The pattern of increases in HIV notification rates over the six year period and recent increases in gonorrhoea and syphilis notification rates emphasise the need to focus and continually reinforce the preventive education aspect of sexual health.... In order to reduce the spread of sexually transmissible diseases and the potential effect of HIV infection on the Queensland community, specific age groups and populations should be targeted by enhanced community based forms of sexual health education. Such campaigns should aim to increase the public profile and awareness of all sexually transmissible diseases as well as to improve screening of at risk groups.

Given the tendency for sexually active teenagers to be at particular risk of sexually transmitted diseases and the serious and long-term consequences to infected

⁴³³ McCall B, "Surveillance of Sexually Transmitted Diseases in Queensland 1988 to 1993" (1995) 19 *Communicable Diseases Intelligence* 58.

⁴³⁴ *Id* at 67.

persons and those with whom they come in contact, which may result from failure to treat such diseases, it would appear to be appropriate to have as few restrictions as possible imposed upon a young person's access to such treatment. If young people do not seek treatment for sexually transmitted diseases it may be out of fear of their identities becoming known. Young people may not want their parents to know that they are sexually active. There is, however, a genuine public interest in having sexually transmitted diseases treated.

A number of submissions to the Discussion Paper and individuals involved in the consultation meetings referred to sexually transmitted diseases - many emphasising the belief that they and other sexual and sexuality problems are key issues for young people in the 1990s. Health care providers from throughout Queensland acknowledged that sexually transmitted diseases and other sexuality and sexual health problems are a significant concern.⁴³⁵

Health care providers in rural and isolated areas often saw these problems as being exacerbated in those areas - possibly because of the lack of choice in health services and entrenched conservative attitudes.⁴³⁶ The Commission heard from one respondent that there were many sexually active 11 and 12 year olds, particularly in small towns and that "the current law doesn't meet the needs of these children in terms of advice or treatment".⁴³⁷

Queensland Health believes that by facilitating young people's access to health care in a manner such as the Commission proposed in the Discussion Paper.⁴³⁸

[Y]oung people in rural Queensland will have wider access to seeking appropriate treatment and enhance their ability to consent to it. Enhanced community support for primary health care may encourage a change in attitude towards young people seeking health care in provincial towns. The lack of anonymity in rural towns has led many young people to avoid seeking treatment because they fear a breach of confidentiality within the community.

A community based counselling service for young people observed, in the context of sexual health matters generally, that enabling young people to access health care for such matters on their own may be a step towards addressing the public health issues involved.⁴³⁹

⁴³⁵ For example, Consultation meetings 7, 12, 17 and 22.

⁴³⁶ For example, Consultation meeting 7.

⁴³⁷ Consultation meeting 12.

⁴³⁸ Submission 62.

⁴³⁹ Submission 8.

Contraception and sexual health are controversial areas in terms of consent for young people because they are related to young people being sexually active and highlight the tension between the rights of young people as individuals and the responsibilities of parents and guardians as caregivers. Such controversy is unlikely to be resolved by legislation in regard to consent, so there is no reason for this particular area to be treated any differently to other health services young people access.

However, consideration should be given to the public health issues of STDs and unwanted pregnancies. There are many compelling reasons for our community to teach young people about sexual responsibility and for this to happen young people need to feel confident that they can access services and advice without information being revealed to other parties.

Similarly, Queensland Health noted:⁴⁴⁰

Young people should be able to access information and treatment. Most health professionals would prefer that young people discuss such issues with their parents; however, in the absence of a parent, for example, in cases of previous child abuse, then young people should be able to seek advice in a non-judgemental manner. Their participation in the decision making process to access treatment needs to be acknowledged.

The then Department of Family and Community Services (now the Department of Families, Youth and Community Care) noted:⁴⁴¹

This Department agrees that there is a genuine public interest in having sexually transmitted diseases treated and that in many cases a young person would feel uncomfortable seeking advice and treatment from a health care provider if it was a condition of that advice and treatment that consent of their parents was required. This Department agrees ... that it would appear to be appropriate to have as few restrictions as possible imposed upon a young person's access to treatment.... No distinction should be drawn between this and other treatments by the provision of a different test of competency.

A public policy organisation similarly observed:⁴⁴²

The problem is that although it is in the interests of both the individual infected person and the rest of the community that a person with STD be properly diagnosed and treated, young people may be inhibited in seeking medical attention for STD symptoms if they believe their parents may find out. It is necessary to choose between two evils: (a) inadequate treatment, and (b) concealing from parents information which is relevant to the care and upbringing of their child. In our opinion, (b) is the lesser evil. Thus, we believe children should be able to consent to diagnosis and treatment of sexually transmissible diseases.

Some submissions emphasised that reforms should be concerned with stemming

⁴⁴⁰ Submission 62.

⁴⁴¹ Submission 79.

⁴⁴² Submission 3.

the decline in the moral standards of the community and that one way of doing that would be to ensure that parents are always involved in health care decisions affecting their child or at least informed of their child's problems before health care commences, to enable parents to fulfil their perceived counselling role.⁴⁴³

The Commission acknowledges the importance of parental guidance in many situations. However, the Commission believes, on balance, that it is more important that young people should have access to appropriate health care, both for their own sakes and in the public interest. The Commission is of the view that there should be no legal restrictions on the ability of young people to obtain health care for sexually transmitted diseases.⁴⁴⁴

(c) Contraceptive health care

(i) Contraceptive health care not involving a touching

There is no statutory restriction in Queensland on the sale or supply of contraceptives to people whatever their age.⁴⁴⁵ Similarly, there is no statutory restriction on doctors or other health care providers advising a young person on the use of contraceptives.

Simple advice would not constitute an assault - so there should be no fear on the part of the health care provider that he or she may be civilly liable for trespass, or criminally liable for assault or battery. However, the fitting by a medical practitioner of an inter-uterine device or other internal contraceptive device would involve physical contact with the patient and could therefore form the basis of an action for trespass or a charge of assault.

Other consequences to the health care provider of carrying out non-touching health care without an appropriate consent may be difficult to define. In *Gillick's case*⁴⁴⁶ it was argued by Mrs Gillick that a doctor who advised her daughters on contraception would be committing a criminal offence, as principal, of causing or encouraging unlawful sexual intercourse with a girl

⁴⁴³ For example, Submission 42.

⁴⁴⁴ See the Commission's recommendation at 303-308 of this Report and clauses 28, 34, 36 and 41 of the draft legislation in Ch 17.

⁴⁴⁵ Note, however, *Health Act 1937* (Qld) s106, by which the sale or supply of contraceptives by means of automatic machines or similar devices may be prohibited by regulation. The *Health Regulation 1996* (Qld) s204 prohibits the sale or supply of condoms by means of an automatic machine in a State school or non-State school, within the meaning of the *Education (General Provisions) Act 1989* (Qld) and in a grammar school, within the meaning of the *Grammar Schools Act 1975* (Qld).

⁴⁴⁶ See 53-59 of this Report.

under sixteen contrary to section 28 of the *Sexual Offences Act 1956* (UK), or committing an offence of being an accessory to unlawful sexual intercourse with a girl under the age of sixteen contrary to section 6 of the 1956 Act. Subsection 28(1) of the 1956 Act makes it an offence for a person to cause or encourage the commission of unlawful sexual intercourse with a girl under the age of sixteen for whom he is responsible. Subsection (3) provides:

The persons who are to be treated for the purposes of this section as responsible for a girl are ...

(c) any other person who has the custody, charge or care of her.

It was held at first instance that when a young person went to the doctor she was not thereby in the doctor's care. In relation to the offence in section 6 of the *Sexual Offences Act 1956* (UK), Woolf J stated that the doctor may not, by the provision of contraceptive advice, be intending to encourage sexual intercourse. He or she may merely be recognising that, whether or not he or she prescribed contraceptives, intercourse would take place and provision of contraceptives would merely protect the girl from unwanted pregnancy or disease. The doctor could not therefore be said to be an accessory before the fact. Nor could the prescription of contraceptives be said to be aiding or abetting an offence, as contraceptives were "not so much the instrument for a crime or anything essential to its commission but a palliative against the consequences of the crime."⁴⁴⁷ The same conclusions as to criminal responsibility were reached by the House of Lords in the final appeal in this matter.⁴⁴⁸

Woolf J also held that interference with "parental rights" could only occur if the doctor's actions amounted to a trespass. The fact that the young person is under the age of sixteen does not automatically mean that he or she cannot give consent to any treatment.⁴⁴⁹

During the consultation meetings conducted by the Commission similar concerns were expressed about the legality of prescribing contraceptives to under-age females. However, it is unlikely that a health care provider simply by providing contraceptive advice or treatment to a young person under the

⁴⁴⁷ *Gillick v West Norfolk and Wisbech Area Health Authority* [1984] QB 581 at 595 [QB: Div Ct].

⁴⁴⁸ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112. For example, per Lord Fraser at 174-175.

⁴⁴⁹ Following *Gillick's* case, whether or not a young person is capable of giving the necessary consent will depend on the child's intelligence, maturity and understanding and the nature of the health care that is required. The young person must be capable of making a reasonable assessment of the advantages and disadvantages of the health care proposed, so that the consent, if given, is true consent. If the young person is not capable of giving consent then his or her parents can do so on the child's behalf. If what is involved is some health care of a minor nature, and the young person is of normal intelligence and approaching adulthood, it will be easier to show that the young person is capable of giving the necessary consent. It will be otherwise if the implications of the health care are long-term.

"age of consent"⁴⁵⁰ in Queensland could be seen as a party to a sexual offence under the *Criminal Code* (Qld)⁴⁵¹ for the same reasons used by Woolf J to reject such a suggestion in *Gillick's* case.

The provision of contraceptive advice to a young person without the knowledge and/or consent of the young person's parents may incur the wrath of the parents if they discover that it has taken place. However, it is unlikely that a medical practitioner would be liable in civil or criminal law, unless negligence were involved.

(ii) Contraceptive⁴⁵² health care involving a touching of the young person

It is common practice when a woman seeks advice from her medical practitioner on the most appropriate form of contraception, for the medical practitioner to undertake an internal examination of the woman. It may also be appropriate, if the woman is already sexually active, for the medical practitioner to suggest that she undergo a pap smear. Any of these procedures will involve a touching of the patient by the medical practitioner, as will the insertion of an intra-uterine device into a woman.

(iii) When should a young person be able to consent to contraceptive health care?

A number of submissions in response to the Discussion Paper and the earlier Information Paper identified contraceptive advice, treatment and supply in relation to young people as a significant and controversial area of concern.

Respondents to the Commission's Discussion Paper were divided in their opinion on whether there should be any restrictions on a young person's ability to obtain contraceptive advice or treatment without the involvement of parents. Those in favour of restrictions were primarily religious organisations and parents or parent groups. Reasons given included, for example, the fact that the current "age of consent" is 16.⁴⁵³ One religious organisation noted:⁴⁵⁴

⁴⁵⁰ See, for example, *Criminal Code* (Qld) s215 (carnal knowledge of girls under 16) and s229B (maintaining a sexual relationship with a child under 16).

⁴⁵¹ See *Criminal Code* (Qld) ss7-10 (Parties to offences).

⁴⁵² In this context, the Commission is referring to temporary, reversible contraception not involving surgical intervention and excluding sterilisation, termination of pregnancies and the "morning after pill".

⁴⁵³ There is no "age of consent", as such, under Queensland law. Rather, there are a number of offences relating to sexual relations with females under the age of 16 years.

⁴⁵⁴ Submission 27.

We would regard it as anomalous and inappropriate that contraceptive treatment should be made available to persons under the legal age of consent as provided in the Criminal Code.

Similarly, a doctor noted:⁴⁵⁵

I do not see why doctors should prescribe the pill to girls aged less than 16 as this is the age of consent. I believe not to do so for any age may make them consider the matter again and act as a disincentive. If they are old enough to consent to intercourse, they should also be made to accept responsibility for their actions and possible consequences.

But of course, contraception would always be an available option to competent adults.

At least one respondent distinguished between advice and treatment and said that every one should have the right to seek advice but that a young person needs guidance and counsel on any treatment that will affect his or her health or well-being.⁴⁵⁶

For example a young person could seek advice about the contraceptive pill, but should not be able to receive the pill until guidance and counsel is sought from a parent or guardian.

Those in favour of there being few, if any, restrictions on the availability of contraceptive advice and treatment to young people appeared to be health care providers and others working with young people and Government Departments involved in the welfare of young people. For example, both Queensland Health and the Department of Family and Community Services (now called the Department of Families, Youth and Community Care) expressed the view that there should be no restrictions on young people's access to contraceptive advice and treatment, as did a psychologists' association, youth health nurses, a community youth service and the administrator of a public hospital. Youth nurses noted that in almost 90% of cases in their health practice in the community and schools, young people do not want their parents to know about the fact that they have sought contraceptive advice.⁴⁵⁷ They were generally of the opinion that contraceptive advice should be unrestricted. One case example provided by the nurses illustrated their concerns:⁴⁵⁸

⁴⁵⁵ Submission 26. Of course a health care provider cannot be forced to provide health care to a patient.

⁴⁵⁶ Submission 28.

⁴⁵⁷ Submissions 3, 8, 35, 58, 62, 79.

⁴⁵⁸ Submission 35.

A 13 year old girl requesting contraception advice and currently sexually active with a 14 year old boy next door late at night after parents sleeping. No knowledge of safe contraception or sexually transmitted diseases. In my assessment this girl is immature and would not consent to parental involvement. Do you, not give information and put child at risk of pregnancy and sexually transmitted diseases, or do you give information and put yourself at risk of challenge from parents should the facts become known to them?

Other respondents, including parents, young people, medical professionals, youth organisations and welfare organisations argued in favour of young people of any age, or above a particular age, being able to consent to contraceptive advice and treatment although there was some difference of opinion regarding the maintenance of confidentiality. A paediatrician wrote in response to the Information Paper:⁴⁵⁹

I think experience has shown that ignorance results in more trauma to young persons than the risks of confidentiality in matters of contraception and S.T.D. I would therefore recommend that young persons of any age should be able to seek such treatment. Doctors treating such young persons should encourage the young person to seek the support and advice of their family, and that confidentiality should be able to be breached [if there are reasonable grounds to believe that the young person does not understand the significance of the treatment, and that not to breach confidentiality might place the young person at undue risk of physical or emotional abuse. Young persons seeking treatment should be warned of these limitations by the health care provider].

A health care facility wrote:⁴⁶⁰

Young people of any age should be able to seek such treatment without knowledge or approval of parents as young people of all ages may be involved in sexual behaviour which puts their health at risk. The choice of whether they inform their parents is theirs. Our medical practitioners ... do not wish to take on a policing role of informing parents. Our medical practitioners believe that confidentiality to the young person should be maintained.

A boarding school nurse wrote:⁴⁶¹

If they are old enough to ask the questions and are sexually active or planning to be they should have access to this information.

A counselling organisation observed:⁴⁶²

Young people of any age should be able to seek treatment regarding

⁴⁵⁹ Information Paper Submission 1.

⁴⁶⁰ Information Paper Submission 6.

⁴⁶¹ Information Paper Submission 7. Also Information Paper Submission 8.

⁴⁶² Information Paper Submission 40.

contraception and sexually transmitted diseases without the knowledge or approval of parents. Any other situation places the young person's health at risk as well as leaving health-care providers at risk of litigation. Any young person seeking such treatment is clearly already making their own decisions regarding sexuality and therefore has the right and responsibility to make decisions regarding related medical treatment. The parents' role in guiding their children about sexuality is by this stage completed. Those parents expressing concern about issues involving children's moral standards should feel confident that their own children will make the right choices based on their own family values and moral upbringing. It is wrong for those parents to impose a particular moral code on other parents who trust their children to make their own decisions.

An organisation working with Brisbane's transient and chronically homeless youth who have little or no contact with parents or guardians observed:⁴⁶³

While [we do] not promote the idea of an active sex life for young people under the legal age of consent, we do recognise that many of these young people are already sexually active and are no less susceptible to pregnancy, S.T.D., H.I.V./A.I.D.S. than those over the legal age. Indeed they may be more vulnerable due to the reticence of many medical practitioners to advise and assist them.

What a young person deems appropriate for him/herself, may not necessarily agree with the perceptions of a parent or guardian. Parental refusal is neither a deterrent against sexual activity, nor protection against pregnancy, S.T.D. or H.I.V./A.I.D.S. A young person seeking contraception and/or advice on sexual health from a medical practitioner should not be required to produce parental consent.

Similarly, another youth organisation⁴⁶⁴ expressed the concern that fear of parental reaction could present a significant barrier to young people's use of contraception or safe-sex practices if parental involvement were to be compulsory. The respondent considered that the risk of unwanted pregnancy or infection with sexually transmitted diseases, including H.I.V. and Hepatitis B, outweighs the possible benefits which may flow from compulsory parental involvement for some young people.

A youth health service wrote:⁴⁶⁵

Consideration should be given to the public health issues of S.T.D.s and unwanted pregnancies. There are many compelling reasons for our community to teach young people about sexual responsibility and for this to happen young people need to feel confident that they can access services and advice without information being revealed to other parties.

⁴⁶³ Information Paper Submission 53.

⁴⁶⁴ Information Paper Submission 61.

⁴⁶⁵ Information Paper Submission 82.

(iv) Is contraceptive health care a special case to which young people should not be able to consent?

Young women more often seek contraceptive advice or treatment from medical practitioners, family planning officers, school nurses and other health care providers, than do young men. Young men, if wanting condoms for contraceptive or STD prevention purposes, are often able to obtain them from more accessible locations such as vending machines and supermarkets.⁴⁶⁶ There is no age or maturity test in these circumstances.

Of course, young women may also have access to condom vending machines, but if they are also seeking advice on options in relation to contraception, they usually have little choice but to seek professional assistance, often including a pharmaceutical prescription. To limit the ability of young women to seek such assistance may in fact deny them access to the most appropriate contraception for them.

It has been submitted to the Commission that such limits may, in effect, if not in intent, create or perpetuate a bias against young women.⁴⁶⁷

The ethical and moral arguments surrounding the issue of contraceptive advice and treatment for young people are polarised, as are a number of the medical opinions relating to whether or not young people should have access to contraception advice and treatment.

It is unlikely that a restriction on the current or future availability of contraceptive advice, information and products to young people will alter their perceptions and practices relating to sexual relations. It is more likely that sexual activity will continue - without precautions - and that the rate of transmission of sexually transmitted diseases and of unwanted pregnancies and terminations of pregnancies will increase within the community.

It is acknowledged that many parents would want to know if their children were seeking contraceptive advice or were engaged in sexual activity - so that they could provide guidance to their children. There is, however, no requirement to that effect under the current law.

The Western Australian Law Reform Commission⁴⁶⁸ has observed that contraceptive advice or treatment to young women:

⁴⁶⁶ But see note 445 of this Report as to the restriction on the sale or supply of condoms in schools.

⁴⁶⁷ Information Paper Submission 23.

⁴⁶⁸ Law Reform Commission of Western Australia, Discussion Paper *Medical Treatment for Minors* (1988) at paras 6.10 and 6.11.

is sometimes a major cause of disagreement between parent and child, ... [t]he evidence (of the type referred to above) ... leads to the conclusion that minors have a great need for contraceptive advice and treatment. This could be dealt with either by having special rules dealing with the provision of contraceptive advice and treatment, or by ensuring that the general rules governing a minor's ability to consent to medical treatment are suitable to cover contraceptive advice and treatment. The Commission prefers the latter alternative, and believes that its proposed statutory scheme⁴⁶⁹ meets this need. Special rules for contraceptive advice and treatment would in practice only apply to women, and in the Commission's view it is undesirable to suggest anything which is inconsistent with the principle that responsibility for sexual behaviour and its consequences is, or ought to be, shared by both male and female.

An indication of the need young people have for confidential advice and treatment relating to sexuality matters is given by the statistics compiled by one of the 24 hour crisis telephone services available to young people. Kids Help Line⁴⁷⁰ reports that of the 20,518 calls about sex-related problems received in the 12 months ending August 1995: contraception accounted for 7 per cent, sexual harassment accounted for 9 per cent; sexual activity accounted for 44 per cent, pregnancy accounted for 37 per cent and sexually transmitted diseases accounted for 3 per cent.⁴⁷¹

The Commission is of the view that there should be no significant legal restrictions on the ability of young people to obtain contraceptive advice and treatment.⁴⁷²

4. SPECIAL NEEDS OF HOMELESS YOUNG PEOPLE

While the health problems and needs of homeless young people are similar to the health needs of young people in general, there are special considerations with regard to the likely severity of their problems, their increased vulnerability, and the way in which they interact with those providing health care.⁴⁷³ A Federal Parliamentary Committee report defined homelessness in the following terms, although recognising that other definitions may be appropriate depending on the

⁴⁶⁹ Id at paras 5.9-5.22.

⁴⁷⁰ Kids Help Line Infosheet 2: Statistical Summary (August 1995).

⁴⁷¹ Id at 2.

⁴⁷² See the Commission's recommendation at 308-313 of this Report and clauses 29, 35, 36 and 42 of the draft legislation in Ch 17.

⁴⁷³ National Health and Medical Research Council, *Health Needs of Homeless Youth* (1992) at 2.

context within which homelessness is being considered:⁴⁷⁴

Young people are homeless if they are living without family assistance in the following circumstances:

- (a) no accommodation at all (eg. streets, squat, car, tent etc);
- (b) only temporary accommodation (with friends, relatives or moving around between various forms of temporary shelter);
- (c) emergency accommodation (refuge or crisis accommodation etc); and
- (d) other long term supported accommodation for homeless people (eg. hostels, youth housing programs, transitional accommodation).⁴⁷⁵

In 1989 the report of the National Inquiry by the Human Rights and Equal Opportunity Commission into Homeless Children was presented to the Commonwealth Parliament. That report, often referred to as the Burdekin Report, is the only comprehensive report on homeless young people in Australia. It highlights a number of problems experienced by homeless young people. Significant concern was expressed in the Report about the health of homeless young people. The Report estimated that there were between 20,000 and 25,000 young people in Australia who were homeless or at serious risk of becoming homeless,⁴⁷⁶ notwithstanding that an inquiry commissioned by it concluded that there could be as many as 50,000 to 70,000 homeless young people in Australia each night.⁴⁷⁷

Other estimates of the number of homeless young people in Australia have put the figure at the same time at 15,000 to 19,000.⁴⁷⁸ In 1994 there were estimated to be 25,000 to 30,000 school students who experienced homelessness.⁴⁷⁹ Obviously,

⁴⁷⁴ House of Representatives Standing Committee on Community Affairs, *A Report on Aspects of Youth Homelessness* (May 1995) at 26.

⁴⁷⁵ "Homelessness" was defined in the report of the Human Rights and Equal Opportunity Commission, *Our Homeless Children* (the Burdekin Report) (1989) at 7, in the following terms:

"Homelessness" describes a lifestyle which includes insecurity and transiency of shelter. It is not confined to a total lack of shelter. For many children and young people it signifies a state of detachment from family and vulnerability to dangers, including exploitation and abuse broadly defined, from which the family normally protects a child. However, ... there is a growing number of children who are 'homeless' because the whole family cannot find adequate shelter.

⁴⁷⁶ *Id* at 69.

⁴⁷⁷ Dr Rodney Fopp was commissioned to examine all available data and prepare an estimate of the numbers of homeless children and young people. His conclusions appear at 365 of the Burdekin Report.

⁴⁷⁸ MacKenzie D and Chamberlain C, "How Many Homeless Youth?" (1992) 11(4) *Youth Studies Australia* 14.

⁴⁷⁹ MacKenzie D and Chamberlain C, "The National Census of Homeless School Students" (1995) 14(1) *Youth Studies Australia* 22.

because of different definitions of homelessness and different criteria used for assessing the extent of homelessness among young people, it would not be possible to assess accurately at any one point the number of homeless young people in Australia or in Queensland.

However, more certain than the number of homeless young people are the characteristics of young homeless people such as, for example: the peak age of homeless youth is 16-17 years; young women are more vulnerable to homelessness than young men; and more females tend to leave home "for reasons of physical or sexual abuse or other exceptional circumstances" compared with young males who were more likely to be "not allowed to live at home".⁴⁸⁰

During the consultation meetings held by the Commission following release of its Discussion Paper, the Commission heard that the number of homeless young people in Queensland and the health problems experienced by them were of major concern to Queensland health authorities and youth workers.⁴⁸¹

It was apparent to the Burdekin Inquiry that the lifestyle of the homeless involves many risks to life and health including:⁴⁸²

- . "malnutrition and other diet-related illnesses";
- . "skin and respiratory infections from exposure and the lack of adequate accommodation";
- . "unwanted pregnancies";
- . "venereal diseases and AIDS from prostitution";
- . "drug and alcohol addictions (and the risk of death from overdoses and of AIDS from sharing of needles)";
- . "behavioural disorders, the causes of which may lie in the isolation, alienation and rejection of the homeless";
- . "psychiatric illnesses";

⁴⁸⁰ House of Representatives Standing Committee on Community Affairs, *Report on Aspects of Youth Homelessness* (May 1995) at 36-37.

⁴⁸¹ A number of innovative programs have been established in Queensland to address the problems associated with youth homelessness. See McLean K, *Evaluation Report Innovative Health Services for Homeless Youth Program* (1993). Also note Queensland Health, *Youth Policy Reports by Region 1993*.

⁴⁸² The Burdekin Report at 235.

- . "depression and attempted suicide".

It was also noted that another lifestyle feature - violence - endangers the health and lives of homeless young people.

Other physical and psychosocial health problems experienced by homeless young people, identified by the National Health and Medical Research Council, include:⁴⁸³

- . "low self-esteem, which may be aggravated by the stress of homelessness and result in the development of entrenched behaviour problems";
- . "feelings of lack of control";
- . "social isolation";
- . "feelings of hopelessness";
- . "physical and sexual abuse ... (which may generate) anger, a sense of powerlessness, physical injury, and sexually transmitted diseases";
- . "poor nutrition";
- . "sleeping problems";
- . "poor physical and dental hygiene";
- . "skin infestations and infections";
- . "respiratory and gastrointestinal infections";
- . "lack of preventive health care - e.g. dental checks, pap smears, chlamydia testing, use of contraceptives";
- . "poor sexual health from multiple sexual partners, from abuse or prostitution e.g. sexually transmitted diseases (papilloma virus, chlamydia, herpes, hepatitis B, AIDS), pelvic inflammatory disease, infertility (Note: STDs may spread very rapidly in some subgroups of streetkids)";
- . "pregnancies resulting in miscarriages and premature deliveries appear to be more common";
- . "infertility may result from factors such as drug abuse";

⁴⁸³ National Health and Medical Research Council, *Health Needs of Homeless Youth* (1992) at 4-5.

- . "children born to homeless young women are at high risk of physical abuse and neglect";
- . "gender confusion is frequent, particularly amongst young males involved in homosexual prostitution";
- . "frequent use and abuse of both legal and illicit drugs":

In a survey by Victorian Salvation Army youth workers of 200 homeless young people, 89% smoked tobacco regularly, 67% said they had an alcohol or drug problem, 50% used cannabis, 36% used pills and illicit amphetamines and 20% claimed they used heroin regularly.

- . "poor care of chronic illnesses such as asthma, diabetes and lack of or failure to use appropriate aids, such as spectacles";
- . "musculoskeletal problems";
- . "functional aches and pains"; and
- . "unresolved anger, combined with low self-esteem may lead to physical harm to oneself or others from self-mutilation, fights or suicidal behaviour".

The most comprehensive view of the health status of young people provided to the Burdekin Inquiry was by doctors and health workers at an inner city health service. The most common ailments suffered by homeless young people seeking assistance at the service were described as follows:⁴⁸⁴

... the most common presentations relate to viral illnesses such as colds, flu, gastroenteritis, glandular fever, hepatitis B. Skin complaints are a frequent reason for attendance, maybe acne, eczema, dermatitis or very commonly infections related to poor nutrition or abscess formation after unskilled needle use....

Unwanted pregnancy, surprisingly enough, has not been a common problem to date at our Centre but we believe this probably relates to factors such as no ovulation and amenorrhoea as a result of drug abuse or poor nutrition, rather than the success of educational programs on contraception.

Syphilis and gonorrhoea are not commonly encountered in our experience in street kids but herpes, chlamydia and hepatitis B are very common. Approximately 85% of girls under 18 attending our Centre have had human papilloma virus - wart virus - identified on routine pap smears and wart virus is now known to have a very strong association with cervical cancer in the longer term.

The fact of homelessness impedes the management of the health problems of young people.

⁴⁸⁴ Burdekin Report at 236, quoting Dr Vicky Pearson.

The Burdekin Report noted that young homeless people lack self-esteem and are often uninterested in their own well-being. Other impediments to the health of these young people, based on the lifestyle of homelessness and transiency were described:⁴⁸⁵

For example, some conditions will only improve if rest accompanies the treatment. Rest and recuperation are impossible for young people in squats or on the streets. Some homeless youth cannot tolerate the hospital environment, discharging themselves before they are well enough. As a result, conditions do not heal and infections recur. Healing of even minor conditions is hindered and even prevented when a young person has no access to running water to clean wounds (and so on) and when living conditions are unhygienic. Specialist care is difficult both to obtain and to afford and many young homeless people are too intimidated to keep an appointment with a specialist. They are also unlikely to be able to afford spectacles, non-routine dental work and other necessary items. Drug and alcohol abuse compound all of these problems.

Drug and alcohol addiction and behavioural disturbances are major sources of concern to people working with homeless young people and with young people in youth accommodation.

In North Queensland, the Gold Coast and Brisbane, the Burdekin Inquiry heard that drug and alcohol abuse was a major problem among young homeless people. A Brisbane drug and alcohol service reported that one-third of those presenting in 1987 had been homeless and that all 12 residents during November 1987 were homeless.⁴⁸⁶ The majority of witnesses to the Burdekin Inquiry linked substance abuse to low self-esteem and other psychological, developmental and social factors. For example, one witness observed:⁴⁸⁷

It [drug use] relieves emotional and psychological distress. Basically it provides emotional anaesthesia. It can operate to maintain the present-centredness that blocks out the past and it helps avoid thinking about the future.

Homeless young people, even with their "pervasive and extremely serious health problems", are less likely than young people generally to utilise existing health services, such as they are, "because they lack adult 'sponsors' into the health system and independent information about the availability of services, and because

⁴⁸⁵ Burdekin Report at 237.

⁴⁸⁶ Ibid, submission of H Polkinghorne, Mirikai Drug Rehabilitation Centre. Note also National Centre for Epidemiology and Population Health and Australian Institute of Criminology, *Drug Use and HIV Risk Among Homeless and Potentially Homeless Youth in the Australian Capital Territory* (1993) which found that from a sample of 155 people homeless or potentially homeless (i.e. those who had lived away from home in the last 12 months) the majority used alcohol, tobacco, pain relievers and marijuana at some time in their lives. One-third to one-half had used inhalants, hallucinogens, sleeping tablets, amphetamines and "Avil". Much less frequently used were cocaine, heroin and other opioids and barbiturates. The rates of illicit drug use are higher than those reported by survey respondents in schools. Three issues of particular concern arose from the study: high levels of binge drinking, physical and sexual abuse, and attempted suicide.

⁴⁸⁷ Burdekin Report at 238.

of their alienation from society in general".⁴⁸⁸

There are numerous barriers to homeless young people seeking medical attention, if it is available. The Burdekin Inquiry heard that cost was a major barrier. Many young people did not have their own Medicare card⁴⁸⁹ or a Health Care card, nor could they afford to fill prescriptions.⁴⁹⁰ Specialist care, including dental treatment and physiotherapy, was beyond the reach of most homeless young people. Further, homeless young people often distrusted authority figures such as professionals and feared that parents may be contacted.⁴⁹¹ The National Health and Medical Research Council also observed that there are particular problems relating to consent to treatment in "under-age adolescents" because they lack access to parents and guardians.⁴⁹²

5. YOUNG PEOPLE LACKING READY ACCESS TO PARENTAL ASSISTANCE

Young people who are not legally competent to consent to their own health care due to age or physical or intellectual disability may be in a situation where there is no available parent who can consent to necessary health care. If the situation does not involve an emergency⁴⁹³ and the young person has not been the subject of an application for care and protection,⁴⁹⁴ or an appropriate application either to the

⁴⁸⁸ Id at 239.

⁴⁸⁹ Id at 52. The National Health and Medical Research Council, *Health Needs of Homeless Youth* (1992) at 7 noted that the lack of health care cards or Medicare cards or money for prescriptions means that Accident and Emergency Department services tend to be used by homeless young people, despite their inappropriateness for primary or follow-up care. The Health Insurance Commission has advised the Queensland Law Reform Commission that a Medicare card can be issued to a person under the age of 15 years:

if they are homeless, in foster care or attending boarding school. Documentation to confirm the need for the issue of a separate card would be a letter from one of the following confirming the person's identity and personal circumstances:

- parent
- teacher
- social worker
- minister of religion
- youth refuge worker
- member of the legal profession.

(letter from the Health Insurance Commission, Medicare Customer Service Manager (11 December 1996)).

⁴⁹⁰ Burdekin Report at 52.

⁴⁹¹ Id at 52 per submission of T Campbell, Hedland Community Youth Services.

⁴⁹² National Health and Medical Research Council, *Health Needs of Homeless Youth* (1992) at 6.

⁴⁹³ See discussion on the issue of consent in emergency situations at 44-51 of this Report.

⁴⁹⁴ *Children's Services Act 1965* (Qld) ss49(2), (2B), (2C).

Supreme Court⁴⁹⁵ or to the Family Court,⁴⁹⁶ a health care provider or other person caring for the young person may be in a dilemma as to the legal requirements to be met prior to the health care being provided.

The Commission has been informed of residential facilities in Queensland for the accommodation and care of people with disabilities where some young residents have little or no contact with their parents. Some of those young people have not been the subject of an application to the appropriate court to seek authorisation for health care, or to determine who is to have decision-making authority over the young person in the absence of legally competent parents or in light of refusal by parents to consent to appropriate health care.⁴⁹⁷ Those caring for young people owe various legal duties to them - such as the duty to provide necessities of life including appropriate health care.⁴⁹⁸ However, in fulfilling those duties a health care provider may find himself or herself liable, at least under the civil law, for proceeding with the health care without a valid consent or authorisation.⁴⁹⁹

The following scenarios have been put to the Commission by a residential facility. The scenarios illustrate the particular problems confronting the young person and the health care provider:

⁴⁹⁵ Under that Court's *parens patriae* jurisdiction. See discussion at 94-95 of this Report.

⁴⁹⁶ Under that Court's welfare jurisdiction, in relation to certain serious forms of treatment. See 96-97 of this Report. See also the discussion of *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 at 59-61 of this Report.

⁴⁹⁷ The Commission has been informed that there is a reluctance by some organisations caring for young people to seek to have the young people made wards of the State through care and protection proceedings. This is particularly so when there is a chance that parents and child can be re-united. The best interests of the young person may also be served by avoiding any possible stigma attached to being a ward.

⁴⁹⁸ See discussion on parental duties and responsibilities in Ch 5 of this Report.

⁴⁹⁹ See the discussion of the *Criminal Code* (Qld) s31 at 88-89 of this Report.

A 14 year old has always lived in either the residential facility's nursing home or one of the supported accommodation units. The mother had spasmodic contact with the young person until her death 2 years ago. The father has had no contact with his child for 10 years. Currently, contact is only achieved at the facility's instigation through a time consuming and complicated process.

Four years ago the young person was assessed as needing a back operation to maintain physical ability. At the time the mother refused to give consent for a blood transfusion which may have been needed during the operation.

Without the operation the young person is slowly deteriorating to a stage that it is predicted the young person will be bed-ridden. There is a maximum of 1 year in which the operation can now be performed.

Since the mother's death the maternal grandmother has been refusing consent for the blood transfusion. The father has directed that the grandmother is to make the decision.

The facility acknowledged its duty of care to ensure the best available health care for the young person, but was concerned about its ability to consent to the operation and about the authority, if any, the grandmother may have had to refuse health care for her grandchild.

In this scenario, it appears that the mother's refusal to consent to a blood transfusion could have been overridden under section 20 *Transplantation and Anatomy Act 1979* (Qld).⁵⁰⁰

The grandmother would have no authority at law to consent to, or to refuse, health care for her grandchild, and the father would have no authority to delegate his power to make decisions in relation to the health care of his child. The residential facility would have a duty to ensure the young person was treated in the best possible manner, but it would have no automatic right to consent to the health care.

⁵⁰⁰ See the discussion of this provision at 30-32 of this Report.

A 13 year old, who was placed in the nursing home at birth, went to a general practitioner and was prescribed antibiotics for a slight infection. The young person's parents were unable to be contacted as their whereabouts were unknown.

The medication has side effects which were explained to the support staff. The staff were concerned about the medication and would not have accepted the risk of the side effects for their own children. The residential facility was uncertain whether it had a right in law to request the doctor to prescribe an alternative.

A further case, which has been recently recounted to the Commission by a legal practitioner, is described below.

A 16 month old child with a septic knee required an operation to avoid being permanently disabled. The condition was not an immediate threat to the child's life. The hospital in which the child was a patient would not proceed with the operation without an appropriate consent. The child's parents could not be contacted in the short term. After much deliberation the child's doctors decided to operate in the absence of consent.

In these scenarios, without seeking to make the young people wards of the State⁵⁰¹ and thereby possibly jeopardising their future relationship with their parents, or going to the expense and effort of making an application to the Family Court or to the Supreme Court in its *parens patriae* jurisdiction, there is currently no mechanism in Queensland to obtain a valid consent or authorisation for the health care of young people who are not legally competent. In these circumstances, health care providers might consider the risks to themselves of criminal prosecution or civil litigation to be outweighed by the immediate or short-term needs and interests of the young person. However, it could also be that some of the most vulnerable people in our community - abandoned children - are thereby denied the protection and security of the law which is currently available to young people in the care of legally competent parents and, to a certain extent, to adults who are not legally competent.⁵⁰²

⁵⁰¹ Pursuant to care and protection proceedings under the *Children's Services Act 1965* (Qld) s49.

⁵⁰² See this Commission's Report *Assisted and Substituted Decisions* (R49, June 1996).

Similar dilemmas may arise where a young person who is not legally competent is in need of health care whilst in a boarding school or even whilst attending day school if parents are not contactable or not easily contactable.

Of significant concern to health care providers and those working with young people is the situation where a young person is cared for by an individual other than a parent or legal guardian. During the consultation meetings the Commission heard of a number of situations where health care providers were faced with a dilemma when a young person in need of health care was presented by an adult who was not the young person's parent or legal guardian. This is a particularly common occurrence in communities where children are raised or cared for by someone other than a birth parent - such as in many Aboriginal communities where child-rearing is regarded as an extended family responsibility.⁵⁰³

The Queensland Department of Education and individual school authorities would owe certain duties of care to young people under their care, but do not appear to have any specific protection from liability for participating in health care decisions for young people unable to provide their own effective consent.

Duties of care may also arise where a young person is being cared for pursuant to an informal arrangement between his or her parent/s and another person - for example, where a grandmother agrees to raise her grandchild.

Without a court-ordered delegation of authority to consent to health care, the person caring for the young person would not be able to provide a valid consent to the young person's health care. This may pose a significant hindrance to meeting the health needs of the young person. Health care providers may also be reluctant to treat without a valid consent, due to possible criminal and/or civil law consequences.

In the view of the Commission there is an urgent need to facilitate health care of young people in these circumstances, to protect health care providers from criminal and civil liability for assault, and to encourage carers to seek the health care that young people in their charge require.⁵⁰⁴

⁵⁰³ In its submission (No 79) the Department of Family and Community Services (now the Department of Families, Youth and Community Care) suggested that a wider definition of "parent" was needed to cater for situations, especially in Aboriginal Communities, where a child is in the care of his or her extended family. See the broad definition of "parent" recommended by the Commission at 337 of this Report.

⁵⁰⁴ See the Commission's discussion and recommendations in Ch 9 of this Report.

6. CONFIDENTIALITY⁵⁰⁵

(a) Introduction

Doctors, nurses and other health care providers are in the possession of information provided to them by, or otherwise concerning, their patients upon the stated or implied understanding that the information will remain confidential.

In addition to any personal obligation not to reveal certain information obtained from patients, many health care providers in possession of such information are bound by the ethics of their professions not to breach the confidence of their patients. For example, the Code of Ethics of the Australian Medical Association (AMA) restrains, to a certain extent, members from revealing confidential information obtained by them during their professional relationships.⁵⁰⁶

Keep in confidence information derived from your patient, or from a colleague regarding your patient, and divulge it only with the patient's permission. Exceptions may arise where the health of others is at risk or you are required by order of a court to breach patient confidentiality.

Appendix 5 to this Report sets out the ethical positions of a number of other health care providers in relation to confidentiality. None of the Codes of Ethics reviewed by the Commission expressly excludes a legally competent young person from the health care provider's ethical obligation to maintain confidentiality. Most, however, are silent with regard to any duty of confidentiality owed to a young person who is not legally competent.⁵⁰⁷

The practice of designating certain information as confidential has a twofold aim.⁵⁰⁸ First, it seeks to facilitate communication relating to intimate or other sensitive matters between persons standing in special relationships to each other. Second, the practice is designed to exclude unauthorised persons from access to such information. Confidentiality is therefore linked to control over the disclosure of, and access to, certain information.

⁵⁰⁵ See the Commission's recommendations with respect to confidentiality at 346-348 of this Report.

⁵⁰⁶ Australian Medical Association, *Code of Ethics* (February 1996) 1.3(d). Previously, the AMA Code of Ethics did not specify an exception to the duty of confidentiality relating to "where the health of others is at risk".

⁵⁰⁷ But see, for example, The Australian Psychological Society's *Code of Ethics* in Appendix 5 to this Report, which could be read as denying young people confidentiality in the relationships with their psychologists.

⁵⁰⁸ Confidentiality and the related concept of privacy have been the subject of a number of reports in Australia and overseas. For example: Australian Law Reform Commission, *Report on Privacy* (Report No. 22, 1983); The English Law Commission, *Report on Breach of Confidence* (Report No. 110, 1981); *The Committee on Privacy and Data Banks in Western Australian*, "The Mann Committee" (1976); New South Wales Privacy Committee, *Research and Confidential Data: Guidelines for Access* (1985). See also Report of the Select Committee of the House of Assembly on *Privacy* (1991) (South Australia).

Confidentiality may arise as a result of a contract between the parties or as a result of equitable obligations. The law concerning the obligation to maintain confidentiality in relation to both circumstances is described below.⁵⁰⁹

One of the complicating aspects of the confidentiality issue in the context of the provision of health care to young people, at least on a theoretical level, is that while the law speaks of a "doctor/patient" relationship and of duties flowing from it (be they contractual or equitable), there is very often a third party, namely, a parent, who is an integral part of that relationship. In the case of a very young child, it is usually the parent who has sought health care for the child in the first place. This inevitably raises the question whether the duty of confidence is owed to the parent or to the young person, especially in circumstances where the contract for the provision of services is between the parent and the doctor.⁵¹⁰

(b) Contract

An obligation to maintain confidentiality as a term of a contract may be express or implied. Where there is a contract between a health care provider and his or her patient the courts will imply a term in that contract that the health care provider will maintain confidentiality as regards the patient's affairs.⁵¹¹

Where the obligation as to confidentiality is contractual and the health care provider breaches the confidentiality, the patient may seek damages resulting from the breach. Damages could arguably extend to mental distress caused by the breach, provided that the possibility of such damage was contemplated by the parties.⁵¹² An injunction may lie to restrain a threatened breach of confidence where the disclosure would amount to a breach of contract. If the breach of contract was induced by a third party an action in tort may also lie against that party.

If, in a contractual situation, it is the health care provider's employee or agent and not the health care provider who breaches the confidence, the patient may be able to take proceedings against the health care provider under an implied warranty that his or her employee or agent would maintain secrecy. The patient may also be able

⁵⁰⁹ The Law Reform Commission of Western Australia has summarised the law in this area in its Report *Confidentiality of Medical Records and Medical Research* (Project No. 65 Part II 1990) in Appendix II.

⁵¹⁰ See 144-145 of this Report for a discussion of exceptions to the duty of confidence in relation to the health care of a very young child.

⁵¹¹ *Tournier v National Provincial and Union Bank of England* [1924] 1 KB 461; *Parry-Jones v Law Society* [1969] 1 Ch 1. In the latter case Lord Denning MR stated at 7:
The law implies a term into the contract whereby a professional man [or woman] is to keep his [or her] client's affairs secret.

⁵¹² *Baltic Shipping Company v Dillon* (1993) 176 CLR 344.

to proceed directly against the employee or agent for breach of the fiduciary duty that person owes the patient.⁵¹³

(c) Equitable obligations

There will be situations where there is no contractual relationship between the health care provider and his or her patient - for example, where a doctor employed by a public hospital provides medical services to a patient admitted to the hospital. In such cases the patient may be able to look to equity for protection.⁵¹⁴

Certain relationships are characterised by an equitable duty of confidentiality.⁵¹⁵ Doctor-patient, lawyer-client and banker-customer are some of the relationships giving rise to such a duty.⁵¹⁶

Since such a duty is equitable, the normal equitable remedies apply. The court may grant an injunction to prevent anticipated breaches of confidentiality.⁵¹⁷ Where an injunction is not appropriate, for example, after disclosure has already occurred, the patient may be able to recover damages from the doctor. Although the law is not settled in this area, it appears that these remedies would be available even where the patient could not point to any positive detriment suffered by the disclosure.⁵¹⁸

⁵¹³ A person who has acquired personal information and who knows or ought to have known the confidential nature of the information is subject to the same obligation of confidence as the original confidant (The English Law Commission, *Breach of Confidence* (Report No. 110 1981) paras 4.11-4.12). The *Privacy Act 1988* (Cth) s92 gives a confider a statutory right of action in such circumstances as against the persons to whom the Act applies - Commonwealth officers and agencies and persons subject to the law of the Australian Capital Territory.

⁵¹⁴ The equitable jurisdiction of the courts was developed in response to perceived limitations of the courts of common law. The courts of common law often adopted a literal and legalistic view of the law and were restricted in the remedies they could offer. At common law, the remedy of a successful plaintiff was usually limited to an award of damages - which may not be appropriate in certain circumstances. In equity, courts are able to offer remedies such as specific performance and injunctions, which order someone to take, or to refrain from taking, a particular course of action.

⁵¹⁵ The scope of equitable obligations of confidentiality has been considered in the Federal Court case of *Smith Kline and French Laboratories (Australia) Ltd v Secretary, Department of Community Services and Health* (1991) 99 ALR 679. It was there held that the scope of such an obligation, where one exists, could not be determined by reference solely to the confider's purpose, but turns on a consideration of all the circumstances. There can be no breach of the equitable obligation unless the court concludes that a confidence has been abused - that unconscientious use has been made of the information.

⁵¹⁶ *Baker v Campbell* (1983) 153 CLR 52 per Gibbs CJ at 65:
... the relationship between solicitor and client imposes on the solicitor a duty ... to keep inviolate his client's confidences ...
See also *Attorney-General v Guardian Newspapers (No 2)* [1990] 1 AC 109 per Lord Keith at 255.

⁵¹⁷ Apart from the equitable doctrine of breach of confidence, equity might also be seen as protecting a fiduciary relationship between health care provider and patient. See Herdy W, "Must the Doctor Tell?" 1996 (3) *Journal of Law and Medicine* 270.

⁵¹⁸ Gurry F, "Breach of Confidence" *Essays in Equity* (ed Finn PD, 1985) 110 at 112. *Attorney-General v Guardian Newspapers (No 2)* [1990] 1 AC 109 per Lord Keith at 256. For a contrary view see that of Lord Griffiths in the same case at 270.

A health care provider may need to consult other professionals in his or her field in order to better serve the patient's needs. For example, as part of the investigation and treatment of a patient's condition, a general practitioner may need to consult a specialist. In such a situation confidential information regarding the patient may have to be passed on. The law would regard disclosure to such persons as being implicitly authorised by the patient. However, those people would also be subject to an equitable duty of confidence as regards the information entrusted to them. The duty cannot be legally overridden merely on the instructions of the confidant's superior.⁵¹⁹

(d) Statutory obligations

Certain health care providers will also be subject to a statutory duty of confidence.

Subsection 62(1) of the *Health Services Act 1991* (Qld) provides:

An officer, employee or agent of an [Regional Health] Authority or a public sector health service must not give to any other person, whether directly or indirectly, any information acquired by reason of being such an officer, employee or agent if a person who is or has been a patient in, or has received health services from, a public sector health service could be identified from that information.

Section 138 of the *Health Rights Commission Act 1991* (Qld) provides that people involved with the administration of that Act are restricted in the use of confidential information gained as a result thereof.

Section 49 of the *Health Act 1937* (Qld) provides that people involved with the administration of the notifiable diseases provisions under the Act are restricted in the use of information coming to them in their official capacity.

Sections 100E and 100I of the *Health Act 1937* (Qld) impose similar restrictions on people involved in the administration and notification of incidents of cancer.

(e) Exceptions to the duty of confidence

The duty of confidence is not absolute. There are circumstances in which confidential information may, or even must, be disclosed.⁵²⁰ A health care provider may disclose confidential information where his or her interests require disclosure - for example, in order to defend a legal action brought by the patient or to enforce a

⁵¹⁹ *Slater v Bissett and Another* (1986) 85 FLR 118, a decision of the Supreme Court of the Australian Capital Territory.

⁵²⁰ Such information may be disclosed with the consent of the patient. Disclosure with consent is not an exception to the duty of confidence since the quality of confidentiality no longer applies to the information.

debt against the patient.⁵²¹ Sometimes the health care provider must disclose confidential information - for example, where a doctor is a witness in court proceedings and is asked a question about the patient's condition or where the medical records are discoverable in a court action or are subpoenaed. There are a number of statutory provisions in Queensland that impose mandatory reporting requirements for certain diseases or conditions.⁵²²

The law of confidentiality also recognises that a health care provider's duty to the public may override his or her duty of confidence to the patient. The cases where disclosure has been held to be so justified concern criminal or illegal activity or the prevention of harm to innocent people.⁵²³

Subsection 62(2) of the *Health Services Act 1991* (Qld) also provides for a number of exceptions to the statutory duty of confidence contained in subsection 62(1) of that Act.

As far as very young people who are not legally competent are concerned, it appears to be the law that the duty of confidence owed by a doctor to a "patient" does not prevent the disclosure of information related to the health care of a young person to the young person's parents. In *Furniss v Fitchett*⁵²⁴ (the trial of which proceeded on the footing that it was a claim in tort and not in contract) Barrowclough CJ considered that in certain circumstances the public interest would require a doctor to disclose information that a doctor would normally have a duty not to disclose:

But I cannot think that that duty is so absolute as to permit, in law, not the slightest departure from it.... Take the case of a patient of very tender years or of unsound mind. Common sense and reason demand that some report on such a patient should be made to the patient's parent or other person having control of him. But public interest requires that care should be exercised in deciding what shall be reported and to whom. Publication or communication of the report to other than appropriate persons could still be a breach of the duty owed by the doctor.

A similar view of the law was expressed by Lord Templeman in his dissenting speech in *Gillick v West Norfolk and Wisbech Area Health Authority*.⁵²⁵

⁵²¹ See Australian Law Reform Commission, *Report on Privacy* (Report No 22, 1983) Vol 1 para 915.

⁵²² For example, notifiable diseases under the *Health Act 1937* (Qld) s32A.

⁵²³ See *W v Edgel* [1990] Ch 359. See also Neave M, "AIDS - Confidentiality and the Duty to Warn" (1987) 9 *Univ of Tas LR* 1 on whether there is a duty to disclose in certain circumstances, for example where the patient's condition poses a threat to the community.

⁵²⁴ [1958] NZLR 396 at 405-406.

⁵²⁵ [1986] AC 112 at 203.

[I]n my opinion, confidentiality owed to an infant is not breached by disclosure to a parent responsible for that infant if the doctor considers that such disclosure is necessary in the interests of the infant.

The other exceptions to the duty of confidence noted above would apply, in appropriate circumstances, to a young person who is not legally competent, as well as to a legally competent young person.

(f) Disciplinary proceedings

In addition to the possibility of being subject to legal proceedings for breach of confidence, a health care provider may also be subject to disciplinary proceedings. For example, a complaint may be made to the Medical Assessment Tribunal, which has the authority to discipline or deregister a medical practitioner for "misconduct in a professional respect".⁵²⁶ The Board would need to determine whether the disclosure of information in the circumstances constituted such conduct.⁵²⁷

A successful complainant before a disciplinary board would derive no direct benefit from the Board's decision. In any event there may be a tension between the general law of confidentiality as laid down by the courts and the rules of "professional ethics" as laid down by professional or other organisations.

(g) Who benefits from confidentiality?

The maintenance of confidentiality might be seen in many cases as an aspect of privacy - something belonging to the patient of the health care provider. For example, the protection of information provided to a doctor by a patient may be seen as a recognition of the personal distress the patient might experience should his or her medical condition be revealed to the public.

Confidentiality could also be seen from a broader perspective, as an essential element of the community in which we live. It could, for example, be seen as an essential element of an effective health care system, without which patients might be less inclined to expose themselves to the scrutiny of health care providers. Fear of disclosure could fundamentally undermine the doctor-patient relationship. This would be relevant irrespective of the age of the patient.

⁵²⁶ *Medical Act 1939* (Qld) s35. See also *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 at 521-522.

⁵²⁷ Other examples are the Professional Conduct Committee of the Queensland Nursing Council established under the *Nurses Act 1992* (Qld) and the Psychologists Board of Queensland established under the *Psychologists Act 1977* (Qld).

(h) Confidentiality and health care of young people

A young person's desire for confidentiality and privacy may be in direct conflict with his or her parents' desire to be involved in all decisions affecting the young person's health care.

The fear held by a young person that health care providers will insist on parental involvement may deter the young person from seeking health care in the first place. The consequences of a failure to be treated may be tragic.

There may also be circumstances where the absence of parental involvement, due to the health care provider maintaining the confidential nature of the relationship with his or her young patient, would be detrimental to the young person - for example, where parents alone had knowledge of their child's medical and treatment history.

In the Discussion Paper the Commission did not make general recommendations about confidentiality, primarily because the law relating to confidentiality has a broader application than simply in relation to the provision of health care to young people. Nevertheless, in relation to the treatment of conditions for which the Commission recommended there be no restriction as to legal competency, the Commission recommended that:⁵²⁸

[T]he health-care provider shall, subject to any statutory requirement to the contrary, respect the young person's wishes relating to confidentiality.

This requirement would have been in addition to any current common law requirement as to confidentiality. Only three respondents to the Discussion Paper addressed the issue of confidentiality. One respondent, a community based support organisation for young people, stated:⁵²⁹

Being young does not mean that young people have different human rights to the rest of the community. Thus the same rules should apply. There are three legal rationales for disclosure of information without consent:

- where statutory provisions allow for disclosure,
- where it is implied by the circumstances, and
- where there is a higher public duty.

These circumstances should be enough to allow health care providers ... to reveal information where it is necessary.

There is no way that giving information to a third party can be seen as part of treatment of an individual young person, so the young person's capacity to consent to treatment

⁵²⁸ Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995), at 13 and 206 (Recommendation 18). See also the Discussion Paper at 185-186.

⁵²⁹ Submission 8.

has no bearing on the professional relationship of the health care provider and the duty of care associated with this relationship.

Queensland Health⁵³⁰ also agreed that confidentiality between a health care provider and a young patient should be respected in the circumstances suggested in the Discussion Paper, as did a school counsellor.⁵³¹

The issue of confidentiality for young people needs to be considered.⁵³² In this regard the Commission endorses the comments of the Honourable John Lee in the United Kingdom during the House of Commons debates on the introduction of the *Family Law Reform Act 1969* (UK):⁵³³

Once we accept the concept that a person ... is likely to be mature enough to weigh up these matters, if we destroy confidentiality, not only shall we put them in a difficult position in a disciplinary way, which may be justified, but we may inhibit them from seeking treatment which [is] the most important aspect.

7. YOUNG PEOPLE'S INVOLVEMENT IN THEIR HEALTH CARE

(a) Introduction

The inclusion of young people in their health care decision-making - for example, through access to information, or an active role in the decision-making process - may facilitate the treatment process and increase positive psychological adjustment.⁵³⁴

Over all, there appears to be growing support for the belief that involving children in treatment decisions in some manner is beneficial both for their psychological well-being and for the ultimate success of the treatment endeavour. The nature and extent of such involvement may be determined by factors such as the legal, ethical and clinical issues that are relevant, and the age, maturity and desired role of the child in question.

The majority of submissions to the Health Rights Commission's *Invitation to Develop a Code of Health Rights and Responsibilities 1993* agreed that when a young person

⁵³⁰ Submission 62.

⁵³¹ Submission 54.

⁵³² See 346-348 of this Report.

⁵³³ *Parliamentary Debates*, House of Commons (UK), 9 July 1969 at 1414-1416.

⁵³⁴ Weithorn L, "Children's Capacities for Participation in Treatment Decision-Making" *Emerging Issues in Child Psychiatry and the Law* (eds Schetky D and Benedek E, 1985) 22 at 27-28.

is old enough to understand a procedure or the implications of an intervention, he or she should be consulted.⁵³⁵

A number of submissions to this Commission's Discussion Paper also recognised the value of involving young people in the health care decision-making process. For example, in relation to proposed medical examinations of young people suspected of having been abused, many submissions suggested that it would be inappropriate to examine a young person against his or her wishes.⁵³⁶

A submission from a community based youth support service noted:⁵³⁷

No matter what the circumstances, an examination of a young person against their wishes can be a very damaging thing. Where such an examination is necessary it would be much more important to work through a process where the young person was able to feel in control of the situation and understand the rationale for the examination. Any objections the young person has need to be also addressed and considered.

In the context of matters before the Family Court, the law has long recognised the importance of involving young people in the process of decision-making that will affect them. The legal incompetence of a young person will not necessarily reduce the significance of his or her involvement.

Section 67ZC of the *Family Law Act 1975* (Cth) provides, in effect, that, in deciding whether to make an order relating to the welfare of a young person, the court must regard the best interests of the young person as the paramount consideration. Section 68F provides, in part, that, in determining what is in the young person's best interests, the court must consider any wishes expressed by the young person and any factors (such as the young person's maturity or level of understanding) that the court thinks are relevant to the weight it should give to the young person's wishes.⁵³⁸ However, section 68H of the *Family Law Act 1975* (Cth) provides, in effect, that in proceedings relating to a young person, the court or any person

⁵³⁵ Health Rights Commission, Discussion Paper *A Code of Health Rights and Responsibilities* (November 1994). A final draft of the Code of Health Rights and Responsibilities with recommendations for implementation has been submitted to the Minister for Health and a Government response is awaited.

⁵³⁶ See Queensland Law Reform Commission, Research Paper *Medical Examinations in Cases of Suspected Child Abuse* (MP17, June 1996).

⁵³⁷ Submission 8.

⁵³⁸ Note *H v W* (1995) FLC ¶92-598 where the Full Court of the Family Court of Australia discussed the weight to be attached to the wishes of children and concluded "recent social forces have indicated that more realistic weight should be attached to the wishes of the children than may have been the practical realities in the years past". See also *GWW and GMW* (Unreported, Family Court of Australia HB 1447/1996, 21 January 1997) per Hannon J at 12, 13. See also the *Children Act 1989* (UK) s1(3)(a), which provides that when a court determines any question with respect to the upbringing of a young person, the court shall have regard to the ascertainable wishes and feelings of the young person concerned (considered in the light of his or her age or understanding).

cannot require the young person to express his or her wishes in relation to any matter.

Although the *Family Law Act 1975* (Cth) prescribes a number of alternative methods for conveying the wishes of a young person to the court,⁵³⁹ a young person's wishes are most commonly conveyed via a young person's separate representative. The court has the power to appoint a separate representative for a young person when it appears to the court that a young person ought to be separately represented.⁵⁴⁰ Although a separate representative must convey a young person's wishes to the court, a separate representative may make submissions contrary to a young person's wishes if he or she considers that it is in the best interests of the young person to do so.⁵⁴¹ The other methods for conveying the wishes of a young person to the court are rarely utilised.⁵⁴²

The number of young people whose parents have been involved in divorce during recent years has averaged about 45,000 a year.⁵⁴³ In the 1993 financial year, the Legal Aid Commissions approved the appointment of separate legal representatives to protect the interests of 677 of these young people. By the 1995 financial year, that figure had grown to 2,577.

Although the new version of Part VII (Children) of the *Family Law Act 1975* (Cth), which has been in operation since 11 June 1996, will encourage the separating parents of a young person (who intend to make decisions about their child's welfare without seeking the intervention of the court) to ensure that their child's wishes are

⁵³⁹ See, for example, s62G which empowers the court to direct a family and child counsellor or welfare officer to furnish a report to the court on matters relevant to the proceedings; O23, r5(1) of the *Family Court Rules* which provides that a Judge can interview a young person in chambers or elsewhere; O23, r5(5),(6) which effectively provide that, with the leave of the court, a young person can be called as a witness and can swear an affidavit; and O30A which enables a person to be appointed as a court expert for the purpose of preparing a report on the young person's wishes.

⁵⁴⁰ The court's power to appoint a separate representative is found in the *Family Law Act 1975* (Cth) s68L. In *Re K* (1994) FLC ¶92-461 at 80,773-80,776, the Full Court of the Family Court of Australia commented on 13 types of cases where a court should normally find that a young person ought to be separately represented. The final category referred to was the situation where there is an application made pursuant to the court's welfare jurisdiction relating, in particular, to the medical treatment of a young person, where the young person's interests are not adequately represented by one of the parties.

⁵⁴¹ *Pagliariella and Pagliariella* (1993) FLC ¶92-400 at 80,107.

⁵⁴² The appointment of a "next friend" under the *parens patriae* jurisdiction should usually be confined to those cases where it is asserted that the young person is *Gillick* competent "because in such a case the child should clearly be given an opportunity to present his or her own case to the Court": *P v P* (1995) FLC ¶92-615 at 82,156-157 (Full Court of the Family Court of Australia). Nevertheless, the Court in *P v P* observed that a separate representative should be appointed in such cases, given the limitation on the duties of the next friend. Those limitations include: unlike a separate representative, a next friend has no obligation to present evidence of the young person's wishes or capacity to consent; a next friend has no obligation to put before the court all available evidence; and a next friend does not have an obligation to cross-examine witnesses. It was also stressed in that case at 82,157 that the discussion of "the role of the separate representative and his or her duties and the circumstances in which a next friend is to be appointed are intended by way of guideline only and there may well be cases where a different approach is warranted".

⁵⁴³ Family Law Council, *Report Involving and Representing Children in Family Law* (August 1996) at 5.

considered,⁵⁴⁴ it would seem that currently in practice most young people have little or no involvement in making these types of decisions.⁵⁴⁵

Some overseas jurisdictions have introduced legislation to establish a right of young people to "co-determine" in relation to all the young person's personal matters. Section 31 of the Norwegian *Children and Parents Act 1981*, provides:⁵⁴⁶

As the child develops and matures, the parents shall listen to the child's opinion before making decisions in the child's personal matters. They shall pay due regard to the opinion of the child. The same applies to those with whom the child lives or who are involved with the child.

When the child has reached the age of 12 he or she shall be allowed to state his or her opinion before decisions are made on personal matters on his or her behalf, including the question of which of his or her parents he or she wishes to live with. Great importance shall be attached to the child's wishes.⁵⁴⁷

It is most likely common practice for health care providers to seek the views of even very young patients before providing health care. In some cases, this may be to seek the co-operation of the patient or to allay the fears that the patient may have. The result may be that a young person, although possibly not competent to consent to health care, is given some power or control in the situation.

One justification for adopting a paternalistic stance in relation to young people is that, as one respondent to the Discussion Paper observed,⁵⁴⁸ "people under the age of 16 generally have much experience of being powerless in relation to adults and little experience of making independent decisions". As Leng notes:⁵⁴⁹

⁵⁴⁴ See, for example, s63B which provides that parents of a young person are encouraged firstly, to agree about matters concerning the young person rather than seek an order from the court and secondly, in reaching their agreement to regard the best interests of the young person as the paramount consideration. What is in the best interests of a young person will depend, inter alia, on the wishes expressed by the young person: see s68F(2). Note that an agreement reached between the parents of a young person may be registered under s63E and that the court, in determining whether it is appropriate to register the agreement may, but is not required to, have regard to all or any of the matters set out in s68F(2).

⁵⁴⁵ On 20 March 1996, this view was confirmed informally with various Brisbane family law practitioners, including a Family Law Practitioners' Association representative in private practice and a Family Law Practitioners' Association representative in the Family Law Section of the Brisbane Legal Aid Office.

⁵⁴⁶ Ministry of Children and Family Services 1993, English translation.

⁵⁴⁷ *Children and Parents Act 1981* (Norway) s33 provides that:
Parents shall steadily extend the child's right to make his or her own decisions as he or she gets older and until he or she comes of age.

⁵⁴⁸ Submission 33.

⁵⁴⁹ Leng R, "Consent and Offences against the Person: Law Commission Consultation Paper No. 134" [1994] *Criminal Law Review* 480 at 484.

It is well established that this justifies ignoring a child's consent in relation to activity which society judges harmful to children, for instance sexual intercourse and tattooing. The infringement of the child's autonomy is tolerable because it is temporary.

The reason why young people are granted substantial autonomy in relation to therapeutic treatment is that, generally, such treatment is beneficial. Accordingly, the principle of paternalism described above relating to practices judged harmful does not come into play.⁵⁵⁰

(b) Cognitive development

Research indicates that by adolescence young people may be as competent as adults of comprehending the nature and consequences of proposed health care - even at a high level of competency (requiring patients to comprehend information about future possibilities resulting from each of several choices, necessitating the ability to conceptualise abstract ideas).⁵⁵¹ Weithorn suggests, from available empirical research:⁵⁵²

Where appropriate from legal, ethical, and clinical standpoints, most normal adolescents are capable of making competent treatment decisions. Younger children, perhaps as young as age nine, are also capable of meaningful involvement in the decision-making and treatment processes, despite their somewhat less mature cognitive capacities. Related research suggests that children as young as six may be capable of such participation.

According to Piaget's theory of cognitive development, human intelligence or cognition develops over time through a predictable set of stages. This process culminates in adolescence with what Piaget referred to as the "stage of formal operations".⁵⁵³ When this stage has been reached, the young person can think about the future, deal with abstractions, use deductive reasoning, and apply reasoning to hypothetical situations. It is the highest level of cognitive development; and, as Croxton, Churchill and Fellin note, a person's capacity for decision-making does not increase beyond that stage.⁵⁵⁴

⁵⁵⁰ Ibid.

⁵⁵¹ Weithorn L, "Children's Capacities for Participation in Treatment Decision-Making" *Emerging Issues in Child Psychiatry and the Law* (eds Schetky D and Benedek E, 1985) 22 at 29-30 citing Piaget, Grisso and Vierling.

⁵⁵² Ibid.

⁵⁵³ Piaget J and Inhelder B, *The Psychology of the Child* (1969) at 132 and 133. Piaget was referred to by the High Court in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218.

⁵⁵⁴ Croxton T, Churchill S and Fellin P, "Counselling Minors Without Parental Consent" (1988) 67(1) *Child Welfare* 3 at 8.

The difference between a teenager and the adult in decision-making is the amount of experience one has in the decision-making process. Knowledge and depth of understanding can be increased, but the capacity and the competence for natural decision-making are in place by early adolescence.

They also note, however, that adolescents under age 15 may be too vulnerable to making deferential responses to those in authority.⁵⁵⁵

This suggests that professionals dealing with minors must be especially sensitive to their influence over minors, or, in the alternative, that agencies adopt policies setting the minimum age of counselling (the particular topic of the authors) without the consent of parents at age 15 or above.

Grisso and Vierling argue that adolescents are inclined to defer to a health care provider in the treatment situation and hence are unable to give a voluntary consent.⁵⁵⁶

The psychological evidence is unclear as to the voluntariness of young people's health care decisions. Grisso and Vierling conclude on the basis of research by Milgram (1971), Patel and Gordon (1960), Costanzo and Shaw (1966) and others that:⁵⁵⁷

below 15-17 years, then there is reason to question whether minors in general can satisfy the voluntary element of consent.

Morgan believes these conclusions are too pessimistic.⁵⁵⁸ She makes the point that to restrict a young person's capacity to consent to his or her own health care by requiring parental involvement, or parental or court decision-making, can only increase the feeling of "externality of control".⁵⁵⁹ Involving young people to some extent in their health care decisions is likely to increase their sense of "internal control" and may indicate that young people have the capacity, even if it is not fully exploited, to make their own decisions.

⁵⁵⁵ Id at 9.

⁵⁵⁶ Grisso T and Vierling L, "Minors consent to treatment: a developmental perspective" [1978] *Professional Psychology* 412.

⁵⁵⁷ Id at 423.

⁵⁵⁸ Morgan J, "Controlling Minors' Fertility" (1986) 12 *Mon ULR* 161 at 193.

⁵⁵⁹ Id at 194.

Morgan concludes that:⁵⁶⁰

it seems clear that by the age of 14, most minors have the capacity to understand doctors' communications and are able to exercise voluntary consent.... The claim of capacity is justified for most 14 year olds. Piaget's theoretical work and the empirical material exploring his thesis, provide no guarantee that any particular 14 year old is capable of giving informed consent. We do not refuse adults medical treatment on these grounds.

A psychiatrist sought in his submission to the Commission's Discussion Paper to clarify Morgan's conclusion.⁵⁶¹

In quoting Morgan in relation to 14 year olds, I think there is a danger of looking at this issue in a way which is back to front. Morgan concludes that "We do not refuse adults medical treatment on these grounds" ie that there is no guarantee that a 14 year old has developed adequately to the point of being capable of giving informed consent. However the concept of informed consent specifically requires that the individual is, in fact, able to cognitively understand the issues involved and rationally reach a conclusion based upon adequate information. Under these criteria there are adults who are truly unable to give informed consent and therefore medical treatment should be refused.

However, the respondent appears to be confusing the concept of informed consent, which is normally used in relation to liability for negligence,⁵⁶² with the concept of consent for the purposes of legitimising what would otherwise be an assault. An adult patient need only have a broad understanding of the nature of the proposed health care before being deemed competent to consent to health care involving physical contact. Such a consent would relieve the health care provider from liability for criminal and civil assault.

A young person must satisfy a much more onerous test before he or she is able to give an effective consent to what would otherwise constitute an assault (and thereby relieve the health care provider from potential liability for assault). A young person must be intelligent and mature enough to understand the nature and consequences of the proposed health care.⁵⁶³

⁵⁶⁰ Id at 195.

⁵⁶¹ Submission 81.

⁵⁶² In Australia at least, if the health care provider fails to inform the patient of information "material" to the health care proposed for the patient, then the health care provider may be liable in negligence for damage resulting from the health care: *Rogers v Whitaker* (1992) 175 CLR 479. See 24 and 240 of this Report.

⁵⁶³ See the discussion of *Gillick's* case [1986] 1 AC 112 in Ch 3 of this Report.

(c) Interests to be taken into account

Croxtan, Churchill and Fellin identify three sets of interests that require attention and protection in relation to the provision of health care to young people:⁵⁶⁴

1. The interests of the young person in privacy and saving themselves from perceived harm;
2. The interests of the parents in family autonomy and raising their children as they see fit; and
3. The interests of the state in social stability.

Occasionally, these interests may clash. For example, in cases of neglect and abuse, the interests of the State and presumably those of the young person outweigh the parents' autonomy.

In the United States, a number of States have concluded that, in cases of venereal disease, the interest of society in disease control outweighs the rights of parents to know about all health problems of their children.⁵⁶⁵

Croxtan, Churchill and Fellin suggest that the tandem of the young person and the professional health care provider protects the interests of both the young person in informed decision-making and the interests of the State in protecting the young person from harm.⁵⁶⁶

Given that both research and experience tell us that adolescents have the same capacity as adults to make informed decisions, one should have little doubt about adolescent competency in decision making. As an additional protective mechanism, however, we have the integrity and training of a professional, often licensed by the state. We are not here talking of adolescents being able to make decisions in isolation from adults, but rather being able to act on the basis of professional advice, judgment, and consent.

Croxtan, Churchill and Fellin consider that, ideally, parents should be involved in health care decisions regarding their adolescent children and their participation should be promoted and otherwise encouraged, though not to the exclusion of the privacy rights of the children. In recognition of the respective rights and interests of all the parties involved, including the interests of the health care provider, they recommended the following statutory language:⁵⁶⁷

⁵⁶⁴ Croxtan T, Churchill S and Fellin P, "Counselling Minors without Parental Consent" (1988) 67(1) *Child Welfare* 3 at 10.

⁵⁶⁵ *Id* at 11.

⁵⁶⁶ *Ibid*.

⁵⁶⁷ *Ibid*.

Any minor who is 14 years of age or older may give effective consent for any legally authorised medical or mental health services for himself or herself and the consent of no other person shall be necessary. Providers of such services shall encourage the minor to inform and gain the co-operation of his or her parents in treatment, but notification prior to the provision of services shall not be required. [Code of Alabama].

In his submission to the Commission's Discussion Paper, a psychiatrist who commented on Croxton, Churchill and Fellin's second set of interests, would appear to agree with their proposed statutory provision when he stated:⁵⁶⁸

there are difficulties with regard to the boundary between what a family may perceive as fit behaviour in raising their children, and what may, in fact, be in the best interests of the child. Parental autonomy, I believe, should not be a blanket consideration without definable limits of acceptability.

A number of other submissions agreed. For example, a religious organisation observed:⁵⁶⁹

We consider that it is appropriate to involve parents in the decision-making process where that is not detrimental to that process. We recommend that health care providers be asked to at least inquire of children as to why their parents can not be involved and give their consent. If, however, the children have already taken responsibility (or had that responsibility imposed upon them due to circumstances) for their own welfare, then the health care provider will be able to proceed on the competent child's consent alone. We recognise that where children present for medical treatment by themselves, they probably, by that fact, do not have parents who could be usefully involved in the process. However, some children may need help or reassurance in talking with their parents, or in even finding their parents.... The law need not be any more onerous than to require health care providers to certify that they had raised with the child the possibility of their parents being involved.

Similarly an organisation of psychologists stated:⁵⁷⁰

Health care providers ... should encourage young people to inform their parents and discuss the decision with them prior to treatment ...

The Department of Family and Community Services (now the Department of Families, Youth and Community Care)⁵⁷¹ agreed that health care providers should encourage young people to inform their parents about proposed treatment, but emphasised that this should not be an obligation on the health care provider's part.

⁵⁶⁸ Submission 81.

⁵⁶⁹ Submission 30.

⁵⁷⁰ Submission 58.

⁵⁷¹ Submission 79.

(d) Chronological approach

Devereux,⁵⁷² in reviewing the research carried out by Gerber and Rahemtula,⁵⁷³ notes that the law prevents people under certain ages from doing certain things (such as purchasing cigarettes or driving a motor vehicle). Such age limits appear to be arbitrary, yet by their force have acquired a degree of validity. One approach to answering the question of when young people may validly consent may be to decide which out of the current categories best approximates to the category of treatment decisions. Such an approach has the virtue of applying a common standard to comparable situations. Devereux referred to the following categories:⁵⁷⁴

- giving evidence: most young people understand at any early age the necessity of telling the truth in serious situations.
- working: set at a minimum age to allow young people to develop independence and allow the earning of an income. It also avoids exploitation.
- tattooing: as the treatment is cosmetic rather than therapeutic, capacity to consent should be postponed until after the young person is able to consent to therapeutic treatment.
- smoking, drinking and driving: as the first two may have a deleterious effect on health, the age should be set so that the young person has developed some immunity from peer group pressure and commercial exploitation.
- sexual intercourse and marriage: as marriage is regarded as establishing the basic family unit, it is natural that it be grouped with the young person's capacity to consent to sexual intercourse.

Devereux suggests that a young person's ability to consent to health care should be placed before his or her capacity to consent to tattooing. Devereux gives it priority over smoking, drinking, driving, marriage and sexual intercourse.⁵⁷⁵

⁵⁷² Devereux J, "The Capacity of a Child in Australia to Consent to Medical Treatment - Gillick Revisited?" (1991) 11 *Oxford Journal of Legal Studies* 283 at 294-295.

⁵⁷³ Gerber P and Rahemtula A, "Who has the Right to Advise Children on Birth Control?" (1986) 144 *The Medical Journal of Australia* 419.

⁵⁷⁴ Devereux J, "The Capacity of a Child in Australia to Consent to Medical Treatment - Gillick Revisited?" (1991) 11 *Oxford Journal of Legal Studies* 283 at 295.

⁵⁷⁵ Ibid.

A type of chronological approach has been used in several States in the United States of America, by giving "emancipated" young people legal status.⁵⁷⁶ Wilkins notes that an "emancipated" young person is one who is treated as an adult by reason of an agreement with or conduct by the parents establishing the young person's independence from them.⁵⁷⁷ An "emancipated" young person is able to give consent to certain health care. Evidence of "emancipation" usually consists of age, marriage, pregnancy or parenthood, military service, maintaining a separate residence from the parents, management and control over his or her financial affairs, or a combination of these. Some jurisdictions in the United States of America have provided that young people who have graduated from high school or who are in the military service may consent in their own right to health care.⁵⁷⁸

(e) The Commission's view

The Commission's view is that, it would be best practice on the part of health care provider's to involve young persons, if possible, in the decision making process relating to their health care irrespective of their legal competence to consent to or to refuse health care.⁵⁷⁹

⁵⁷⁶ See 188-190 of this Report for a discussion of the position in the United States of America.

⁵⁷⁷ Wilkins LP, "Children's Rights: Removing the Parental Consent Barrier to Medical Treatment of Minors" [1975] *Arizona State Law Journal* 31 at 54 and 59.

⁵⁷⁸ Note that at 246-247 of this Report, the Commission has rejected a proposal that emancipation be a criterion for competence to consent to health care.

⁵⁷⁹ See 349 of this Report.

CHAPTER 7

THE NEED FOR REFORM

1. SUMMARY OF THE COMMON LAW

(a) For adults (18 years of age or older)

Health care providers may be liable for criminal and/or civil assault for any touching involved in the health care of an adult if they do not have a valid consent. Adults are generally competent to consent to health care if they are able to understand broadly the nature of the decision to be made.⁵⁸⁰ Irrespective of the issue of consent, a health care provider may also be liable for negligence if he or she breaches a duty of care owed to the patient and the patient suffers damages as a result.⁵⁸¹

(b) For young people (0-17 years of age)

- (i) As is the case with adults, health care providers may be liable for criminal and/or civil assault for any touching involved in the provision of health care to a young person of any age (0-17 years of age) if they do not have a valid consent. Additionally, they may be liable if the health care is not in the best interests of the young person.⁵⁸² For health care not involving a touching of the young person, there may be liability for false imprisonment, depending on the circumstances of the case. In any case there may be liability for negligence, although consent to health care is not normally relevant to liability for negligence.⁵⁸³
- (ii) For there to be a valid consent from a young person of any age (0-17 years of age), the young person must be intelligent and mature enough to understand the nature and consequences of the proposed health care (generally referred to as "*Gillick* competence"). *Gillick* competence is relative to the health care being proposed. Presumably a very young child could be competent to consent to relatively minor procedures and a young person of any age, depending on his or her

⁵⁸⁰ See 15-16 of this Report.

⁵⁸¹ See 24 and 240 of this Report for a discussion of the law of negligence in this context.

⁵⁸² See 90-91 of this Report.

⁵⁸³ See 24 and 240 of this Report for a discussion of the law of negligence in this context.

maturity and understanding, could consent to any health care, however serious.⁵⁸⁴

- (iii) If a young person is not in fact *Gillick* competent to consent to his or her own health care, a health care provider who relies on the purported consent of the young person may be liable for treating the young person without a valid consent. It is irrelevant that the health care provider honestly believed the young person to be *Gillick* competent.⁵⁸⁵
- (iv) A health care provider who treats a young person upon a wrong, albeit honest, assessment as to which treatment is in the young person's best interests will not be relieved of liability for assault of the young person.⁵⁸⁶
- (v) A health care provider can obtain a valid consent to treat a young person from a parent, although it is not clear whether a parent can still give a valid consent once the young person is competent to consent on his or her own behalf.⁵⁸⁷
- (vi) It is not clear whether a young person can refuse health care to which a parent has consented.⁵⁸⁸
- (vii) People with a legal duty to seek health care for a young person, other than parents and legal guardians, are not automatically entitled by law to consent to such health care.⁵⁸⁹
- (viii) Parents are unable to consent to certain non-therapeutic forms of health care (such as sterilisations for non-therapeutic purposes) for their children without first obtaining court approval (*Marion's case*).⁵⁹⁰

⁵⁸⁴ See Ch 3 of this Report.

⁵⁸⁵ The health care provider may, however, have a defence to any criminal liability under s24 of the *Criminal Code* (Qld). See the discussion of this defence at 26 of this Report.

⁵⁸⁶ See 90-91 of this Report. The health care provider may, however, have a defence to any criminal liability under s24 of the *Criminal Code* (Qld). See the discussion of this defence at 26 of this Report.

⁵⁸⁷ See 72-74 of this Report.

⁵⁸⁸ *Ibid.*

⁵⁸⁹ See Ch 5 of this Report.

⁵⁹⁰ See 59-61 of this Report.

- (ix) A health care provider and any other person can treat a young person in an emergency situation without a valid consent.⁵⁹¹

2. INEFFECTIVENESS OF THE COMMON LAW

The submissions received by the Commission in response to the Discussion Paper and the earlier Information Paper highlighted the uncertainty and confusion that have resulted from the current law in Queensland relating to the authorisation of health care for young people. The confusion results primarily from the fact that the law in this area is the common law and that, in the absence of relevant Australian case law, United Kingdom cases provide the only persuasive statements of the law.

The paucity of case law relevant to the issues covered by this Report may be a result of the reluctance of law enforcers to invoke the criminal law in situations involving health care providers and their patients. It may also result from the inability or unwillingness (perhaps through ignorance) of young people and those concerned with their interests to pursue civil law remedies against health care providers in appropriate circumstances.

Very few criminal charges relating to the provision of health care are brought in Australia against health care providers. The Commission is unaware of any reported cases in Australia of a medical practitioner or other health care provider being charged with assault arising from health care provided to a young person without a valid consent either from the young person (if legally competent) or from the young person's parents or guardian. Similarly, the Commission is unaware of any reported cases of health care providers being charged with an offence such as "deprivation of liberty" (false imprisonment) under the *Criminal Code* (Qld)⁵⁹² or its equivalent in other Australian jurisdictions.

To date, the common law in this area has primarily been concerned with the protection from civil liability of health care providers who treat young people. Although the common law has paid regard to the "best interests" of young people, it has paid very little regard to the unfulfilled need some young people have for health care. Concepts such as self-determination and autonomy have played little or no part in the development of the common law to date.

Despite the lack of relevant case law and the inadequacy of criminal and/or civil remedies for non-consensual health care not involving a touching, there is an obvious concern, at least within the medical profession, that health care providers

⁵⁹¹ See 44-48 of this Report.

⁵⁹² *Criminal Code* (Qld) s355.

are in a vulnerable position. That concern manifests itself in a reluctance by a number of health care providers to treat young people without parental involvement. It also manifests itself in policies of health care organisations which identify parental knowledge or involvement as a prerequisite for the provision of health care to young people.

None of the respondents to the Discussion Paper, nor anyone with whom the Commission has consulted on this matter, has challenged the Commission's view as to the ineffectiveness of the common law in addressing the needs of young people in the context of the provision of health care.⁵⁹³

A number of respondents suggested that the Commission was proposing to take away from parents certain rights that they currently have in relation to their children. However, those respondents appeared generally to have misunderstood the state of the current law.⁵⁹⁴

In fact, the current law would enable health care providers to provide any health care to a young person of any age, without the knowledge or approval of parents, provided the young person was intelligent and mature enough to be able to understand the nature and consequences of the proposed health care.⁵⁹⁵

It is apparent that the law in its present state may in fact hinder a young person's ability to obtain the health care he or she needs. If the young person is too young to seek health care on his or her own, his or her parents will usually assist by way of arranging for the health care and providing a valid consent for the health care to proceed. However, even if the young person is old enough to take the initiative to consult a health care provider on his or her own, he or she will not be able to give a valid consent unless he or she satisfies the competency test. Further, the young person must first find a health care provider willing to treat in the absence of parental involvement. If the health care provider proceeds without a valid consent even though he or she honestly believes there was a valid consent, he or she may be liable under the criminal law for assault, and/or to pay damages under the civil law for trespass to the person.

⁵⁹³ But see Manitoba Law Reform Commission, Report *Minors' Consent to Health Care* (Report #91, 1995) in which that Commission has recommended the retention of the common law of Manitoba (which appears to be similar to the common law in Queensland) in relation to consent to health care of young people, with the exception of legislation to protect a health care provider who acts in accordance with a young person's instructions and believes in good faith that the young person possesses the necessary capacity. The Manitoba Law Reform Commission was confident that the current common law principle relating to mature young people's capacity to consent to health care "has a sufficient degree of flexibility to allow for the sensitive resolution of current and future questions" (at 340).

⁵⁹⁴ For example, Submissions 6, 11, 13, 17, 20, 22, 25, 26, 37, 38, 47 and 48. Many of those respondents were concerned with one treatment or procedure in particular, namely, abortion. See Ch 3 of this Report for a summary of the current law on competence to consent to health care.

⁵⁹⁵ See Ch 3 of this Report.

The current test of a young person's capacity to consent to health care pays no regard to the relative independence or emancipation of the young person.

The situation is even more confused in relation to a young person's refusal of health care. The common law as stated in *Gillick's* case⁵⁹⁶ says nothing about a *Gillick* competent young person's ability to refuse health care to which his or her parents have consented. Given the variety of judicial opinions expressed *Gillick's* case, it is also unclear whether a *Gillick* competent young person's parents are able to override the young person's consent to health care.⁵⁹⁷

Nor has the common law resolved the confusion that may result when parents differ in their opinion as to what is in the best interests of the young person - apart from providing that the Supreme Court, exercising its *parens patriae* jurisdiction,⁵⁹⁸ can make such a determination (provided, of course, someone with a sufficient interest in the matter takes the time and trouble and undergoes the expense of applying to the court for an exercise of that jurisdiction). It is not clear whether a health care provider can, in a particular case, rely on any one consent over the objection of another relevant party. For example, the young person may have refused a particular treatment; one of his or her parents may insist that the treatment proceed; and the other parent may be indifferent as to whether or not the treatment should proceed. All may have the best interests of the young person at heart - but may be influenced by different considerations when determining what would be in the young person's best interests.

It is also unclear what rights and responsibilities parents have, at law, in relation to the health care of their children. Parents are under a duty to protect their children and to provide them with the necessities of life (including health care when required). However, their authority to make decisions relating to their children, particularly medical decisions, is limited in two important respects. Parents are unable to provide a valid consent to health care for their child that is not in the child's best interests. They are also unable to make decisions relating to health care which is at law required to be authorised by a court (for example, sterilisation).

When a young person is incapable, by reason of his or her age, of making his or her own decision, the young person's parents ordinarily assume that role and their decision is usually respected unless there has been a judicial or medical

⁵⁹⁶ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112. See Ch 3 of this Report for an analysis of this case.

⁵⁹⁷ See, however, Ch 4 of this Report. The approach adopted by the English Court of Appeal in *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 and *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 in its interpretation of *Gillick's* case is that a young person cannot refuse treatment to which his or her parents have consented and if the young person consents to treatment, that cannot be overridden by the young person's parents.

⁵⁹⁸ See 94-95 of this Report.

determination that the decision made would not be in the best interests of the young person.

The common law has not yet devised a definitive set of circumstances that would give a parent final decision-making authority in relation to his or her child. It cannot be said that a parent now has the right to consent to, or to refuse, particular health care for his or her child - particularly if there is a question as to whether or not the young person is legally competent, or if there is a question as to whether or not the health care would be in the child's best interests.

Gillick's case has been cited as authority for the proposition that, as a young person matures, parental authority yields to the young person's developing capacity to make his or her own decisions in relation to proposed health care. It is unclear, however, what role or "rights" are left to the parents once the young person is considered to be capable of making his or her own decisions. The decision in *Gillick's* case does not of itself prevent the health care provider from informing the young person's parents about the proposed health care (although that would probably constitute a breach of the health care provider's duty of confidence to the young person);⁵⁹⁹ nor does that decision require the health care provider to accept the consent of a *Gillick* competent young person.

The common law position of health care providers other than medical practitioners is also uncertain. It is not clear whether health care provided by persons other than health care providers is covered by the principle(s) for which *Gillick's* case is claimed to be authority, although from the Commission's observations it is widely assumed that all health care providers are covered.

From the health care provider's perspective, it is unclear in what circumstances he or she will be protected from liability for touching a young person in the course of an examination or treatment of the young person. If the young person purports to consent to the health care but does not wish to involve his or her parents, the health care provider must assess whether or not the young person is intelligent and mature enough to be capable of understanding the nature and consequences of the proposed health care. It would seem that the health care would also have to be in the young person's best interests. At common law, if the health care provider is mistaken as to the young person's maturity, or mistaken as to what is in the best interests of the particular young person, he or she may be liable for criminal and/or civil assault for treating the young person without a valid consent.⁶⁰⁰

It is also unclear what the effect of the common law (as found in *Gillick's* case) is on the provision of advice or information or on non-touching health care (such as hypnosis or counselling) as opposed to health care involving physical touching of

⁵⁹⁹ See 140-147 and 346-348 of this Report.

⁶⁰⁰ See Ch 2 of this Report.

the young patient. Even though the facts of *Gillick's* case related solely to the provision of contraceptive advice to young people, the case has been relied upon to justify what would otherwise constitute a criminal and/or civil assault (as in physical contact) on the young person. It is generally considered that little, if any, liability exists, apart from potentially in negligence, for non-touching health care provided without a valid consent. The requirement of a valid consent is usually justified on the basis that it ensures protection for the patient against unauthorised interference with his or her right to bodily integrity - that is, where physical contact is threatened or applied. The common law has failed to develop a general consent requirement for health care not involving a touching. An action for false imprisonment may be unrealistic in many of the situations envisaged by the Commission.

The provision of certain forms of counselling, psychiatric treatment, hypnosis and other serious non-touching "treatments" may result in profound consequences for the young person.⁶⁰¹ If the health care provider need not obtain the consent of either the young person or his or her parents before providing such health care, then there may be little or no protection for the young person from inappropriate treatment.

The common law has also failed to address particular problems relating to the treatment of infants whose parents are not adults.⁶⁰² It has also failed to ensure that people other than parents, who have the care and control of a young person, are able to provide a valid consent for the young person's health care - despite the fact that they may be under a common law and/or statutory duty to seek such health care.

There is a need for clarity in the area of consent to health care of young people. It is unlikely that the common law will provide that clarity in the foreseeable future. It has failed to do so since *Gillick's* case, apart from the relatively restricted number of procedures covered by the High Court of Australia's decision in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)*.⁶⁰³

⁶⁰¹ A number of submissions made the point that interference with a person's psychological integrity can result in serious damage to the person. For example, a submission from a psychiatrist (submission 81): "[T]here are increasing anecdotes appearing in the British press about stage hypnosis leading to serious psychological disturbance as a result of a hypnotic suggestion being made to the individual, then being carried through into the normal waking state subsequently. In fact, there is on record an account of a young man suddenly dropping dead following the instruction that he should imagine that he is being electrocuted by a power line. I would submit therefore that hypnotherapy can be an extremely powerful tool, which, whilst there may not be any actual physical contact between therapist and patient, the suggestion taking place during hypnotherapy can subsequently lead to serious consequences beyond the control of the subject."

⁶⁰² See Ch 14 of this Report.

⁶⁰³ (1992) 175 CLR 218. See the discussion of this case at 59-61 of this Report.

Since *Marion's* case, the High Court has not had occasion to examine further issues relating to consent to health care of young people.⁶⁰⁴

The Commission believes that, in view of the important issues that the common law does not address, it would be unrealistic to leave the development of the law in this area to the common law of Queensland.

3. THE ROLE OF THE COMMON LAW IN THE COMMISSION'S PROPOSED LEGISLATIVE SCHEME

The Commission does not propose that its legislative scheme outlined in Volume 2 of this Report be a code of the law relating to consent to health care of young people, although it is anticipated that it would be rare for a health care provider or other person working under the scheme to have to go beyond the legislation to ascertain the law on any particular issue relating to consent to health care of a young person.

To the extent that the scheme specifically states the law on any issue, then the current common law on that issue will be displaced by the relevant legislative provision. Otherwise the common law is retained. For example, the common law limitations on the power of a parent to consent to health care of a child are not affected.⁶⁰⁵

In relation to those aspects of the common law that have broader application than the health care of young people - such as the law in relation to emergency health care and confidentiality - the common law is specifically preserved by the legislation. The draft legislation merely proposes changes to certain aspects of the law with respect to emergency health care of young people.

The Commission recommends that the legislative scheme be regarded as a modification rather than a codification of the existing law regarding consent to health care of young people.

⁶⁰⁴ However, the High Court has determined the interaction of the Family Court's welfare jurisdiction under the *Family Law Act 1975* (Cth) and the jurisdiction of any State or Territory body with power to make sterilisation decisions about a "child of a marriage": see *P v P* (1994) 181 CLR 583, which is discussed at 97-99 of this Report.

⁶⁰⁵ See Ch 5 of this Report.

CHAPTER 8

REFORMS IN OTHER JURISDICTIONS

In a number of Australian and overseas jurisdictions, legislation has been introduced to address some of the problems discussed above.

1. AUSTRALIA

(a) New South Wales

New South Wales was the first Australian jurisdiction to address, by way of legislation, the question of the effect of a young person's consent to health care.

Pursuant to section 49 of the *Minors (Property and Contracts) Act 1970* (NSW),⁶⁰⁶ a person who gives medical or dental treatment to a young person under the age of 16 is protected from an action for assault where a parent or guardian has consented. In the case of a young person aged 14 years or upwards, the consent of the young person is similarly effective. These provisions were adopted from a 1969 Report of the New South Wales Law Reform Commission. That Commission recommended a provision that was enacted, without change, in the form of section 49 of the *Minors (Property and Contracts) Act 1970* (NSW).⁶⁰⁷ The Commission explained the reason for its recommendations as follows:⁶⁰⁸

The law is uncertain at present and we think that this section would effect a useful, though still incomplete, clarification. The section is limited to claims for assault: it has nothing to do with negligence. It would protect persons acting with reasonable care and with consent, but that is as far as it goes. In the case of a minor up to 15 years of age, the consent of a parent or guardian of his [or her] person would be effective; in the case of a minor aged 14 years of age or upwards, the consent of the minor himself [or herself] would be effective. There is an overlap, but we see no harm in that. We think that these special provisions are justified having regard to the needs which arise for the treatment concerned and having regard to the fact that the treatment will be by, or under the direction of, members of skilled and responsible professions. The consent in question may or may not be contractual in character: the matter is at least an incidental matter within our terms of reference.

The New South Wales Government in introducing section 49 indicated that it had no firm views on the matter of the provision of health care to young people, which

⁶⁰⁶ This section is set out in Appendix 6 to this Report.

⁶⁰⁷ Draft *Minority Bill* 1969 cl 48 (Appendix F to the New South Wales Law Reform Commission's Report *Infancy in Relation to Contracts and Property* (LRC6, 1969)).

⁶⁰⁸ New South Wales Law Reform Commission, Report *Infancy in Relation to Contracts and Property* (LRC6, 1969) at 88 (para 44).

matter was ancillary to the main object of the legislation, but agreed with the Commission's view that "there are obvious advantages in laying down standards which will remove the existing uncertainty".⁶⁰⁹

The New South Wales provision would, on its face, enable a young person "aged 14 years or upwards" to seek medical or dental treatment whether or not he or she understood the treatment proposed. The effect of such consent would be to relieve the treating doctor or dentist from liability for assault or battery.

Similarly, a practitioner who performed medical or dental treatment upon a young person less than 16 years of age, with the prior consent of a parent or guardian, would also be relieved of liability for assault or battery.

The section provides specific protection from liability for claims for assault and battery, but does not otherwise affect the common law. Any false imprisonment or negligence claim brought on behalf of the young person is not affected.

Section 49 does not empower a young person to consent to medical or dental treatment so much as it restricts the rights of a young person to sue for assault a person who has treated the young person with his or her consent.⁶¹⁰ The provision does not take away a parent's or guardian's power to withhold or refuse consent to treatment.

Helsham CJ in *K v Minister for Youth and Community Services* stated in relation to section 49:⁶¹¹

It is a protective section at least in one respect, that is in the case of a fourteen to sixteen year old, because it takes away a right to sue which he [or she] otherwise would have, notwithstanding his [or her] consent, if the treatment were performed without consent of his [or her] parent or guardian. It does not take away any power of a guardian to withhold consent or to refuse. Whether the section of itself would have the effect of requiring the court to refuse relief to a guardian who sought to restrain an unwarranted operation (take, for example, an unnecessary sterilisation) about to be performed with the consent of a fourteen-year-old, it is unnecessary to decide. I rather think it would not take away the right of the guardian to relief. But in the present case the most that could be said about the operation of the section is that if an abortion were to be performed by a medical practitioner in the course of his or her practice of medicine or surgery then the consent of this girl would free the practitioner from liability under any claim by her for assault or battery because of its performance.

⁶⁰⁹ See Second Reading Speech of the Hon Mr Waddy, Assistant Minister for the Attorney-General, *Parliamentary Debates*, House of Assembly (NSW), 19 August 1970 at 5275.

⁶¹⁰ [1982] 1 NSWLR 311 at 321.

⁶¹¹ *Ibid.*

Thus, a parent would probably be entitled to seek a court order prohibiting, in the interests of his or her 14 or 15 year old child, performance of health care to which the child had consented. The court would then have to decide the dispute according to the principle that the interests of the young person are paramount.

Conversely, on the view of Helsham CJ, the New South Wales provision deprives a young person of the right to sue a doctor for assault and/or battery in respect of health care to which a parent, but not the young person, has consented. Accordingly, a doctor could, on the consent of a parent or guardian, lawfully carry out health care, such as cosmetic surgery, on a patient under 16, despite the young person's objections to that health care.

For young people of 16 and 17 years of age in New South Wales, it would appear that their wishes must prevail over those of their parents or guardians.⁶¹²

(b) South Australia

(i) *Consent to Medical Treatment and Palliative Care Act 1995*

This Act, proclaimed in November 1995, repealed the *Consent to Medical and Dental Treatment Act 1985* (SA) which was the legislation in force at the time this Commission's Discussion Paper was released. Provisions similar to the relevant provisions of the 1985 Act are found in the current Act - despite attempts at one stage to alter radically the effect of the relevant provisions of the 1985 Act.⁶¹³

The South Australian legislation is the most comprehensive Australian legislative scheme relating to consent to health care of young people. It appears that it and the similar provisions in the *Consent to Medical and Dental Treatment Act 1985* (SA) have worked well over the last 10 years to achieve some certainty in this area of law in South Australia.⁶¹⁴

⁶¹² Weeks P, "Family Planning and the Law (Part III)" (1989) 8 *Healthright* 10 at 14 (footnote 22) notes that s49 of the *Minors (Property and Contracts) Act 1970* (NSW) deals expressly only with children aged 14 to 16, so that the primacy of the wishes of children aged 16 and 17 is implied.

⁶¹³ See Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995) at 157-160.

⁶¹⁴ Submission 22 to the Information Paper (a doctor, who worked in South Australia and who is now Medical Superintendent of a Queensland hospital, wrote to the Commission stating that the South Australian legislation "works extremely well, and I would recommend it as a model"). This opinion was confirmed by the doctor during a consultation meeting held following the release of the Discussion Paper - Meeting 18). The South Australian Branch of the Australian Medical Association has advised the Commission that it is unaware of any adverse comments from its members relative to the South Australian Act and from that "I can only assume that they have no particular problems or concerns with the Act" (letter from the President dated 7 January 1994).

Section 6 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides:⁶¹⁵

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

Although the *Consent to Medical and Dental Treatment Act 1985* (SA) referred specifically to the ability of a young person of or above 16 years of age to consent or refuse medical and dental treatment as if the person were an adult, it is unlikely that the phrase "make decisions about" in section 6 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) would be interpreted more narrowly so as to exclude a decision to refuse treatment.

Section 12 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) provides:⁶¹⁶

A medical practitioner⁶¹⁷ may administer medical treatment to a child if -

- (a) the parent or guardian consents; or
- (b) the child consents and -
 - (i) the medical practitioner who is to administer the treatment is of the opinion that the child is capable of understanding the nature, consequences and risks of the treatment and that the treatment is in the best interest of the child's health and well-being; and
 - (ii) that opinion is supported by the written opinion of at least one other medical practitioner who personally examines the child before the treatment is commenced.

"Parent" is defined in subsection 4(1) of the Act to include a person *in loco parentis* [in the place of a parent] to the child.⁶¹⁸

The Act also provides for the situation where a person, of whatever age, is incapable of consenting in an emergency situation. Section 13 provides:

- (1) Subject to subsection (3), a medical practitioner may lawfully administer medical treatment to a person (the "patient") if -

⁶¹⁵ This section has the same effect as s6(1) of the *Consent to Medical and Dental Treatment Act 1985* (SA).

⁶¹⁶ This section is of similar effect to s6(2) of the *Consent to Medical and Dental Treatment Act 1985* (SA).

⁶¹⁷ The term "medical practitioner" is defined in s4(1) of the South Australian legislation to mean a medical doctor and a dentist.

⁶¹⁸ The term "child" is defined in s4(1) as "a person under 16 years of age".

- (a) the patient is incapable of consenting; and
 - (b) the medical practitioner who administers the treatment is of the opinion that the treatment is necessary to meet an imminent risk to life or health and that opinion is supported by the written opinion of another medical practitioner who has personally examined the patient; and
 - (c) the patient (if of or over 16 years of age) has not, to the best of the medical practitioner's knowledge, refused to consent to the treatment.
- (2) A supporting opinion is not necessary under subsection (1) if in the circumstances of the case it is not practicable to obtain such an opinion.
- ...
- (5) If the patient is a child, and a parent or guardian of the child is available to decide whether the medical treatment should be administered, the parent's or guardian's consent to the treatment must be sought but the child's health and well-being are paramount and if the parent or guardian refuses consent, the treatment may be administered despite the refusal if it is in the best interests of the child's health and well-being.

Section 15 of the Act imposes a duty on medical practitioners and dentists to explain proposed treatment to their patients.⁶¹⁹

A medical practitioner has a duty to explain to a patient (or the patient's representative), so far as may be practicable and reasonable in the circumstances -

- (a) the nature, consequences and risks of proposed medical treatment; and
- (b) the likely consequences of not undertaking the treatment; and
- (c) any alternative treatment or courses of action that might be reasonably considered in the circumstances of the particular case.

Section 16 of the Act affords protection to medical practitioners and dentists who act in accordance with the Act:

A medical practitioner responsible for the treatment or care of a patient, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability for an act or omission done or made -

- (a) with the consent of the patient or the patient's representative or without consent but in accordance with an authority conferred by this Act or any other Act; and

⁶¹⁹ There was no similar provision in the *Consent to Medical and Dental Treatment Act 1985* (SA), although "consent" in that Act was defined in terms of "informed consent": see s4 of that Act.

- (b) in good faith and without negligence; and
- (c) in accordance with proper professional standards of medical practice; and
- (d) in order to preserve or improve the quality of life.

As appears to be the case in New South Wales, in South Australia the wishes of 16 and 17 year olds prevail over those of their parents (section 6). Section 12 provides that for young people under 16 years of age - as with young people between 14 and 16 years of age in New South Wales - the consent of either a parent or the young person is effective. A parent may be able to seek a court order prohibiting, in the interests of a young person, performance of health care to which the young person has consented.⁶²⁰ The court would then have to decide the dispute according to the principle that the welfare of the young person is paramount.

Based on Helsham CJ's interpretation of section 49 of the *Minors (Property and Contracts) Act 1970* (NSW) in the context of the converse situation of parental consent in the face of a child's opposition, Weeks has noted:⁶²¹

He regarded the statutory provisions in New South Wales as depriving the child of the right to sue a doctor for battery for treatment to which her parent, but not she, had consented. It follows that in New South Wales and, by analogy, South Australia, a doctor could lawfully carry out, for example, a termination of pregnancy of a patient under 16 in the absence of her consent.

A rider to this would have to be that whatever health care is performed on a young person, it must be in the best interests of the young person's health and well-being. Further, it would not be possible to force a health care provider to treat a young person in circumstances where he or she did not believe the treatment to be in the best interests of the young person, or for some other reason did not want to treat the young person.⁶²²

(ii) Background to the South Australian legislation

The provisions in the current South Australian legislation⁶²³ relating to consent to medical treatment of young people were derived from the *Consent to Medical and Dental Treatment Act 1985* (SA), the Bill for which was

⁶²⁰ See *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311 per Helsham CJ at 321.

⁶²¹ Weeks P, "Family Planning and the Law (Part III)" (1989) 8 *Healthright* 10 at 12.

⁶²² Ch 4 of this Report discusses the law relating to refusal of treatment. See also 236-237, 241-242, 255-256, 264-265, 278-279 and 283-284 of this Report, where the Commission has recommended that a young person should be able to object to certain health care, including, for example, a termination of pregnancy.

⁶²³ *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

introduced into the South Australian Parliament in 1984. The Bill was based upon a Report of the South Australian Minister of Health's Working Party Consent to Treatment.⁶²⁴

The Working Party considered the situation in South Australia, which was similar to the current situation in Queensland. The Working Party was of the opinion that, given the uncertainty of the common law, it would be appropriate to enact legislation to recognise the ability of mature young people to consent to treatment.

The Working Party noted that the medical profession has generally adopted as a yardstick in deciding whether to provide treatment to young people the so-called "emancipated or independent minor" rule. That rule assumes that a young person (usually 16 years of age or over) who is living away from his or her parents and who is capable of providing financially for himself or herself, is able to provide an effective consent to proposed treatment. However, the Working Party was of the opinion that the social situation of a young person should not necessarily strengthen or affect the young person's ability to give a valid consent to treatment - but rather, that it was the young person's capacity to evaluate the information provided to him or her and to make a reasoned decision based on that information that was important.⁶²⁵

The Working Party concluded in relation to young people 16 years of age and older.⁶²⁶

[G]enerally a minor of sixteen years should be able to give informed consent to a treatment. Under existing legislation a minor of that age is able to consent to sexual intercourse and drive a motor vehicle, and can also be employed and undertake most of life's roles and responsibilities.... [A]t sixteen years a minor will be able to assess the information provided to him [or her] and by making a decision based on that information decide his [or her] own fate. This ... is of fundamental importance and priority should be given to ensuring that minors of sixteen years or over should be able to exercise a right to influence decisions about their own treatment.

The Working Party noted that a number of jurisdictions have legislated to permit people of 16 years of age and over to give an effective consent.⁶²⁷ The result of such legislation is that the young person or his or her parents cannot then assert that, because the young person lacked the capacity to

⁶²⁴ The Report was published in December 1983.

⁶²⁵ *Report of the Working Party on Consent to Treatment* (December 1983) at 21 and see the discussion of emancipation legislation in the United States of America at 188-190 of this Report.

⁶²⁶ *Id* at 23.

⁶²⁷ For example, *Minors (Property and Contracts) Act 1970* (NSW) and the *Family Law Reform Act 1969* (UK).

consent, the medical practitioner has "assaulted" the young person; the legislation has confirmed the young person's capacity to give an effective consent.

Legislation enabling a sixteen or seventeen year old to give an effective consent to health care would clarify the rights and responsibilities of those presently involved in decision-making of this nature.⁶²⁸

Statutory provision would have the advantage of giving some reassurance to medical practitioners, treating in good faith, minors of sixteen or over. Presently such practitioners, when relying solely on a minor's "consent" take a risk that the validity of that consent could be disputed by the minor or his [or her] parents in a court of law. Also a minor might be urged to sue his [or her] medical practitioner if an adverse result occurs (notwithstanding that he [or she] had "consented" to treatment) by alleging that he [or she] could not have given a valid consent. The reluctance or hesitation to act in such circumstances might sometimes not be in the best interests of a minor's health and delays in obtaining parental advice could jeopardise necessary or urgent treatment.

The Working Party did not wish to disregard the role of parents in the decision-making process. The Working Party stated that:⁶²⁹

The prudent medical practitioner should, where practicable and possible, involve parents in the process but should also respect the minor's wishes as to parental involvement.

However, the Working Party's sentiments as to parental involvement did not form the basis of a separate recommendation, and were not specifically referred to in the legislation.

The Working Party was also concerned that the legislation should not deny the right of young people under sixteen years of age to consent to some forms of health care. It concluded that the capacity of such young people to consent should be dependent upon their level of understanding.⁶³⁰

The ability to understand the treatment of conditions such as fractures and lacerations is within the comprehension of minors of a much younger age than sixteen years. There are probably many situations occurring every day when minors require treatment of a routine or uncomplicated nature. Delays in waiting for parental consent could be avoided if the minor is asked to consent to treatment. Treatments which cannot be delayed for too long, yet which are not life threatening, pose a problem for medical practitioners. The Working Party feels that notwithstanding legislation, minors less than sixteen years

⁶²⁸ *Report of the Working Party on Consent to Treatment* (December 1983) at 24.

⁶²⁹ *Ibid.*

⁶³⁰ *Id* at 25.

should be able to consent to treatment if they are able to give an informed consent, ie they understand the nature and consequences of the treatment. Thus any consent which would have been valid at common law (when the minor has the capacity to understand the nature and consequences of the proposed treatment) should remain valid under the legislation. Caution would need to be exercised by the attending medical practitioner in assessing the minor's ability to give informed consent in any situation.

During the second reading speech for the Bill based upon the Working Party's recommendations, the then South Australian Minister of Health claimed that the Bill sought to clarify the existing common law relating to consent to medical or dental treatment of young people and to treatment of people in emergency situations.⁶³¹

The basic premise upon which the legislation was drafted was stated as:⁶³²

it aims to allow minors access to the health care that they need, not merely the care that their parents say they can have.

The then Minister of Health further justified the Bill by noting:⁶³³

- The Bill is based upon the individual's right to self-determination in relation to medical and dental treatment.
- The Bill clarifies the position of doctors and dentists who may otherwise be reluctant to act for fear of legal action. Although the fear may rarely, if ever, develop into a real threat of legal action in Australia, nevertheless doctors and dentists should not be asked to treat patients in a legal vacuum.
- Health care is a right in Australia today, not a privilege and no one should be denied the health care they require.
- At 16 years of age, young people are usually able to realise the nature and consequences of treatment proposed for them. This reflects the maturity of 16 year olds in today's society. Under existing legislation young people at 16 years of age are able to consent to sexual intercourse, drive a motor vehicle, be employed and undertake most of life's roles and responsibilities:⁶³⁴

⁶³¹ *Parliamentary Debates*, Legislative Council (SA), 14 November 1984 at 1852.

⁶³² The Hon JR Cornwall, Minister of Health, *Parliamentary Debates*, Legislative Council (SA), 20 February 1985 at 2651.

⁶³³ *Parliamentary Debates*, Legislative Council (SA), 14 November 1984 at 1852.

⁶³⁴ *Ibid.*

It is right that such self-determination of their own lives be extended to allow them to make a choice about medical and dental care. If a person is mature enough to seek such care, he or she should not be denied treatment solely because of age.

- Young people under the age of 16 who are able to understand the nature and consequences of a proposed procedure should be able to consent to the procedure.⁶³⁵

For example, where a child is injured at school, it is not beyond the comprehension of most children to understand that they must receive treatment, say, for a broken limb. In such a situation a child would be able to provide valid consent if required.

The Bill did not meet strong opposition during the debates, although a number of concerns were expressed. One concern was whether such legislation was needed at all given the scarcity of cases coming before the courts in Australia.⁶³⁶ The lack of prosecutions could suggest that the then current practices posed no real problem.

A concern was also expressed about imposing a greater obligation on the medical and dental professions by requiring them to establish that the young person was capable of consenting, that is, that he or she could understand the nature and consequences of the proposed procedure.⁶³⁷

For example, looking at the question of an abortion for a girl below the age of 16 years - and this is a controversial area - the girl may not wish her parents to know ... then there seems to me to be some difference in accordance with the situation in which she is living. If it were a case where the parents could not be located or where the parent/child relationship had completely broken down, then that would be one thing. But, if the child were living at home in a stable relationship with her parents and wanted to give consent to an abortion without her parents knowing, that to me is quite a different thing. Especially on the matter I have been referring to, of the onus thrown on the doctor and the ability of the minor to understand the procedure and the nature and consequences of the procedure, the case of abortion is very much in point.

For a 14 year old girl, or whatever the age may be, it may be very difficult for her to contemplate, appreciate and understand the medical consequences, but even more particularly the psychological consequences, of having an abortion, and what she may feel at a later stage. [Doctors] that I have spoken to have a point when they say that they have cast on them a very grave onus in that they have to certify, in effect, that the minor was capable of understanding the nature and consequences of the procedure, and did appreciate the explanation given.

⁶³⁵ Ibid.

⁶³⁶ The Hon JC Burdett, *Parliamentary Debates*, Legislative Council (SA), 4 December 1984 at 2018.

⁶³⁷ Ibid.

Another concern was that the legislation would enable young people to go behind their parents' backs to give consent without consulting or informing their parents, particularly in circumstances where many people would think it proper for parents to know. Many would think that parents should at least have some knowledge of what is going on, even if they are not given the power to give or withhold consent. Procedures which might be of particular concern to parents included: abortion, sterilisation and cosmetic surgery. However, the Honourable J R Cornwall noted that parental consent for treatment of a young person under 16 years of age is normally withheld for one of two main reasons: either the parent is not available or, in the event that one or both parents are available, they refuse to provide consent.⁶³⁸ Only if the young person's health or life is at risk will the doctors or dentists proceed in the absence of parental consent or effective consent from the young person.

A related objection to the legislation was that it sought to usurp the rights of parents.

The Honourable J R Cornwall responded to this argument by stating.⁶³⁹

That is not true in stable family situations. However, as well as the stability of the nuclear family we have to consider that ultimately the child's health is the most important issue....

In an ideal situation where there is a stable family environment I believe that it is highly desirable not only that the parents are involved in the consultation with the child but also that they support the child in whatever the best choice might be.

However, that is the situation in an ideal world. The reality, and one only has to go to some of the kids' shelters or drop in centres around Adelaide to realise this, is that there are very many situations that are far from ideal. It is a quite different thing, and sometimes a quite dramatically different thing, when the child is not in the situation of a stable family environment.... If one accepts that that is the situation, then by extension we can argue, and I do argue, that we do not believe that a child at home should be denied a similar right to privacy, provided the medical practitioners are able to certify that the children are capable of giving informed consent. In that situation they should not be denied a right to privacy and the right to determine their own treatment.... If you extend that right of privacy to one area for a 15 year old, then it is perfectly legitimate ... to extend it across the board.

During the debates the question was raised as to who would be responsible for the cost of medical or dental treatment on young people where parents had not been consulted or had not consented to the treatment. At common

⁶³⁸ *Parliamentary Debates*, Legislative Council (SA), 20 February 1985 at 2651.

⁶³⁹ *Ibid.*

law, "minors" are only responsible for the cost of necessities of life.⁶⁴⁰ Medical treatment would normally constitute a "necessary of life". Doctors and dentists would, however, usually ensure that there was someone willing to pay the accounts before commencing treatment of the young person. Medicare is also able to issue separate cards to people under the age of 15.⁶⁴¹

A Parliamentary Committee responsible for the Bill relating to the current *Consent to Medical Treatment and Palliative Care Act 1995* (SA) stated that it had had nothing brought to its attention to indicate that the *Consent to Medical and Dental Treatment Act 1985* (SA) had not been working well over the previous 8 years.⁶⁴²

(iii) Disagreement between parents

No guidance is given in the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) on what to do if the parents of a young person disagree as to whether or not the proposed health care should proceed. Presumably the medical practitioner need only have the consent of one parent before carrying out the health care and can ignore the refusal of the other parent. Further, for young people under the age of 16, it is apparent that the *parens patriae* jurisdiction of the South Australian Supreme Court could be invoked where there is a concern that the proposed health care is not in the best interests of the young person's health and well-being.⁶⁴³ Also the Family Court of Australia could be approached to intervene pursuant to its welfare jurisdiction.⁶⁴⁴

(iv) Young person's refusal; role of courts⁶⁴⁵

The South Australian legislation would enable a young person 16 years of age or over to make health care decisions, which would include refusal of treatment, "as validly and effectively as an adult".⁶⁴⁶ This goes further than

⁶⁴⁰ See Queensland Law Reform Commission, Report *Minors' Civil Law Capacity* (R50, December 1996).

⁶⁴¹ See 357-359 of this Report.

⁶⁴² The Hon MJ Evans, *Parliamentary Debates*, House of Assembly (SA), 18 February 1993 at 2118.

⁶⁴³ See 94-95 of this Report.

⁶⁴⁴ See 96-97 of this Report.

⁶⁴⁵ See Ch 4 in relation to competence to refuse health care and 282 of this Report for the Commission's recommendation in relation to refusal of health care by a competent 16 or 17 year old young person.

⁶⁴⁶ *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s6.

section 8 of the *Family Law Reform Act 1969* (UK) which only refers to the "consent" of a young person who is 16 years of age or older being as effective as it would be if he [or she] were of full age.⁶⁴⁷

As noted in Chapter 4 of this Report, in the English case of *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)*⁶⁴⁸ the Court of Appeal confirmed that subsection 8(1) of the *Family Law Reform Act 1969* (UK) allows 16 and 17 year olds to give valid consent, but does not empower them to refuse health care.⁶⁴⁹ In that case, it was made clear that the "Gillick principle" does not confer upon a legally competent young person in the United Kingdom a power of veto over health care, and that the High Court may intervene to prevent death and serious injury regardless of the age of the young person.

Young people of 16 years and over in South Australia currently have the power to make all treatment decisions, which would include the power to refuse treatment, with no proviso that such decisions must be in their best interests. It is unclear whether the *parens patriae* jurisdiction of the courts in South Australia has been excluded for competent 16 and 17 year olds.⁶⁵⁰

During one of the Commission's consultation meetings⁶⁵¹ a case was discussed where a young person was refusing treatment for bed sores. Lack of treatment could have resulted in very serious consequences for the young person. If such a situation were to arise in South Australia in relation to a 16 or 17 year old, it is unclear whether a court would be able to override the decision of the young person, (assuming the young person was held to be legally competent) even though such treatment might be life-saving or aimed at avoiding serious damage to the young person's health.

For people under 16 years of age, the South Australian provision does not appear to alter the common law position as clarified by *In re W*. However, as noted in Chapter 4 of this Report, *In re W* may well not be followed in Australia.⁶⁵²

⁶⁴⁷ See 179-181 of this Report.

⁶⁴⁸ [1993] Fam 64.

⁶⁴⁹ See 68-71 of this Report.

⁶⁵⁰ See 94-95 of this Report for a discussion on the displacement of the *parens patriae* jurisdiction by statute. Note, that in the Commission's legislative scheme, the jurisdiction has been expressly retained for young people under 18 years of age: see 284 of this Report.

⁶⁵¹ Consultation meeting 18.

⁶⁵² See 72-74 of this Report.

(v) Limited application

The South Australian and New South Wales legislation only applies to health care proposed or performed on young people by medical practitioners and dentists. The legislation does not apply to the provision of health care by other health care providers from whom young people might seek treatment.

There is no readily discernible reason why the legislation is so limited. Possibly it was assumed that young people would only, or primarily, seek health care from medical practitioners and dentists and that, perhaps, health care by those health care providers posed the greatest threat to young people if performed without a valid consent.

However, as stated at the outset of this Report, the Commission seeks to remove unnecessary legal barriers to young people seeking any health care that may assist them to attain good health and well-being. If statutory protection is offered only to medical practitioners and dentists, it is likely that other health care providers will be reluctant to treat young people through fear of potential liability for assault. It is also likely that young people will not seek appropriate health care from other types of health care providers, such as psychologists, counsellors and nurses, through fear that those health care providers would want to involve the young person's parents (perhaps to ensure that they have a valid consent before proceeding with the health care).

(c) The Northern Territory

Subsection 174(4)(b) of the Northern Territory *Criminal Code* provides that where a girl is under the age of 16, or is otherwise incapable in law of giving consent, the consent of a person having legal authority to consent is necessary before a medical termination of pregnancy is carried out. This is an exception to the *Gillick* test of competence.

2. ENGLAND AND WALES

Section 8 of the *Family Law Reform Act 1969* (UK) provides that persons 16 years of age and older can give their own consent. This provision is in accordance with a recommendation made in the *Report of the Committee on the Age of Majority* (UK).⁶⁵³ Section 8 provides:

⁶⁵³ (1967) Cmnd 3342 at 116-118 (The Latey Committee).

- (1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his [or her] person, shall be as effective as it would be if he [or she] were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his [or her] parent or guardian.
- (2) In this section "surgical, medical or dental treatment" includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.
- (3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

The scope of subsection (3) is unclear. Devereux suggests that the section is "inherently ambiguous".⁶⁵⁴

Sub-section (1) seems to suggest that, apart from that sub-section, consent of a minor to medical treatment is ineffective. The third sub-section, however, leaves open the possibility that a minor can validly consent, irrespective of the legislation. The Act does, however, make provision for some minors to give valid consents (viz those sixteen and over).

In introducing the United Kingdom Bill the Attorney-General stated that subsection 8(3) would cover the consent of patients under 16 years of age where the common law would have permitted them to consent.⁶⁵⁵ Others have suggested that it covers the consent given by a parent of a patient aged 16 or 17 who has refused health care, or whose consent the medical practitioner has not sought.⁶⁵⁶ It has also been suggested that the subsection covers emergencies.⁶⁵⁷ Samuels suggests:⁶⁵⁸

This [subsection] means that parental consent previously valid in respect of a minor 0-21 remains valid. So, if the minor is 16½, the parents give consent, the minor does not consent or possibly even objects, the doctor operates, he [or she] is protected. In practice, the doctor will seek to ascertain the age of the minor, and, if he [or she] believes the minor to be 16 or over, look to the minor for consent. In any event he [or she] would be most unlikely to act in the face of objection by the minor.

⁶⁵⁴ Devereux J, "The Capacity of a Child in Australia to Consent to Medical Treatment - Gillick Revisited?" (1991) 11 *Oxford Journal of Legal Studies* 283 at 289-290.

⁶⁵⁵ Sir Elwyn Jones (Attorney-General), *Parliamentary Debates*, House of Commons (UK), 9 July 1969 at 1419.

⁶⁵⁶ Samuels H, "Can a Minor (Under 16) Consent to a Medical Operation?" (1983) 13 *Family Law* 30.

⁶⁵⁷ *Ibid.* However, note that the Alberta Institute of Law Research and Reform in its Report *Consent of Minors to Health Care* (December 1975) at 4 considered this to be unlikely because the subsection speaks of consent, not of absence of consent.

⁶⁵⁸ Samuels A, "Can a Minor (Under 16) Consent to a Medical Operation?" (1983) 13 *Family Law* 30.

It is unlikely that at the time the provision was enacted, that is, prior to *Gillick's* case, subsection 8(3) was intended to protect doctors acting solely on the consent of a young person aged under 16.⁶⁵⁹ It is apparent, however, that section 8 was intended to clarify the capacity of young people to consent to health care by providing that anyone 16 years of age or over could give a valid consent.⁶⁶⁰

There was relatively little opposition expressed during the United Kingdom Parliamentary Debates on the provisions of the *Family Law Reform Bill* (UK) relating to consent to medical treatment.⁶⁶¹ One concern related to treatment of 16 and 17 year old school boarders. The Honourable Eldon Griffiths was concerned that giving 16 year olds the ability to consent to medical treatment would also automatically give them the right to forbid a doctor to divulge information to any third party including parents, about the treatment, or about the condition which makes such treatment necessary.⁶⁶²

In response to this concern, the Honourable John Lee noted:⁶⁶³

The fallacy of that [argument] is simply this. Either the House takes the view that a person of 16 is mature enough to consent to medical treatment or it does not. Either we accept that 16 is a reasonable age for people to exercise this power themselves or we do not. It does not matter whether they are in an educational institution ... Once we accept the concept that a person of a given age is likely to be mature enough to weigh up these matters, if we destroy confidentiality, not only shall we put them in a difficult position in a disciplinary way, which may be justified, but we may inhibit them from seeking treatment, which [is] the most important aspect.

The Attorney-General also noted that it may have been the law already that a person 16 years of age or older could give a valid consent to any surgical, medical or dental treatment. A primary object of the Bill was to make the law clear in this area.

The *Children Act 1989* (UK) represented a major restructuring of the law relating to young people as well as the duties and responsibilities of local authorities in respect of young people. A court, in exercising its powers to make welfare orders under the Act, is obliged to have regard to the welfare checklist in subsection 1(3) of the Act.⁶⁶⁴ The first item in the checklist is the ascertainable wishes and feelings of the

⁶⁵⁹ Id at 30.

⁶⁶⁰ Sir Elwyn Jones (Attorney-General), *Parliamentary Debates*, House of Commons (UK), 17 February 1969 at 43.

⁶⁶¹ *Parliamentary Debates*, House of Commons (UK), 9 July 1969.

⁶⁶² Id at 1407-1412.

⁶⁶³ Id at 1414-1416.

⁶⁶⁴ *Children Act 1989* (UK) s1(4).

young person (considered in the light of his or her age and understanding). This is not the court's sole consideration, nor the paramount one,⁶⁶⁵ but the court must nonetheless have some regard to a young person's wishes and feelings.

More specifically, in the case of emergency protection orders and child assessment orders, a child who is "of sufficient understanding" may refuse to submit to a medical or psychiatric examination or other assessment regardless of a court order authorising a person to carry out the assessment.⁶⁶⁶ Commentators on the Act have noted that such provisions are in accordance with the "Gillick principle".⁶⁶⁷ Accordingly, a legally competent young person who is the subject of suspected abuse or otherwise in need of state protection can validly refuse medical treatment. Subsequent decisions of the Court of Appeal in England have deprived "not at risk" young people of this right.⁶⁶⁸

3. SCOTLAND

Prior to the *Age of Legal Capacity (Scotland) Act 1991* the position in Scotland with respect to the age at which a young person could give a legally effective consent was as unclear as the current situation in Queensland. As Edwards notes:⁶⁶⁹

[P]rior to the 1991 Act it appeared that parents could give their consent to medical procedures in respect of their children to the age of 18 or at least 16, whether as tutors, curators or custodians of their children. However, the issue was considerably more complicated than this. Many doctors believed erroneously that, as a matter of UK law, children could consent at the age of 16, not knowing that this age was only statutorily defined for children in England and Wales under the Family Law Reform Act 1969, s8. It was also in practice not unknown for them to accept the consent of children under 16, particularly in difficult areas complicated by issues of confidentiality such as contraceptive services. Another school of belief was that the parent's right to consent to medical treatment ended with the termination of tutory at 12 for a girl, 14 for a boy, since, under one view of minority, only tutors had rights over the persons of their wards, while curators of minor children controlled only their property. Still another argument, probably the dominant one, was that the parental right to consent to medical treatment was an aspect of custody, not guardianship, and therefore lasted till the age of 16 when custody rights now terminate [under family law in Scotland].

⁶⁶⁵ The Court's paramount consideration is the child's welfare: *Children Act 1989* (UK) s1(1).

⁶⁶⁶ *Children Act 1989* (UK) ss43(8), 44(7).

⁶⁶⁷ Eekelaar J and Dingwall R, *The Reform of Child Care Law* (1990) at 86; Masson J, "Children Act 1989" *Current Law Statutes Annotated* 1989 (4) (1990) at 41-94, 41-99. See also *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

⁶⁶⁸ See Ch 4 of this Report.

⁶⁶⁹ Edwards L, "The Right to Consent and the Right to Refuse; More Problems with Minors and Medical Consent" [1993] *The Juridical Review* 52 at 52-53.

The 1991 legislation clarified a number of aspects of the law in Scotland that had been further muddled by *Gillick's* case. While, under the general scheme of the 1991 Act, a young person under 16 has, as a general rule, no capacity to enter into any legal transaction, an important exception is found in subsection 2(4), which provides:

A person under the age of 16 years shall have legal capacity to consent on his [or her] own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him [or her], he [or she] is capable of understanding the nature and possible consequences of the procedure or treatment.

Edwards notes that the effect of this provision is in most cases to take what was already common medical practice and make it specifically sanctioned by the law.⁶⁷⁰ Unlike the South Australian provision there is no reference to the welfare principle.⁶⁷¹ The doctor is not required to assess whether the proposed treatment is in the best interests of the young person, only whether the young person is capable of understanding the nature and consequences of the treatment. This is also in contrast to the House of Lords decision in *Gillick's* case.

A number of problems still remain unresolved despite the Scottish Act. For example:

- It is not clear what the attributes are of a young person who meets the competency test in subsection 2(4) (or, elsewhere - what the attributes of a *Gillick* competent young person are.)
- It is still unclear whether the parental right to consent also continues in cases where the young person under 16 is competent under subsection 2(4) (or *Gillick* competent) or whether, once the young person's capacity begins, the parental right terminates. The *Age of Legal Capacity (Scotland) Act 1991* should be read together with the *Children (Scotland) Act 1995*. The latter Act makes it clear that a parent's statutory responsibility to ensure that a child receives necessary medical treatment and a parent's statutory right to consent to such medical treatment both terminate once the child reaches the age of 16 years: see sections 1 and 2 of the *Children (Scotland) Act 1995*. It should also be noted that section 6 of the *Children (Scotland) Act 1995* imposes an obligation on a parent to have regard to the views of a child who

⁶⁷⁰ Id at 54.

⁶⁷¹ This is not an accidental omission. It was based on the conclusion of the Scottish Law Commission in its *Report on the Legal Capacity and Responsibility of Minors and Pupils* (No 110, 1987) para 3.77, that a best interests test was restrictive and unnecessary. The Commission considered the rejection of a best interests requirement to be logically coherent with a scheme in which a young person had already been found to be sufficiently mature to give his or her own consent. Maturity connotes a willingness to take the consequences of one's choices whether good or ill. The idea that a test of best interests can be imposed objectively by a doctor, parent or even court is illusory in areas such as contraception and abortion, which are never unequivocally in the young person's best interests.

is under 16 years before making any major decision concerning proposed medical treatment of the child.

- *Gillick's* case and subsection 2(4) speak only of the balance of rights and powers between parent and child. What remains to be settled is the balance of power between the court where its authority has been invoked (possibly by wardship in England or under its inherent protective jurisdiction) and the young person. Thus, if a young person refuses a medical procedure, does (or should) the court have the power to override that refusal?

Section 90 of the *Children (Scotland) Act 1995* provides that any examination or treatment can only be carried out on a child under 16 who is subject to a supervision requirement or an assessment order, or kept in a place of safety under a child protection order or a warrant, or subject to a parental responsibilities order and who has the legal capacity to consent mentioned in subsection 2(4) of the *Age of Legal Capacity (Scotland) Act 1991* if the child consents to the examination or treatment. The express reference to subsection 2(4) of the *Age of Legal Capacity (Scotland) Act 1991* in section 90 of the *Children (Scotland) Act 1995* indicates that the Scottish Parliament intended the phrase "capacity to consent" in subsection 2(4) to be interpreted so as to include capacity to refuse consent.

4. NEW ZEALAND

New Zealand legislation enables young people 16 years of age and older to consent to medical and dental procedures, as if they were adults.

Section 25 of the *Guardianship Act 1968* (NZ) provides:

- (1) Subject to subsection (6) of this section, the consent of a child of or over the age of 16 years to any donation of blood by him [or her], or to any medical, surgical, or dental procedure (including a blood transfusion) to be carried out on him [or her] for his [or her] benefit by a person professionally qualified to carry it out, shall have the same effect as if he [or she] were of full age.
- (2) The consent of or refusal to consent by a child to any donation of blood or to any medical, surgical, or dental procedure (including a blood transfusion) whether to be carried out on him [or her] or on any other person, shall if the child is or has been married have the same effect as if he [or she] were of full age.
- (3) Where the consent of any other person to any medical, surgical, or dental procedure (including a blood transfusion) to be carried out on a child is necessary or sufficient, consent may be given -
 - (a) By a guardian of the child; or
 - (b) If there is no guardian in New Zealand or no such guardian can be found with reasonable diligence or is capable of giving consent, by a

person in New Zealand who has been acting in the place of a parent;
or

- (c) If there is no person in New Zealand who has been so acting, or if no such person can be found with reasonable diligence or is capable of giving consent, by a District Court Judge or the Director-General.
- (4) Where a child has been lawfully placed for the purpose of adoption in the home of any person that person shall be deemed to be a guardian of the child for the purposes of subsection (3) of this section.
- (5) Nothing in this section shall limit or affect any enactment or rule of law whereby in any circumstances -
 - (a) No consent or no express consent is necessary; or
 - (b) The consent of the child in addition to that of any other person is necessary; or
 - (c) Subject to subsection (2) of this section the consent of any other person instead of the consent of the child is sufficient.
- (6) Except to the extent that this section enables a blood transfusion (as defined in subsection (1) of section 126B of the Health Act 1956) to be administered to a child without the consent of any other person, nothing in this section shall affect the provisions of the said section 126B.

Section 25A provides that a female child of any age can consent to an abortion or refuse an abortion and "her consent or refusal to consent shall have the same effect as if she were of full age".

Presumably the common law would apply in relation to consent to all other types of medical treatment for under 16 year olds.

Under subsection 25(3)(a), where the consent of any other person to any medical, surgical or dental procedure on a young person under 16 years of age is necessary or sufficient, consent may be given by the young person's guardian. If there is no guardian in New Zealand capable of giving consent or if no such guardian can be found, a person in New Zealand who has been acting in the place of a parent may give consent.⁶⁷² If no such person can be found in New Zealand, or the person is not capable of giving consent, a District Court Judge or the Director-General may give consent.⁶⁷³

If there is a guardian and that guardian refuses to consent to the proposed treatment, application may be made under section 9 of the *Guardianship Act 1968* (NZ) to place the young person under the guardianship of the High Court, which

⁶⁷² *Guardianship Act 1968* (NZ) s25(3)(b).

⁶⁷³ *Id* s25(3)(c).

may then, as guardian, grant the necessary consent.⁶⁷⁴ Thus the High Court of New Zealand can assume the powers of consent referred to in section 25,⁶⁷⁵ despite the presence of a guardian in New Zealand who is capable of giving consent, but refuses to do so. The young person comes within the High Court's umbrella of protection once the application is commenced. Accordingly, although strictly speaking no guardianship order may have been made, the High Court's consent should be sought, particularly in emergency situations.⁶⁷⁶

The situation is different under section 25A. In *Re S*⁶⁷⁷ it was held that the High Court had no power to override section 25A in pursuance of any other broader power. Thus section 25A, unlike subsection 25(3), is a code dealing with consent in the context of abortion.⁶⁷⁸

Where a young person wholly or partly lacks the capacity to understand the nature and to foresee the consequences of decisions in respect of matters relating to his or her personal care and welfare, or has such capacity but cannot communicate decisions in respect of such matters,⁶⁷⁹ then the *Protection of Personal and Property Rights Act 1988* (NZ) becomes relevant. If a young person is not and has never been married, a welfare guardian may be appointed under subsection 12(1) of the *Protection of Personal and Property Rights Act 1988* (NZ) if no parent or guardian of the young person is living or in regular contact with the young person and the court is satisfied that it is in the young person's best interests to make the appointment.⁶⁸⁰ Such a guardian may consent to non-excepted forms of medical treatment.⁶⁸¹ The *Protection of Personal and Property Rights Act 1988* (NZ) falls within the terms of subsection 25(5)(c) of the *Guardianship Act 1968* (NZ) as being any enactment whereby the consent of any other person instead of the consent of the young person is sufficient. It is arguable that a young person who fulfilled the criteria of subsection 6(1) of the *Protection of Personal and Property Rights Act 1988* (NZ) and

⁶⁷⁴ *Re V* [1993] NZFLR 369; *Director-General of Social Welfare v B* [1994] NZFLR 516.

⁶⁷⁵ *Director-General of Social Welfare v B* [1994] NZFLR 516 at 517.

⁶⁷⁶ *Re V* [1993] NZFLR 369 at 374-375, citing and quoting from *W v Director-General of Social Welfare* [1990] 1 NZLR 378 at 383.

⁶⁷⁷ High Court, Wellington, CP 430/91, 16 July 1991. Unreported judgment referred to in *Re V* [1993] NZFLR 369 at 376-377.

⁶⁷⁸ *Re V* [1993] NZFLR 369 at 376-377.

⁶⁷⁹ *Protection of Personal and Property Rights Act 1988* (NZ) s6(1).

⁶⁸⁰ *Id* s12(3).

⁶⁸¹ *Id* s18; Grant E, "Consent to Medical Procedures and the *Protection of Personal and Property Rights Act 1988*" (1989) 7 *Otago Law Review* 161 at 175.

who was or had been married would fall within the jurisdiction of that Act, and therefore that a variety of orders relating to medical treatment could be made by the court, including the appointment of a welfare guardian who could consent to the necessary treatment.⁶⁸²

The New Zealand *Bill of Rights* provides that "everyone has the right to refuse to undergo any medical treatment".⁶⁸³ The question of how this applies to a young person who is *Gillick* competent has not yet been decided in the New Zealand courts. However, it seems that it was not intended to remove the existing restrictions on young people's rights to decide about health care for themselves.⁶⁸⁴ It has been held that "everyone" in section 11 means "every person who is competent to consent", and that "everyone" does not include a committed psychiatric patient.⁶⁸⁵

Subsection 25(1) of the *Guardianship Act 1968* (NZ) does not empower a young person of or over 16 years of age to refuse treatment, and nowhere does the Act specifically deal with a parent's right to override any such refusal. Subsection 25(5) contemplates a situation where no consent is required; where a young person's consent is required in addition to that of another person; and, where the consent of another person is sufficient instead of the consent of the young person.

Section 14 of the *Guardianship Act 1968* (NZ) provides that a young person of or over the age of 16 who is affected by a decision or by a refusal of consent by a parent or guardian in an important matter may apply to a Family Court Judge who may, if he or she thinks it reasonable in all the circumstances to do so, review the decision or refusal and make such order in respect thereto as he or she thinks fit. It has been suggested that "decision" in this section is wide enough to cover a consent that would purport to override a young person's refusal.⁶⁸⁶

⁶⁸² Grant E, "Consent to Medical Procedures and the *Protection of Personal and Property Rights Act 1988*" (1989) 7 *Otago Law Review* 161 at 175-176.

⁶⁸³ *New Zealand Bill of Rights Act 1990* (NZ) s11.

⁶⁸⁴ New Zealand Government, White Paper, *A Bill of Rights for New Zealand* (1985). For a detailed discussion of this question see Austin G, "Righting a Child's Right to Refuse Medical Treatment - Section 11 of the New Zealand Bill of Rights Act and the *Gillick* Competent Child" (1992) 7 *Otago Law Review* 578 at 579 (footnote 9).

⁶⁸⁵ *Re S* [1992] 1 NZLR 363 at 374-375.

⁶⁸⁶ Austin G, "Righting a Child's Right to Refuse Medical Treatment - Section 11 of the New Zealand Bill of Rights Act and the *Gillick* Competent Child" (1992) 7 *Otago Law Review* 578 at 579 (footnote 9).

5. UNITED STATES OF AMERICA⁶⁸⁷

The Supreme Court of the United States has supported young people's access to contraceptive devices and services.⁶⁸⁸

Some States have legislated to allow young people of particular ages to have independent access to other forms of health care such as outpatient mental health care or treatment for substance abuse.⁶⁸⁹

Weithorn observes that there is a "patchwork" of State laws governing the mental hospitalisation of young people.⁶⁹⁰

Some States consider a "voluntary" admission of a minor voluntary only if the minor consents to the hospitalisation. If the minor does not consent, or is not competent to consent, admission can be sought only through a judicial hearing. Other States permit "voluntary" admissions of minors, and still others have ... several variations of these procedures and policies.

Each of the fifty States sets the age of majority and specifies requirements for medical consent for young people. State laws regarding the capacity of young people to consent to medical treatment vary, and exceptions to the parental consent requirements tend to fall into four general categories:

- Exceptions arising out of the jurisdictions of juvenile and family courts over abused and neglected young people.
- Exceptions related to the status and characteristics of individual young people (that is, "emancipated" or "mature" young people).
- Exceptions for emergency situations.
- Exceptions for specific health problems and services:

⁶⁸⁷ This discussion is based on information kindly provided to the Commission by the US Department of Health and Human Services: see letter from Acting Deputy Assistant Secretary for Population Affairs, 23 March 1993 and Office of Technology Assessment (US), "Consent and Confidentiality in Adolescent Health Care Decision Making" *Adolescent Health* (1991) at 111-123 - 111-155.

⁶⁸⁸ *Carey v Population Services International* (1977) 431 US 678.

⁶⁸⁹ Wilkins LP, "Children's Rights: Removing the Parental Consent Barrier to Medical Treatment of Minors" [1975] *Arizona State Law Journal* 31 at 92.

⁶⁹⁰ Weithorn L, "Children's Capacities for Participation in Treatment Decision-Making" *Emerging Issues in Child Psychiatry and the Law* (eds Schetky D and Benedek E, 1985) 22 at 24.

- (a) health services related to sexual activities - family planning and abortion services; pregnancy related services; health services related to sexually transmitted diseases;
- (b) pregnancy-related health services that permit young females to obtain testing to determine pregnancy without parental consent, and pregnant young females to obtain prenatal care and delivery services without parental consent;
- (c) health services for drug and alcohol abuse treatment; and
- (d) mental health services.

Approximately one half of the States have legislation permitting young people to obtain family planning services (usually excluding sterilisation and abortion procedures), some with restrictions as to the young person's age or level of maturity.

Since the Federal statute governing the national family planning program requires that the provision of services be confidential, young people may provide their own consent for services in the program. Clinics funded through this program must provide confidential services to adolescents, thereby superseding any State law that may require parental consent or notification for such services.

Although in 1981 the Federal Government proposed to implement a new requirement that would have made parental notification mandatory in the national family planning program for services requiring a prescription, the courts found that there was insufficient basis in the statute for such a requirement.

Five States (Alabama, Kansas, Rhode Island, South Carolina and Oregon) have enacted legislation that specifically authorises young people who have reached a designated age - ranging from 14 to 16 years of age - to consent to medical treatment.⁶⁹¹

Approximately one half of the States have legislation that provides for court-ordered "emancipation" of young people, or that specifies that certain designated acts by a young person's parents, a young person or both constitute emancipation. Some of these statutes explicitly state that emancipation under these statutes removes the disabilities of minority, including the requirement of parental consent for health care. Young people emancipated under these statutes have the right to consent to health care.

A substantial number of States have legislation authorising young people who have attained varying degrees of independence to consent to health care, although they

⁶⁹¹ Ala. Code ss22-8-4 (1984); Kan. Stat. Ann. ss38-123b (1986); R.I. Gen. Laws ss23-4, 6-1(1985); S.C. Code Ann. ss20-7-280 (Law Co-op 1985); Or. Rev. Stat. ss109.640 (1981).

do not use the term "emancipation" or "emancipated" young people. Over half of the States have "independent minor" statutes, which allow young people who are parents to consent to health care for themselves and/or their children. About half of the States have statutes that allow married young people to consent to health care, and some States have statutes that allow independent young people in other categories (for example, young people living apart from their parents and managing their own financial affairs, young people in the military, young people who are high school graduates) to consent to health care.

6. CANADA

At least four Canadian jurisdictions have legislated in relation to consent to health care of young people. Set out below is a brief summary of those enactments and proposals for reform at a provincial level.

(a) Ontario

Ontario has codified the law relating to consent to health care generally. Under the *Consent to Treatment Act 1992* young people who have capacity may consent to or refuse all health care as defined by the Act.

The evaluation of capacity is to be made by the health practitioner applying prescribed standards and procedures to the patient. The health practitioner is protected from liability in respect of errors made in the evaluation. The health practitioner is under no liability if he or she has acted on reasonable grounds and in good faith. Guidance in the evaluation is provided by subsection 2(2) of the *Substitute Decisions Act 1992*, which establishes a presumption that people 16 years of age and older are capable of giving or refusing consent in respect of their own personal care. For young people 14 years of age or over who are assessed as not having capacity, and who do not want their parents involved in the treatment decision, an application can be made to the Consent and Capacity Review Board for a review of the assessment.

Where a young person does not have capacity, there is provision for substitute decision makers. The primary substitute decision maker is the person with parental authority.⁶⁹²

⁶⁹² The Manitoba Law Reform Commission in its Report *Minors' Consent to Health Care* (Report #91, 1995) at 20 (footnote 20) notes that there has been some criticism of the complexity of the Ontario legislation and that it is being substantially revised by the Ontario Government.

Non-emergency surgical operations in public hospitals can be performed upon unmarried young people under the age of sixteen years only with the consent of a parent, lawful custodian or next-of-kin.⁶⁹³

(b) Quebec⁶⁹⁴

Under the Quebec *Civil Code*, parental or guardian consent is necessary for a person under 14 years of age in respect of treatment "required by the state of health" of the young person. A young person 14 years of age or older can consent to such care.⁶⁹⁵

A court may authorise treatment "required by the state of health" for a person under 14 years of age where a parent or guardian has withheld consent. If a young person 14 years of age or older refuses required treatment, such refusal may be overridden by court authorisation or, where there is an emergency and the young person's life is in danger or his or her integrity is threatened, parental or guardian consent is sufficient.⁶⁹⁶ In deciding whether to authorise such treatment the court has to consider the views of experts, parents and the patient, as well as anyone else who shares a special interest in the patient.⁶⁹⁷

For treatment "not required by the state of health" of the young person, people under 14 years of age are not capable of consenting. Parental consent is necessary and sufficient except in relation to treatment involving a serious risk to health or which might cause grave and permanent effects. In the latter cases, court authorisation is necessary.⁶⁹⁸

Young people 14 years of age or older can consent to treatment "not required by the state of health" of the young person, unless it involves a serious risk to the young person's health or may result in grave and permanent effects. In the latter cases, parental consent is also required. The autonomy of the young person 14 years of

⁶⁹³ *Hospital Management Regulation* RRO 1980 Reg 965 made pursuant to the *Public Hospitals Act* RSO 1990 c p40. The Manitoba Law Reform Commission in its Report *Minors' Consent to Health Care* (Report #91, 1995) at 21 notes that this regulation "was of dubious legal effect prior to the enactment of the *Consent to Treatment Act* 1992 and is anomalous at best following the coming into force of the Act".

⁶⁹⁴ The information contained in this section is derived from the Manitoba Law Reform Commission's Report *Minors' Consent to Health Care* (Report #91, 1995) at 21-22.

⁶⁹⁵ Quebec, *Civil Code*, Article 14.

⁶⁹⁶ *Id* Article 16.

⁶⁹⁷ *Id* Article 23.

⁶⁹⁸ *Id* Articles 17, 18.

age and older is again limited in the interests of the young person's overall welfare.⁶⁹⁹

(c) British Columbia

The *Infants Act*⁷⁰⁰ enables a young person of any age to consent to health care, provided the young person understands the nature and consequences of the health care and its benefits and risks, and provided the health care is, in the health care provider's opinion, in the young person's best interests. Section 16 provides:⁷⁰¹

- 16(1) In this section
 "health care provider" includes a person licensed, certified or registered in British Columbia to provide health care;
 "health care" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of health care.
- (2) 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 where 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.
- (3) No request for or consent, agreement or acquiescence to health care by an infant shall 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.

In a standard letter of reply from the British Columbia Attorney General to enquiries concerning section 16, the main reasons for amendments which have been made to section 16 were explained as follows:⁷⁰²

First, constitutional lawyers advised the government that section 16 of the *Infants Act* was contrary to the Charter of Rights since it imposed an arbitrary age limit on the age of consent. The old section applied only to minors aged 16, 17 and 18. The section

⁶⁹⁹ Ibid. Article 24 requires that consent to treatment "not required by the state of health" of the young person must be in writing.

⁷⁰⁰ (RS 1979, c 196) s16 of which came into effect on 1 January 1993.

⁷⁰¹ The British Columbia Supreme Court in *Ney v Attorney-General of Canada* (1993) 102 DLR (4th) 136 held that s16 simply codifies the common law rules and provides certainty with regard to those to whom the common law rules apply.

⁷⁰² Kindly provided to the Commission by the Ministry of Attorney General, Province of British Columbia, in a letter dated 10 March 1995.

stipulated that for this age group to give valid consent to medical treatment, a reasonable effort must be made by the medical practitioner to obtain the consent of a parent or guardian, or to seek a written opinion from another medical practitioner. Since section 16 did not apply to minors under 16 years of age, common law applied to that age group. The common law has always permitted those under 16 years of age to give informed consent to treatment without parental consent so long as the practitioner is certain that the treatment is in the minor's best interest and that the minor is capable of consenting.

Second, the old section 16 contained a very narrow definition of health care by specifying only doctors and dentists. The section thereby created a distinction between those two professions and other health care professionals such as nurses. As a result, a physician taking a blood sample from a child had to gain consent of the parent or guardian, whereas a nurse doing the same procedure did not.

Third, it was a concern that 16 to 18 year olds living in difficult family situations or away from home may avoid seeking medical treatment for sexually transmitted and other communicable diseases, alcohol and drug addiction, or psychiatric disorders.

In such cases, lack of treatment because of concerns of confidentiality may put their health and that of others at risk.

Under common law, minors can give consent to medical or dental treatment only if the health care provider has ascertained that: (a) the minor understands the nature and consequences of the treatment; and (b) the treatment is in the minor's best interest. Thus, with respect to the impact of the new law, the physician or health care professional will continue to determine whether the parent or guardian should be consulted.

With respect to the rights of children to provide consent to or deny treatment, under common law the courts have made it very clear that minors cannot consent to procedures which are not in their best interest, for example aesthetic cosmetic surgery or sterilisation. By the same token minors cannot refuse treatment which is in their best interest, for example chemotherapy or immunisation. This continues to be the case under the new section 16.

The amended section 16 does not state that parents will be excluded from the consent process. In fact, it should continue to be the case that health care professionals will provide information to parents and consult with them about their children's health care. It would only be in situations where minors have attained a sufficient degree of maturity to live away from their parental home, or where health care cannot otherwise be provided because of a capable minor's insistence on confidentiality, that the exclusive consent of the minor is sufficient.

Family values are fundamentally important to this government. I am confident that physicians and other health care professionals will continue to work in consultation with parents to provide sound health care to their children.

(d) New Brunswick⁷⁰³

The *Medical Consent of Minors Act*⁷⁰⁴ is based on the *Uniform Medical Consent of Minors Act* adopted and recommended at the 1975 Annual Meeting of the Uniform Law Conference of Canada. New Brunswick is the only province to have adopted the Uniform Law Conference legislation.⁷⁰⁵

The New Brunswick legislation lowers the age of consent to health care to 16. The consent of a young person under the age of 16 is valid where, in the opinion of the attending medical practitioner, the young person has the capacity to understand the nature and consequences of the proposed health care and the health care is in the best interests of the young person and his or her continuing health and well-being.⁷⁰⁶ Further, as in South Australia, a second medical practitioner must support the first medical practitioner's opinion on both these points.

(e) Alberta

The Alberta Institute of Law Research and Reform in its Report *Consent of Minors to Health Care* recommended that the general age for consent to health care be fixed at 16 years. Although the Institute recommended 16 years as the age of consent in the general situation, it considered four special situations - venereal disease, drugs and alcohol, contraception, and pregnancy and its termination. The Institute stated:⁷⁰⁷

In every one of these [four] situations we understand there is a special reluctance to inform parents, and that the minor will be harmed by failure to obtain treatment, or even by delay in obtaining it.

Because of the importance of obtaining treatment in these four situations the Institute felt that there should be no impediment whatsoever to young people obtaining advice or treatment with respect to these four specific categories. The

⁷⁰³ Information contained in this section is derived from the Manitoba Law Reform Commission's Report *Minors' Consent to Health Care* (Report #91, 1995) at 15-16.

⁷⁰⁴ RSNB-1973 c M-6.1.

⁷⁰⁵ Unlike the proposed Uniform legislation, the New Brunswick legislation does not include the area of contraceptive treatment and advice.

⁷⁰⁶ Presumably young people are also able to refuse health care. In *Walker v Region 2 Hospital Corp* (1994) 116 DLR (4th) 477 (CA), a 15 year old Jehovah's Witness suffering from leukemia refused necessary blood transfusions in the course of his treatment. The prospects of the treatment being successful were not good. His doctors and the hospital applied for authorisation that blood products be withheld in accordance with the patient's wishes. The New Brunswick Court of Appeal applied the Act and found that the young person was a "mature minor" who could determine his own treatment. The parents supported the young person's decision.

⁷⁰⁷ *Consent of Minors to Health Care* (Report No 19, 1975) at 10.

Institute recommended that there should be no minimum age of consent for these four particular categories. Where there is venereal disease involved; where there are problems with alcohol or drugs; or where it is a question of contraception or termination of pregnancy, the urgency of the situation is such that nothing should prevent a young person of any age from seeking treatment, and, if the young person feels inhibited by having to inform his or her parents, the young person should be able to obtain such treatment without any parental involvement. The Institute also made an ancillary recommendation that where a young person was under the age of 16 years, his or her power of consent under the recommendation (just mentioned) would be an alternative to that of his or her parents or guardian. The Alberta Institute's recommendations are yet to be implemented.

(f) Manitoba

In a 1995 report the Manitoba Law Reform Commission has recommended that the common law concept of maturity should be maintained to determine whether or not a young person has the power to make health care decisions.⁷⁰⁸ Thus, the Commission rejected the use of a fixed age to determine a young person's capacity to make health care decisions without parental involvement.

The Commission recommended against codifying the common law because of a concern about the danger that legislation may anchor the law "to inflexible language which reflects contemporary policies and values and by impeding the development of the law to deal with a variety of unforeseen and future changes in society and medical practice".⁷⁰⁹

⁷⁰⁸ Manitoba Law Reform Commission, Report *Minors' Consent to Health Care* (Report #91, 1995) at 33.

⁷⁰⁹ *Id.* at 34.