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CONSENT TO MEDICAL TREATMENT OF YOUNG PEOPLE

Discussion Paper
WP 44

Queensland Law Reform Commission
May 1995

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OF YOUNG PEOPLE**

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PREFACE

1993 Information Paper

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 Paper¹ 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 have been distributed and, to date, approximately 160 oral and written submissions have been received.²

In addition, a large number of individuals and organisations have been approached for information and opinions on relevant matters raised by this reference. The assistance of those who have made submissions and others who provided information and comments to the Commission in the preparation of this Paper is greatly appreciated.

Submissions on the Discussion Paper

The Commission would welcome submissions on the issues discussed in this paper (many of which have been highlighted by bold type and boxes in the text), and on the preliminary proposals for reform set out on pages 9 to 14 below. The Commission has not made a final decision in relation to any of the preliminary proposals, although it is strongly of the opinion that reform in this area is much overdue.

The health needs of young Queenslanders appear to be of little significance in the context of the current common law and in the limited statute law relating to consent to treatment. Those needs have been of principal concern to the Commission.

A further significant consideration has been the vital and appropriate 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.

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.

¹ Queensland Law Reform Commission Information Paper *Consent by Young People to Medical Treatment* May 1993.

² A list of respondents to the Information Paper is found in Appendix 1.

(ii)

Also of concern to the Commission has been the uncertain criminal and civil liability faced by health-care providers when presented with a young patient in a variety of contexts. The young person may not want parental involvement and may in fact refuse or not seek necessary treatment if he or she believed parents would be informed. Parents and child may disagree on the need for, or appropriateness of, proposed treatment. Parents of a young person in need of treatment may themselves not be legally competent to make decisions relating to the child's treatment, or may not be easily contactable to consult with on the treatment.

A number of issues discussed in this Paper 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 from non-treatment and that a requirement of parental involvement may contribute to the failure to be properly treated.

Information about how to make a submission is set out on the following page.

HOW TO MAKE COMMENTS AND SUBMISSIONS

You are invited to make comments and submissions on the issues and on the preliminary proposals in this Paper.

Written comments and submissions should be sent to:

The Secretary
Queensland Law Reform Commission
PO Box 312
ROMA STREET QLD 4003

or by facsimile on: 07 - 247 9045

Oral submissions may
be made by telephoning: 07 - 247 4544

Closing date: 31 August 1995

It would be helpful if comments and submissions addressed specific issues or preliminary recommendations in the Paper.

CONFIDENTIALITY

Unless there is a clear indication from you that you wish your submission, or part of it, to remain confidential, submissions may be subject to release under the provisions of the *Freedom of Information Act 1992* (Qld).

The Commission may refer to or quote from submissions in future publications. If you do not wish your submission or any part of it to be used in this way, or if you do not want to be identified, please indicate this clearly.

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Previous Queensland Law Reform Commission publications on this reference:

Information Paper <i>Consent to Medical Treatment</i> 1993	(MP2)
Research Paper <i>Circumcision of Male Infants</i> 1994	(MP6)
Research Paper <i>Female Genital Mutilation</i> 1994	(MP7)
Report <i>Female Genital Mutilation</i> 1994	(R47)

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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.³ 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 treatment of young people. The second part concerns consent to treatment of intellectually disabled adults.⁴

The first part of the reference has been further divided into distinct research projects to enable the Commission to deal with particular issues in detail, and to avoid confusion between seemingly disparate matters. The research projects currently being undertaken or which have been finalised include:

- (i) female genital mutilation*
- (ii) infant male circumcision*
- (iii) general legislation on consent to medical treatment of young people.*
- (iv) treatment of young people where special consent is required.*

³ Fourth Programme dated September 1990.

⁴ The latter part is dealt with by the Commission in its Draft Report on *Assisted and Substituted Decisions*, February 1995.

The Commission has published, or intends to publish, Papers covering each of these topics and other topics.⁵

2. SCOPE OF DISCUSSION PAPER

This Discussion Paper concerns item (iii) above, which addresses the general issues raised by the first part of the reference. In particular, this Paper considers the ability of young people to consent to, or to refuse, treatment and the power of parents or other substitute decision-makers to consent to, or to refuse, treatment on behalf of young people.

The Commission's principal concern in this Discussion Paper is that young people in Queensland have as great an access as possible to the treatment they require to live as healthy a life as possible. It is not the Commission's intention to diminish parental duties and responsibilities.⁶

The Alberta Institute of Law Research and Reform has identified the problem in the context of consent to treatment:⁷

The problem is to strike a proper balance between the desirability, on the one hand, of preserving the protective role of the parents and the desirability, on the other, of ensuring that a person who needs health care is not prevented from obtaining it by inability to secure the consent of his [or her] parents or by his [or her] unwillingness to disclose to them the condition that needs treatment.

It is also not the Commission's intention to restrict the ability of health-care providers to treat patients in accordance with their respective professional judgment (with the consent of the patient or the appropriate substitute decision-

⁵ The Commission has already published a Research Paper on *Female Genital Mutilation* (December 1993), a Draft Report on *Female Genital Mutilation* (July 1994) and a final Report on *Female Genital Mutilation* (September 1994), and a Research Paper on *Circumcision of Male Infants* (December 1993). These papers were preceded by a general information Paper on *Consent by Young People to Medical Treatment* published in May 1993. The contents and publication dates of future papers have yet to be determined.

⁶ See Chapter 3 for discussion on parental duties and responsibilities.

⁷ *Consent of Minors to Health Care* Report No. 19 1975 at 8.

maker).⁸ The Commission seeks to address the broader 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 should be made to ensure that young people are receiving all necessary health-care.

At present, medical practitioners and other health-care providers may be exposed to liability for criminal assault or civil trespass if the consent of a legally competent patient or substitute decision-maker is not obtained prior to treatment and if the treatment involves physical contact. The law is not certain as to when a young person achieves competence to consent to or to refuse treatment. 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 an appropriate or 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 Parliamentary Debate upon the introduction of the South Australian *Consent to Medical and Dental Treatment Act 1985 (SA)*, the Hon Anne Levy noted the reason she first became interested in this issue:⁹

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 no contact for quite some time, to get their permission to have this lump removed from her breast. Her parents refused to give permission.

Given the uncertain state of the law in Queensland, it is quite possible for a similar incident to occur here.

⁸ 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 treatment on medical, practical or economic grounds. See the UK case of 'Girl B' reported in *The Times* 11 March 1995 at 17. In that case, a health authority had refused to commit £75,000 for the treatment of a 10 year old leukaemia patient with a 2 per cent chance of success. The child's family went to court challenging the health authority's decision. 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* 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 done. 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 High Court's decision was reversed on the same day by the Court of Appeal (UK) which was of the opinion that it is not for the courts to interfere with the way health authorities make medical judgments on funding.

⁹ *Parliamentary Debates Legislative Council (SA)* 13 February 1985 at 2448.

Young people may also be inappropriately treated when a health-care provider acts on the instructions of a person who has a contrary view to the young person or who does not necessarily have the young person's best interests at heart.¹⁰

The Commission has drawn a distinction between the consent required for treatments which young people and/or parents have traditionally had the power to consent to, and consent to those treatments which the Courts or legislatures have said require 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*¹¹ (*Marion's case*) held that parents cannot consent without prior Court approval to non-therapeutic sterilisation procedures.

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 recognised¹² the necessity of making the distinction. Justice Brennan 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.¹³ "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.

As a result of the decision in *Marion's case*, approval of a court exercising *parens patriae*¹⁴ jurisdiction or the Family Court of Australia or, in certain circumstances in other jurisdictions, the approval of a State Guardianship body,¹⁵ is currently required before such a procedure can be performed. In the absence of such

¹⁰ But see pages 33 to 36 as to the limits on the parental power to consent.

¹¹ (1992) 175 CLR 218.

¹² *Id* at 250.

¹³ *Id* at 269.

¹⁴ For discussion on the *parens patriae* jurisdiction, see 36-37 below.

¹⁵ Note, *P v P* (1994) 120 ALR 545 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).

approval those involved in performing the procedure may be liable civilly and/or criminally for assault of the young person.¹⁶

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

Such procedures may include such matters as gender reassignment and serious procedures performed for purely cultural reasons.¹⁷

This Paper concerns treatments not requiring special consent.

¹⁶ It should be noted that 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 recently 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. No discussion was had 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.

¹⁷ The Family Court has recently 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: *In re A* (1993) 16 Fam LR 715.

3. USE OF TERMS

(a) Use of term *young person*

The Commission prefers to use the term "young person" rather than "child" throughout this Paper. 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,¹⁸ many of the "children" the Commission will be considering are in fact young adults.

(b) The concept of *consent*

The absence of a valid consent is a determining factor in establishing liability for criminal assault or trespass to the person. However, the Commission is interested less in health care providers' potential liability for assault than in the desirability of obtaining an appropriate consent before proceeding with any form of treatment - whether or not refusal or absence of consent for any particular treatment would result in the health care provider's criminal or civil liability.

There can be no criminal or civil liability¹⁹ for assault and battery (in Queensland the definition of "assault" under section 245 of the *Criminal Code* includes battery) unless there has been physical contact with the victim or a threat of imminent physical contact by the accused. Accordingly, treatments which do not involve physical contact, such as hypnotherapy or counselling, even if undertaken without the consent of, or in the face of refusal by, the patient, are unlikely to attract criminal or civil liability for assault.

However, interference with a person's psychological integrity can result in serious damage to the person. For that reason, although the current law may fail to provide a remedy to the patient for non-consensual interference with the person's psychological integrity, the law should not be seen as condoning such interference. There is no valid reason known to the Commission why there should not be a statutory prohibition on treating patients (whether involving physical contact or otherwise) without an appropriate consent. The Commission has proceeded on the basis that it is desirable for an appropriate consent to be obtained from the patient before any form of treatment of the patient is undertaken - whether or not treatment involves physical contact.

¹⁸ *Age of Majority Act 1974* (Qld) s5.

¹⁹ Battery and assault are crimes as well as torts. In torts they are two forms of trespass to the person.

The Commission invites comment on the proposal that it be a legal requirement for consent to be obtained before treatment is undertaken whether or not treatment involves physical contact.

(c) Use of term *treatment*

The Commission has adopted a wide definition of the term "medical procedures" as used in the terms of reference to include any type of health-care, treatment or advice provided for the health or well-being of a young person (referred to hereafter as "treatment"). It follows that treatment provided by any health-care provider, including alternative health-care providers, is considered relevant to the reference. Similarly, treatment of any nature, whether or not it involves physical contact (such as counselling, hypnotherapy or the provision of medication) is considered relevant.

There will be some types of relatively minor types of "treatment" (broadly defined) which many people might consider should not be the subject of legal consent requirements.²⁰ The following definition of "health care", which has been used in the Commission's Draft Assisted and Substituted Decisions Bill²¹, may be useful in determining the appropriate definition of "treatment" for the purposes of this Paper:²²

- (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.

²⁰ Note: accepted every day contact between people may not amount to an assault. See 83, 96, 97 below.

²¹ Ch 13 of the Queensland Law Reform Commission's Draft Report on *Assisted and Substituted Decisions* February 1995. Note the Draft Report and Bill relate only to adults.

²² Id at s17. Cf the definition of "health care" in s16(1) *Infants Act* 1992 (RSBC 1979, c196) (see 171-173 below): means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health related purpose, and includes a course of health care.

Example of subsection (2)(c) -

A visual examination of an adult's mouth, throat, nasal cavity, eyes or ears.

The Commission invites comment on the definition of "treatment" for the purposes of this reference.

(d) Use of term *health-care provider*

The doctor-patient relationship is not the only one which results in treatment of health related problems or concerns. Treatment 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. Any person treating another may be criminally and/or civilly liable if the treatment involves physical contact with the patient and if the appropriate consent has not been obtained either from the patient (if competent) or from a substitute decision-maker; liability for unauthorised treatment is not limited to medical practitioners. Moreover, the consequences to the patient of inappropriate or unauthorised treatment may be as serious for treatment provided by an alternative health-care provider as for treatment provided by a medical practitioner.

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. However, the Commission is primarily concerned with investigating issues relating to the treatment of young people by people for reward or by people who profess to be in the business of health-care.²³

The Commission invites comment on the appropriate definition of health-care provider for the purposes of discussion of the issues in this reference.

²³ In its Draft Report on *Assisted and Substituted Decisions* February 1995, 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" (Ch 13 at 129).

4. MATTERS EXCLUDED FROM REFERENCE

The Commission has decided to restrict its consideration to young people from their birth to 18 years of age. Although medical treatment of foetuses is becoming more common,²⁴ there are very strongly held community views and basic philosophical differences concerning the "rights" of the foetus versus the "rights" of the mother/parents.²⁵ Further, the issues involved in the medical treatment of foetuses, 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 medical treatment of young people (being from birth to 18 years of age). In the latter case, the medical treatment of the young person does not involve the interference with the bodily integrity of any other person in order to effect the treatment.

The Commission has not interpreted Item 4(a) of the Fourth Programme to include the ability of young people, or of substitute decision-makers to consent to the withholding, or withdrawal, of life-sustaining treatment. The Commission is of the view that separate, difficult and controversial issues are raised in considering such matters which are equally relevant to the use of life-sustaining treatments on adults. The Commission therefore believes that those issues would be best dealt with in a separate reference concerning life-sustaining treatments.

The Commission is also of the view that consent to participation in medical research should not be covered in this Reference as it may not relate specifically to the treatment of the young person. Similar issues will arise in relation to participation of adults in research projects.²⁶ It may be appropriate for a separate project to be undertaken at a future date on participation in medical research.

5. SUMMARY OF PRELIMINARY RECOMMENDATIONS

The Commission has made the following preliminary recommendations and it invites comments upon each. The Commission has made no firm decisions on any of the issues covered by this Paper.

²⁴ For example, foetuses can now successfully undergo complex surgery within the womb, such as heart operations, 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.

²⁵ If the mother refuses to permit medical intervention to assist her foetus, the foetus may die or be seriously handicapped. 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.

²⁶ In relation to participation in research projects of adults unable to consent without assistance, see Queensland Law Reform Commission Draft Report *Assisted and Substituted Decisions* February 1995.

The Commission's Preferred Scheme

Consent for all treatments

1. No one can treat a person under the age of 18 years unless there is a valid consent in accordance with the recommendations listed below or in an emergency situation where it is not practical to obtain consent. Treatment is to include treatment involving physical and/or non physical contact with the patient.

Treatment of young people 16 or older

2. At 16 years of age a young person can consent to or refuse treatment as if an adult. A health-care provider can treat the young person upon that consent and is prevented from treating the young person if he or she refuses the treatment.
3. The proposed Assisted and Substituted Decisions legislation and the jurisdiction of the Tribunal to be established thereunder should be extended to cover 16 and 17 year olds who are not legally competent to make treatment decisions or who are in need of assistance in making such decisions.

Treatment of young people 15 or younger

4. Where a registered health-care provider treats a young person 15 years of age or younger, the treatment must be, in the registered health-care provider's opinion [subjective test], in the young person's best interests. Where a non-registered health-care provider treats a young person 15 years of age or younger, the treatment must be [objective test] in the young person's best interests.

Treatment of young people 13 or older by registered health-care providers

5. At 13 years of age or older, a young person can validly consent to treatment by a registered health-care provider and a registered health-care provider can treat the young person upon that consent provided that:
 - (a) in the opinion of the health-care provider [subjective test], the young person understands the nature and consequences of the proposed treatment and of the consequences of not being treated;
 - (b) the young person has been provided with relevant information on advantages and disadvantages of the proposed treatment in a mode which the young person is likely to understand;
 - (c) the young person has signed a written "consent to treatment" form;

- (d) in the opinion of the health-care provider [subjective test], treatment is in the young person's best interests.
6. A health-care provider who is registered as a health-care provider pursuant to a Queensland statute or whose registration as a health-care provider in another jurisdiction is recognised in Queensland, acting in accordance with 5 (above) upon the consent of a young person 13 years of age or over is to be immune from criminal liability for assault or battery and from civil liability for trespass to the person or false imprisonment in relation to the provision of treatment consented to. Such immunity should extend to any person acting in aid of the registered health-care provider and under the registered health-care provider's supervision.

Treatment of young people 13 or older by non-registered health-care provider

7. At 13 years of age or older a young person can validly consent to treatment by a non-registered health-care provider and a non-registered health-care provider can treat the young person upon that consent provided that:
- (a) the young person understands [objective test] the nature and consequences of the proposed treatment and of the consequences of not being treated;
 - (b) the young person has been provided with relevant information on advantages and disadvantages of the proposed treatment in a mode which the young person is likely to understand;
 - (c) the young person has signed a written "consent to treatment" form;
 - (d) the treatment is in the young person's best interests [objective test].

Treatment of young people 13 or older upon consent of parent

8. A health-care provider can treat a young person 13 years of age or older upon the consent of a legally competent parent of the young person **BUT QUERY WHETHER** treatment should proceed over the refusal of a legally competent young person of that age.

Treatment of young people 13 or older upon consent of substitute decision-maker

9. Where a parent of a not legally competent young person 13 years of age or older is not himself or herself legally competent or conveniently contactable, or refuses consent to treatment which is in the best interests of the young person, the health-care provider can treat the young person upon the consent of a substitute decision-maker or upon the authorisation of the Supreme Court or the Family Court.

10. A substitute decision-maker for a young person 13 years of age or older who is not legally competent may be appointed by, if and when established, the proposed Assisted and Substituted Decisions Tribunal. **QUERY** alternative of extending the jurisdiction of the Children's Court to make such appointments.

Refusal of treatment by young people 13 or older

11. **QUERY WHETHER**, at 13 years of age or older, a young person who is legally competent to consent to particular treatment should be entitled to refuse such treatment provided, in the opinion of the health-care provider [subjective opinion of registered health-care provider; objective opinion of non-registered health-care provider], he or she understands the consequences of refusal.

Treatment of young people 12 or younger

12. Health-care providers can treat a young person 12 years of age or younger upon the consent of a legally competent parent of the young person. Where a parent of a young person 12 years of age or younger is not legally competent or conveniently contactable, or refuses consent to treatment which is in the best interests of the young person, the health-care provider can treat the young person upon the consent of a substitute decision-maker or upon the authorisation of the Supreme Court or the Family Court.

A substitute decision-maker for the parent of a young person 12 years of age or younger may be appointed by, if and when established, the proposed Assisted and Substituted Decisions Tribunal. **QUERY** alternative of extending the jurisdiction of the Children's Court to make such appointments.

In all cases, a registered health-care provider cannot treat a young person 12 years of age or younger unless, in his or her opinion [subjective test], the treatment is in the young person's best interests. A non-registered health-care provider cannot treat a young person unless the treatment is in the young person's best interests [objective test].

13. A health-care provider who is registered as a health-care provider pursuant to a Queensland statute or whose registration as a health-care provider in another jurisdiction is recognised in Queensland, acting in accordance with 12 (above) upon the consent of the parent of a young person 12 years of age or younger or a substitute decision-maker is to be immune from criminal liability for assault or battery and from civil liability for trespass to the person or false imprisonment in relation to the provision of treatment consented to. Such immunity should extend to any person acting in aid of the registered health-care provider and under the registered health-care provider's supervision.

Involvement of young people and parents in treatment decision-making

14. Health-care providers should be encouraged to involve young people in the decision-making process relating to proposed treatment irrespective of the age and legal competency of the young people.
15. Unless it is considered inappropriate, health-care providers should encourage young people seeking treatment to inform their parents prior to the treatment taking place.

Young people as parents

16. Young people who are parents can consent to the treatment of their children by registered health-care providers provided the young people understand the nature and consequences of the proposed treatment. In all cases, a registered health-care provider cannot treat a child of a young person unless in his or her opinion [subjective test] the treatment is in the child's best interests. A non-registered health-care provider cannot treat a child of a young person unless the treatment is in the child's best interests [objective test].
17. A health-care provider who is registered as a health-care provider pursuant to a Queensland statute or whose registration as a health-care provider in another jurisdiction is recognised in Queensland, acting in accordance with 16 (above) upon the consent of a young person, is to be immune from criminal liability for assault or battery and from civil liability for trespass to the person or false imprisonment in relation to the provision of treatment consented to. Such immunity should extend to any person acting in aid of the registered health-care provider and under the registered health-care provider's supervision.

Treatment of prescribed conditions

18. A registered health-care provider can treat a young person of any age and irrespective of the young person's legal competency, upon the request of the young person, for conditions to be prescribed by regulation. Those conditions may include sexually transmitted diseases and other serious communicable diseases. In such cases, the health-care provider shall, subject to any statutory requirement to the contrary, respect the young person's wishes relating to confidentiality.

Disagreement between parents

19. **QUERY WHETHER**, if the parents of a young person disagree as to the need for or type of treatment required for their child, then the proposed Assisted and Substituted Decisions Tribunal, the Supreme Court or the Family Court may be approached for resolution of the dispute.

Consent to examination of alleged victim of child abuse

20. A young person who is or is suspected of being at risk of abuse may be removed by authorised officers (such as Family Services officers and police) and kept in a place of safety for a 96 hour period, extendable for a further 96 hour period, during which time the Director-General or his or her delegate is deemed to have custody of the young person for the purposes of conducting a medical examination and providing necessary treatment. **QUERY WHETHER** removal should be preceded by a written request to parents or guardian to hand over the young person.

The power of hospital authorities to keep suspected victims of child abuse for a 96 hour period is to be retained, and made extendable for a further 96 hour period.

During the currency of a 96 hour order, the consent of the Director-General or his or her delegate to medical examination or treatment is sufficient in the absence of parental consent.

A written protocol is to be developed as to the obtaining of consent to medical examination and treatment of suspected victims of child abuse.

A medical examination is not to proceed over the refusal of the young person.

Ability to consent where legal duty exists

21. **QUERY WHETHER**, if a person or institution (the carer) is under a legal duty to provide treatment to a young person who is not legally competent and where, in the opinion of a registered health-care provider and the carer, a delay in treating the young person in order to locate legally competent parents or to obtain the appointment of a substitute decision-maker would prejudice the health of the young person, the carer should be able to consent to the treatment and should the registered health-care provider and the carer be immune from liability.

Retention of *parens patriae* jurisdiction

22. The *parens patriae* jurisdiction of the Supreme Court is to be specifically retained.

CHAPTER 2

THE HEALTH OF YOUNG QUEENSLANDERS

1. INTRODUCTION

As noted in Chapter 1 above, the Commission's aim is to ensure, as far as possible, that young people in Queensland are able to access the treatment they require to live as healthy a life as possible. Neither the law nor family influences should prevent young people from being treated when needed. Obviously, even if the law were clear, concise and conducive to young people obtaining necessary treatment, there would be other factors beyond the reach of the legislature which would influence whether or not a young person had access to necessary treatment, such as, for example:

1. 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 children's health and well-being; and fears about potential liability for assault based upon possibly misconceived interpretations of the law;
2. some parents will seek to influence their child's decision whether or not to seek treatment despite the wishes and/or best interests of the child. For example, a parent may threaten to turn their child out of home if the child sought contraceptive advice or treatment without the parent's permission;
3. young people 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;
4. young people may believe they are unable to seek necessary treatment if they do not personally have the ability to pay for the treatment.

It is hoped that the options for reform set out in this paper will either address some of these concerns or inspire more innovative suggestions for reform, by way of submissions, to encourage and facilitate necessary treatment for young people.

2. HEALTH NEEDS OF YOUNG QUEENSLANDERS

Australia's young people generally enjoy good health by world standards, with notable exceptions being Aboriginal and Torres Strait Islander peoples, the

economically disadvantaged and homeless young people.²⁷ Recently acknowledged health problems affecting young people include, in addition to the usual problems:²⁸

child abuse; eating disorders; developmental, behavioural and emotional problems; health-damaging behaviours; suicide and attempted suicide; the health effects of homelessness; and the late recognition and management of mental illness.

The importance of addressing such health concerns in a timely and effective manner will likely result in a healthier adult population:²⁹

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 and adolescence are times of maximum development in physical, psychological and social skills; illness, neglect, abuse and injury can impede developmental processes and have substantial effects, in some cases continuing into adulthood.

Also, at a broader level:³⁰

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, no Australian domestic law has been introduced to give effect to the Convention.³¹

The consequences of not being able to obtain treatment 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 case of

²⁷ Australian Health Ministers' Advisory Council Working Party on Child and Youth Health *The Health of Young Australians* Draft Policy Paper, September 1994 at 2.

²⁸ Ibid.

²⁹ Id at 3.

³⁰ Ibid.

³¹ But see *Minister of State for Immigration and Ethnic Affairs v Teoh* High Court of Australia 1 April 1995, 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 Court held that Australia's ratification of the UN *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 Mason CJ and Deane J at 12-13,15, Toohey J at 15-16, and Gaudron J at 31.

influenza may have no adverse health consequence, apart from a prolonged suffering. 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 to suicide. As will be explained in a later chapter,³² parental involvement in or prior to treatment for psychiatric or psychological disorders in young people may be tragic, as the parent's relationship with the child can sometimes contribute to the problem. At other times parental involvement may be essential for precisely the same reasons.

Health problems and concerns vary in significance for young people.³³

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.

Thus, in infancy and early childhood, significant health issues include: maternal health, low birth weight, immunisation, sudden infant death syndrome, nutritional problems, respiratory and gastro-intestinal illnesses, unintentional poisonings and injuries, developmental issues and child abuse.

In primary school years, concerns include: asthma; middle ear and other infections; communication, learning and behavioural problems; accidental injury; and abuse.

In adolescence and teenage years, emotional health becomes a significant issue, including concerns about self-awareness, sexuality, body image, acne and dieting, health-damaging behaviours such as smoking and binge-drinking. Eating disorders, mental health problems (such as depression and schizophrenia), substance abuse and factors relating to sexual health may arise.

The Australian Health Ministers' Advisory Council has recognised that:³⁴

many of the health issues from the early teens continue into the late teens and early adulthood. For some, a key difference will be in the shift of responsibility for personal health care from the family to the young individual. Many may be coping with limited financial resources. Some will be endeavouring to cope with the problems of parenting and family formation. These tasks will be more complex if they are experiencing unemployment, there is an unintended pregnancy or health is compromised by road traffic or sporting injury or by the onset of mental illness.

³² See 118-128 below.

³³ Australian Health Ministers' Advisory Council Working Party on Child and Youth Health *The Health of Young Australians* Draft Policy Paper, September 1994 at 6-7.

³⁴ *Id* at 7.

The incidence of suicide and suicide attempts in this age group is of great concern. ... The health services issues for this age group are wide ranging and need sensitive management. In particular their psychological health clearly requires special attention.

3. 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.³⁵

In 1989 the report of the National Inquiry by the Human Rights and Equal Opportunity Commission into Homeless Children³⁶ was presented to the Commonwealth Parliament. That report, often referred to as the Burdekin Report, highlights a number of problems experienced by homeless young people in Australia. This is the only comprehensive report on homeless young people in Australia. Significant concern was expressed in the Report about the health of homeless young people. It was estimated that there were between 50,000 to 70,000 young people in Australia who were homeless or at serious risk of becoming homeless.³⁷

The National Health and Medical Research Council repeated the Burdekin Report's observations in 1992.³⁸ It is apparent that similar observations could be made today in Queensland, despite a number of innovative programs established to address the problem.³⁹

It was apparent to the Burdekin Inquiry that the lifestyle of the homeless involves many risks to life and health including:⁴⁰

malnutrition and other diet related illnesses;

³⁵ National Health and Medical Research Council *Health Needs of Homeless Youth* 1992 at 2.

³⁶ Human Rights and Equal Opportunity Commission *Our Homeless Children* 1989 (The Burdekin Report).

³⁷ *Id* at 69.

³⁸ National Health and Medical Research Council *Health Needs of Homeless Youth* 1992.

³⁹ See McLean K *Innovative Health Services for Homeless Youth Program Evaluation Report* 1993. Also note Queensland Health *Youth Policy Reports by Region* 1993.

⁴⁰ The Burdekin Report at 235.

- . 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 needles;
- . behavioural disorders, the causes of which may lie in the isolation, alienation and rejection of the homeless;
- . psychiatric illnesses;
- . 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:⁴¹

- . 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;
- . sleeping problems;
- . poor physical and dental hygiene;
- . skin infestations;
- . gastrointestinal infections;

⁴¹ National Health and Medical Research Council *Health Needs of Homeless Youth* 1992 at 4-5.

- . 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);
- . pregnancies resulting in miscarriages and premature deliveries appear to be more common;
- . infertility may result from factors such as drug abuse;
- . 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 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;
- . musculo skeletal 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:⁴²

... 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. ...

⁴² Burdekin Report at 236 quoting Dr Vicky Pearson.

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.

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.⁴³

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 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.⁴⁴ The majority of witnesses to the Burdekin Inquiry linked substance

⁴³ Burdekin Report at 237.

⁴⁴ Burdekin Report at 237, 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 schools survey respondents. Three issues of particular concern arose from the study: high levels of

abuse to low self-esteem and other psychological, developmental and social factors. For example, one witness observed:

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 of their alienation from society in general".⁴⁵

The barriers to homeless young people seeking medical attention, even if it is available, are numerous. The Burdekin Inquiry heard that cost was a major barrier, as many young people did not have their own Medicare card⁴⁶ or a Department of Health Care card, nor could they afford to fill prescriptions.⁴⁷ Specialist care, including dental treatment and physiotherapy, was beyond the reach of most homeless young people. They often distrust authority figures such as professionals and fear that parents may be contacted.⁴⁸ The National Health and Medical Research Council also observed that there are particular problems related to consent to treatment in "under-age adolescents" because of lack of access to parents and guardians.⁴⁹

binge drinking, physical and sexual abuse, and attempted suicide.

⁴⁵ Burdekin Report at 239.

⁴⁶ Burdekin Report at 52. The National Health and Medical Research Council in *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 to the Commission from the Eligibility and Benefits Manager, Medicare, 8 June 1993).

⁴⁷ Burdekin Report at 52.

⁴⁸ Id at 52 per submission of T Campbell, Hedland Community Youth Services.

⁴⁹ National Health and Medical Research Council *Health Needs of Homeless Youth* 1992 at 6.

4. YOUNG PEOPLE LACKING READY ACCESS TO PARENTAL ASSISTANCE

Young people who are not legally competent to consent to their own treatment due to age or physical or intellectual disability may be in the situation where necessary treatment cannot be consented to by a parent. If the situation does not involve an emergency⁵⁰ and the young person is not a ward of the State⁵¹ or has not been the subject of an appropriate application to the Supreme Court⁵² or to the Family Court,⁵³ health-care providers and those in whose care the young person rests may be in a dilemma as to the legal requirements to be met prior to treatment taking place.

The Commission has been informed of facilities in Queensland for the accommodation and care of people with disabilities in which some young residents have little or no contact with their parents. The young person may not have been the subject of an application to the appropriate court to seek authorisation for treatment 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 the refusal by parents to consent to appropriate treatment.⁵⁴ Those in whose care the young person rests owe various legal duties to the young person - such as the duty to provide necessities of life including appropriate medical treatment.⁵⁵ However in fulfilling those duties the care provider and the health-care provider may find themselves liable, at least under the civil law, for proceeding with the treatment without appropriate consent.⁵⁶ The following scenarios have been put to the Commission by a Queensland Society providing care and accommodation to

⁵⁰ See discussion on the issue of consent in emergency situations at 100-103 below.

⁵¹ Pursuant to care and protection proceedings commenced under the *Children's Services Act 1965* (Qld).

⁵² Under that Court's *parens patriae* jurisdiction. See discussion at 36-37.

⁵³ Under that Court's welfare jurisdiction, in relation to non-therapeutic treatment. See 38-39 below. Also see discussions on *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 at 57-59 below.

⁵⁴ 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.

⁵⁵ See discussion on parental duties and responsibilities in Chapter 3 below.

⁵⁶ See Ch 9 below. A person might be excused from criminal responsibility for the consequences of treating without appropriate consent if in doing so he or she is simply performing a legal duty. Section 31 of the *Criminal Code* (Qld) reads:

A person is not criminally responsible for an act or omission, if he [or she] does or omits to do the act under any of the following circumstances, that is to say -

(1) In execution of the law [emphasis added].

young people with physical, and at times, intellectual disabilities. The scenarios illustrate the particular problems confronting the young person, the care provider and the health-care provider:

A 14 year old has always lived in either the Society's Nursing Home or one of the Society's Supported Accommodation Units. The mother had spasmodic contact with the young person until her death 2 years ago. The father had no contact with his child for 10 years. Currently, contact is only achieved at the Society'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 Society acknowledges its duty of care to ensure the best available treatment for the young person, but is concerned about its ability to consent to the operation and about the authority, if any, the grandmother may have to refuse treatment for her grandchild.

Comment

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).⁵⁷

The grandmother would have no authority at law to consent to or to refuse treatment for her grandchild, and the father would have no authority to delegate his power to make decisions in relation to the treatment of his child. The Society would have a duty to ensure the young person is treated in the best possible manner but it would have no automatic right to consent to treatment.

⁵⁷ See discussion on this provision at 88-90 below.

A 13 year old, who was placed in the Nursing Home at birth, goes to a general practitioner and is prescribed antibiotics for a slight infection. The young person's parents are unable to be contacted as their whereabouts are unknown.

The medication has side effects which are explained to the support staff. The staff are concerned about the medication and would not accept the risk of the side effects for their own children. The Society is uncertain whether it has a right in law to request the doctor to prescribe an alternative.

Comment

In consenting to the original treatment of the young person, the Society could be seen as fulfilling its duty of care to the young person. That duty of care would also, presumably, extend to requesting changes to treatment if undesirable side effects were observed. Criminal and civil liability may be incurred if the Society failed to perform the duty of care.

A further case, which has been recently recounted to the Commission by an experienced lawyer is described below.

A 16 month old child with a septic knee required an operation to avoid being crippled. 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.

Comment

Without seeking to make the child a ward of the State and thereby possibly jeopardising his or her future relationship with his or her parents, and without going to the expense and effort of making an application to the Family Court or to the Supreme Court pursuant to its *parens patriae* jurisdiction, there is currently no facility for substitute decision-making for young people who are not legally competent in Queensland. In these circumstances, health-care providers might consider the risk to them of criminal prosecution or civil litigation to be outweighed by the immediate or short-term needs and interests of the child. However, it could also be that the most vulnerable people in our community - such as abandoned children - are thereby denied the protection and security of the law which is currently available to young people who are not legally competent in the care of legally competent parents and, to a certain extent, adults who are not legally competent.⁵⁸

⁵⁸ See this Commission's Draft Report on *Assisted and Substituted Decisions* February 1995.

Similar dilemmas may arise where a young person who is not legally competent is in need of treatment whilst in a boarding school or is in need of treatment whilst attending day school if parents are not contactable or not easily contactable.

It appears that the Queensland Department of Education does not have specific policies on the treatment of young people in its care apart from a 1988 departmental instruction relating to the administration of medication to students.⁵⁹ The Department and individual school authorities would owe certain duties of care to young people under their care and control but do not have any specific immunities from liability for participating in treatment decisions vis à vis 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 treatment, the person in whose care the young person rests will have no legal authority to consent to the young person's medical treatment. This may pose a significant hindrance to meeting the health needs of such young people. Health-care providers may be reluctant to treat without appropriate consent, due to possible criminal and/or civil law consequences. Care-providers may be reluctant to seek such treatment due also to the possibility of being liable for their actions. However, as illustrated above, the care provider may also be held liable for failing to fulfil legally prescribed duties towards the young person.

Not all individuals and institutions caring for young people who are not legally competent will be the most appropriate substitute decision-makers in relation to proposed treatment for the young people. If substituted decision-making is to be considered as an option for reform in this area it may be appropriate for the non-parent carer (whether an individual or an institution) to be approved by an independent authority such as a Court or Tribunal to make all such decisions. It may also be appropriate to nominate an individual within the institution as a substitute decision-maker, rather than the institution itself in an attempt to ensure that there is a personal interest in the welfare of the young person.⁶⁰

⁵⁹ Informal communication with Litigation and Legal Operations Unit, Administrative Law and Legislative Operations Branch, Department of Education, January 1995.

⁶⁰ See 200-201 below.

CHAPTER 3

PARENTAL DUTIES AND RESPONSIBILITIES

1. THE CURRENT LEGAL POSITION

(a) The Common Law

Parents have an extremely important role in protecting their children. That protection has included protection from the young person's 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 has stated:⁶¹

the 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 treatment 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 the child, including the power to consent to medical treatment on behalf of the child. When young people are in the care and control of adults other than parents, such adults also owe duties of care to these young people. Those in charge of an institution having a young person in its custody are under a statutory duty of care to the young person.⁶²

In *Secretary, Department of Health and Community Services v JWB and SMB*⁶³ (*Marion's case*), Justice Brennan has described the parental power as follows:⁶⁴

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

⁶¹ *Hewer v Bryant* [1970] 1 QB 357 at 369.

⁶² See *Children's Services Act 1965* (Qld) s40 set out on 30 below.

⁶³ (1992) 175 CLR 218.

⁶⁴ *Id* at 278.

limits, the parents' responsibilities and powers may be exercised for what they see as the welfare of their children.

In the same case, Justice McHugh acknowledged the suggestion that the rights and responsibilities of parents arise out of the duty of parents to support and maintain a child which they have brought into the world.⁶⁵ He cited Blackstone's assertion that the duty:⁶⁶

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.⁶⁷

The true basis for the parental power to consent was identified by Justice McHugh as being the child's right of advancement. He explained the basis as follows:⁶⁸

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:⁶⁹

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 perceives 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.

Justice McHugh observed that if, as part of such parental obligations, parents were under a specific duty to provide medical treatment for their children, then the power of a parent to consent to medical treatments would be a necessary corollary of,

⁶⁵ *Id* at 312.

⁶⁶ Blackstone *Commentaries* 17th ed (1830) vol 1 at 452.

⁶⁷ *Marion's case* at 312.

⁶⁸ *Marion's case* per McHugh J at 315.

⁶⁹ Bromley and Lowe *Family Law* 7th ed (1987) at 254.

and derive from, that duty.⁷⁰ However, at least at common law there appears to be no such duty on parents. This may be because in the centuries when the common law was developing, doctors did not hold influential positions in the community. However, over the last hundred years, legislation has made it an offence in certain circumstances for parents to fail to provide medical treatment for their children. In Queensland, for example, it is an offence if parents or other people in charge of a young person wilfully neglect to provide medical treatment for the young person and the neglect is likely to result in harm to the young person.⁷¹

However, Justice McHugh observed of this and similar legislation in the other jurisdictions:⁷²

[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 which parents have towards their children cannot form the basis for the power parents have to consent to medical treatment.

(b) The Family Law Act 1975 (Cth)

The position at common law is now entrenched in the *Family Law Act 1975 (Cth)*, which recognises the status of parents⁷³ as the guardians and custodians of a child, subject to any order of a court, until the child attains the age of eighteen.⁷⁴ 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 medical treatment of their children is not a matter subject to specific regulation under the Act, that power is included within this general grant of rights.

⁷⁰ *Marion's case* per McHugh J at 315.

⁷¹ *Children's Services Act 1965 (Qld)* s69.

⁷² *Marion's case* per McHugh J at 313-314.

⁷³ "Parent" is defined in the Act without reference to age, and includes an adoptive parent of a child (s60), and a person whose spouse or de facto partner has had a child by artificial conception procedures (s60B).

⁷⁴ See *Family Law Act 1975 (Cth)* s63F(1).

(c) The Children's Services Act 1965 (Qld)⁷⁵

Section 40 of the *Children's Services Act 1965 (Qld)* imposes certain duties upon institutions having the custody of a young person.⁷⁶

The governing authority and person in charge of an institution (whether or not established or licensed under this Act) having in its or 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 treatment is established by subsection (d) it does not appear that this overrides the requirement for there to be an adequate consent to the proposed treatment. 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 treatment of the young person.

Section 69 of the *Children's Services Act 1965 (Qld)*, which creates offences in relation to the health of young people, reads in part:

- (3) A person having the charge of a child shall be deemed to have neglected him [or her] in a manner likely to cause him [or her] unnecessary suffering or to injure his health physical or mental, as the circumstances may indicate, if -
- (a) being able to so provide from his [or her] own resources, he [or she] fails to provide adequate food, clothing, medical treatment, lodging or care for such child; or

⁷⁵ Note: this Act is currently being reviewed by the Department of Family Services and Aboriginal and Islander Affairs.

⁷⁶ 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".

- (b) being unable to so provide from his [or her] own resources, he [or she] fails to take all lawful steps within his [or her] 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. ...

(d) The *Criminal Code* (Qld)

Sections 285 and 286 of the Queensland *Criminal Code* establish certain duties in people, who may be punished under the provisions of the Code for the failure to fulfil those duties.⁷⁷ The duties are, for practical purposes, the same as those imposed by the common law.

Section 285 states:

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 himself [or herself] 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 he 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 impose a duty on a boarding school, for example, to provide health care to boarders too young, or for any other reason unable, to do so themselves.

⁷⁷ *Criminal Code* (Qld) ss324 (failure to provide necessaries), 328 (negligent acts causing harm). Similar provisions are found in clauses 227 (negligent acts causing harm) and 230 (failure to provide necessaries) of the *Criminal Code Bill 1994: Draft for Public Consultation* Department of Justice and Attorney-General December 1994.

Whether one person has charge of another is a question of fact,⁷⁸ except where the law imposes the charge.⁷⁹ A person standing *in loco parentis* [in the place of a parent] to a young person would also have the duty to provide necessaries of life. A person is said to be *in loco parentis* towards a young person where he or she assumes the 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.⁸⁰

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

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 his [or her] household, to provide the necessaries of life for such child; and he [or she] 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 respecting the wishes of a legally competent child to refuse medical treatment or to the situation of a parent purporting to override such refusal pursuant to his or her duty. It is also unclear why a 16 years of age limit was imposed on the duty.

The proposed *Criminal Code Bill 1994* (Qld)⁸¹ reproduces section 285 of the Code in plain English.⁸² Section 286 of the Code is sought to be amended and renamed "Duty of Parent". The proposed new provision would cover parents and those standing *in loco parentis* to a young person. It retains the 16 years of age limit on the duty. This may imply that at 16 a young person is not owed a duty by his or her parents relating to the provision of the necessaries of life (irrespective of the maturity and independence of the young person). The proposed clause 56 reads:

⁷⁸ *Bennet v Bennet* (1879) 10 ChD 474 per Jessel MR at 477.

⁷⁹ *R v Macdonald and Macdonald* [1904] St R Qd 151; [1904] QWN 50. Medical attention and remedies may be necessaries. Unreasonable refusal to allow a surgical operation would be a failure to provide medical aid and would so amount to a failure to provide the necessaries of life - *Oakey v Jackson* [1914] 1 KB 216; [1911-13] All ER Rep 681 (parent's refusal to allow child to undergo operation to remove adenoids).

⁸⁰ *Powys v Mansfield* (1837) 3 My & Car 359; 40 ER 964.

⁸¹ Department of Justice and Attorney-General Queensland *Criminal Code Bill 1994: Draft for Public Consultation* December 1994.

⁸² *Id* cl 55.

Duty of Parent

56(1) In this section -

"parent" of a child means a parent, foster parent, guardian or other adult in charge of the child.

(2) A parent of a child under 16 years must -

- (a) provide the necessaries of life to the child; and
- (b) use reasonable care and take reasonable precautions to avoid or prevent danger to the child's life, health or safety; and
- (c) take all reasonable action to rescue the child from danger to the child's life, health or safety.

(3) It is immaterial how the child came to be in the parent's charge.

(4) A person is not in charge of a child only because the person has access to a child under a court order.

If a parent or a person "in charge of" or *in loco parentis* to a young person authorises the treatment of the young person pursuant to one of the duties referred to above, it is unlikely that they or the treating health-care provider would be liable for criminal assault for lack of appropriate consent on the part of a legally competent young person.⁸³ It could be argued that the "assault" was authorised because it arose from the obligation to fulfil a legally imposed duty. Section 246 of the *Criminal Code* provides:

An assault is unlawful and constitutes an offence unless it is authorised or **justified or excused by law [emphasis added]**.

Section 31 of the *Criminal Code* provides:

A person is not criminally responsible for an act or omission, if he [or she] does or omits to do the act under any of the following circumstances, that is to say -

- (i) **In execution of the law ... [emphasis added]**

2. LIMITATIONS ON THE POWER OF A PARENT TO CONSENT

Several limitations are imposed by the courts upon the power of parents to consent to the treatment of their children. They are as follows:

⁸³ But see Ch 9 for a discussion of whether the health-care provider could still be liable for civil assault or battery.

(a) No right to absolute control

In the nineteenth and early twentieth century the power of a parent to consent to medical treatment 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.

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 a child as an independent person. In particular, the emphasis on the welfare of the child as an overriding consideration in disputes of any nature concerning children is inconsistent with complete control by a parent. As noted by the majority of the High Court in *Marion's case*:⁸⁴

The overriding criterion of the child's best interests is itself a limit on parental power.

Justice McHugh, in highlighting that parents are 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)*⁸⁵ that a parent's power to consent to medical treatment on behalf of a child diminishes gradually as the child's capacity and maturity grows. He concluded:⁸⁶

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 child

A parent has no authority to consent to the medical treatment 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.⁸⁷ If a parent purports to consent to a treatment which is not in the best interests of the child, the consent is of no effect and any person acting on such

⁸⁴ (1992) 175 CLR 218 at 240.

⁸⁵ [1986] 1 AC 112. See Ch 6 below.

⁸⁶ *Marion's case* at 315.

⁸⁷ *Id* at 240.

consent would be guilty of assault if any physical interference is involved.⁸⁸ Notably, what is in the best interests of a child is a matter to be determined objectively.⁸⁹

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

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

The accepted fiduciary relationships are sometimes referred to as relationships of trust and confidence or confidential relations. Justice Mason has described the critical feature of these relationships as follows:⁹⁰

The 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:⁹¹

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. Justice McHugh in *Marion's case*⁹² 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.

⁸⁸ See *Marion's case* per McHugh J at 316. It is possible for legally competent adults to consent to treatment which may not be in their best interests.

⁸⁹ See *Marion's case* and the comments of McHugh J at 316 and of the majority at 240. Note that the terms "in the best interests" and "for the welfare" are used interchangeably by the High Court.

⁹⁰ *Hospital Products Ltd v United States Surgical Corporation* (1984) 156 CLR 41 at 96-97.

⁹¹ *Id* at 97.

⁹² *Marion's case* 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. Justice McHugh notes:⁹³

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 section 64(1)(c) of the *Family Law Act 1975* (Cth) 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 assumed.

3. JURISDICTION OF THE COURTS IN RELATION TO CHILDREN

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

The Supreme Court is invested with a jurisdiction known as the *parens patriae* jurisdiction.⁹⁴ That jurisdiction was described by Lord Esher MR in *R v Gyngall*⁹⁵ as follows:⁹⁶

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.

⁹³ Ibid.

⁹⁴ 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.

⁹⁵ [1893] 2 QB 232.

⁹⁶ Id at 241.

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.⁹⁷ In *Marion's case*⁹⁸ the majority of the High Court made the following observation in relation to the *parens patriae* jurisdiction:⁹⁹

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.¹⁰⁰

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.¹⁰¹

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 18.¹⁰²

⁹⁷ This view has attracted some criticism. See, eg, Eekelaar J 'The Eclipse of Parental Rights' (1986) 102 *LQR* 4 at 8, where he 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 *MLR* 569.

⁹⁸ (1992) 175 CLR 218.

⁹⁹ *Id per* Mason CJ, 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 social implications.

¹⁰⁰ *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 69-77 below for a discussion of these cases in the context of the refusal of treatment by a young person.

¹⁰¹ *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.

¹⁰² *In Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1. This Commission has in its recent Draft Report *Assisted and Substituted Decisions* February 1995 recommended at paras 3.8.1 - 3.8.6 that the *parens patriae* jurisdiction over adults with a mental or intellectual disability not be abolished.

(b) Welfare jurisdiction of the Family Court

Amendments to the *Family Law Act 1975* (Cth) made in 1983¹⁰³ 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".¹⁰⁴

Section 63(1) of the *Family Law Act 1975* (Cth) confers jurisdiction on the Family Court "in relation to matters arising under this Part". The "welfare of a child of a marriage" is such a matter, by virtue of section 64 of the Act, which provides:

In proceedings in relation to the custody, guardianship or welfare of, or access to, a child -

...

(c) ... the court may make such order in respect of those matters as it considers proper... **[emphasis added]**

Application can be made to the Family Court pursuant to section 63C of the *Family Law Act 1975* (Cth) to authorise particular medical treatment, which may be beyond the scope of a parent's power of consent.¹⁰⁵ The jurisdiction could also be used to resolve other disputes in relation to the medical treatment of young people.

(c) Relationship between the *parens patriae* jurisdiction of the Supreme Court and the welfare jurisdiction of the Family Court

In *P v P*¹⁰⁶ the majority of the High Court held that the Family Court had power to authorise medical treatment which would otherwise be contrary to the *Guardianship Act 1987* (NSW). In that context, the Court had occasion to consider the relationship between the *parens patriae* jurisdiction of the Supreme Court of New South Wales and the welfare jurisdiction of the Family Court.¹⁰⁷

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*

¹⁰³ *Family Law Amendment Act 1983* (Cth).

¹⁰⁴ *Marion's case* (1992) 175 CLR 218 at 256.

¹⁰⁵ *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.

¹⁰⁶ (1994) 120 ALR 545.

¹⁰⁷ *Id* per Mason CJ, Deane, Toohey and Gaudron JJ at 558.

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 Court addressed that eventuality:¹⁰⁸

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.

¹⁰⁸ *Ibid.*

CHAPTER 4

CONFIDENTIALITY

1. 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 would remain confidential.

In addition to any personal undertaking not to reveal certain information obtained from patients, many health-care providers in possession of such information are bound by the ethics of their profession or by their own moral belief not to breach the confidence of their patients. For example, the Australian Medical Association (AMA) Code of Ethics restrains members from revealing confidential information obtained by them during their professional relationships:¹⁰⁹

In general, keep in confidence information derived from your patient, or from a colleague regarding your patient, and divulge it only with the patient's permission, except when a court demands.

Appendix 2 sets out the ethical position of a number of other health-care providers in relation to confidentiality. None of the Codes of Ethics reviewed by the Commission exclude legally competent young people from the health-care providers' ethical obligation to maintain confidentiality. Most are also silent with regard to any duty of confidentiality to young people who are not legally competent.¹¹⁰

The social practice of designating certain information as confidential has a twofold aim.¹¹¹ 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.

¹⁰⁹ Australian Medical Association *Code of Ethics* July 1992.

¹¹⁰ But see, e.g., The Australian Psychological Society's *Code of Ethics* in Appendix 2 of this Paper, which could be read as denying young people autonomy in the relationships with their psychologists.

¹¹¹ Confidentiality and the related concept of privacy have been the subject of a number of reports in Australia and overseas. For example: The ALRC *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 (1976) the "Mann Committee"; 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.¹¹²

One of the complicating aspects of the confidentiality issue in the context of the treatment of 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 medical treatment 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 medical services is between the parent and the doctor.

The purpose of this chapter, however, is to set out the general law relating to confidentiality, as it applies to those people who at law have the capacity to make their own decisions as to health care. It is not the purpose of this chapter to examine the particular issues of confidentiality which apply to young people who are not legally competent.¹¹³ Moreover, it is not the Commission's intention to make recommendations with a view to altering the law of confidentiality as it relates to young people who are not legally competent, their parents and their health care providers.

¹¹² The Law Reform Commission of Western Australia has summarised the law in this area in its Report on *Confidentiality of Medical Records and Medical Research* (Project No. 65 Part II 1990) Appendix II.

¹¹³ As far as those 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 medical treatment of a young person to the young person's parents. In *Furniss v Fitchett* [1958] NZLR 396 at 405-406 (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* [1986] 1 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 exceptions to the duty of confidence noted in section 5 below would also apply to a young person who is not legally competent, as well as to a legally competent young person.

2. 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.¹¹⁴

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 may extend to mental distress caused by the breach, provided that the possibility of such damage was contemplated by the parties.¹¹⁵ An injunction may lie to restrain a threatened breach of confidence where the breach 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 to proceed directly against the employee or agent for breach of the fiduciary duty that person owes the patient.¹¹⁶

¹¹⁴ *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.

¹¹⁵ *Baltic Shipping Company v Dillon* (1993) 176 CLR 344.

¹¹⁶ 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.

3. 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 client may be able to look to equity¹¹⁷ for protection.

Certain relationships are characterised by an equitable duty of confidentiality.¹¹⁸ Doctor-patient, lawyer-client and banker-customer are some of the relationships giving rise to such a duty.¹¹⁹

Since such a duty is equitable, the normal equitable remedies apply. The court may grant an injunction to prevent anticipated breaches of confidentiality. 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.¹²⁰

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 situations 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 be subject to an equitable duty of confidence as regards the information entrusted to them. The

¹¹⁷ 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.

¹¹⁸ 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.

¹¹⁹ *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 *AG v Guardian Newspapers (No 2)* [1988] 3 WLR 776 per Lord Keith at 781.

¹²⁰ Gurry F 'Breach of Confidence' *Essays in Equity* (1985 ed PD Finn) 110 at 112. *AG v Guardian Newspapers (No. 2)* [1988] 3 WLR 776 per Lord Keith at 782. For a contrary view see that of Lord Griffiths in the same case at 795.

duty cannot be legally overridden merely on the instructions of the confidant's superior.¹²¹

4. STATUTORY OBLIGATIONS

Certain health care providers will also be subject to a statutory duty of confidence. Section 5.1(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 1939* (Qld) provides that people involved with the administration of 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 1939* (Qld) impose similar restrictions on people involved in the administration and notification of incidents of cancer.

5. 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.¹²² 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 debt against the patient.¹²³ 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

¹²¹ *Slater v Bissett and Another* (1986) 85 FLR 118, a decision of the Supreme Court of the Australian Capital Territory.

¹²² Such information may be disclosed with the consent of the client. Disclosure with consent is not an exception to the duty of confidence since the quality of confidentiality no longer applies to the information.

¹²³ See ALRC *Report on Privacy* (Report No. 22 1983) Vol 1 para 915.

the medical records are discoverable in a court action. There are a number of statutory provisions in Queensland which impose mandatory reporting requirements for certain diseases or conditions.¹²⁴

The law of confidentiality also recognises the defence of disclosure "in the public interest". The cases where disclosure has been held to be so justified concern criminal or illegal activity or the prevention of harm to innocent people.¹²⁵

Section 5.1(2) of the *Health Services Act 1991* (Qld) also provides for a number of exceptions to the statutory duty of confidence contained in section 5.1(1) of that Act.

6. DISCIPLINARY PROCEEDINGS

In addition to the possibility of being the subject of legal proceedings, a health-care provider may also be the subject of disciplinary proceedings for breach of confidence. 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."¹²⁶ The Board would need to determine whether the disclosure of information in the circumstances constituted such conduct.¹²⁷

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.

¹²⁴ For example, notifiable diseases under s32A *Health Act 1937* (Qld).

¹²⁵ See *W v Edgell* [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.

¹²⁶ *Medical Act 1939* (Qld) s35. See also *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513 at 521-522.

¹²⁷ 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).

7. 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.

8. CONFIDENTIALITY AND TREATMENT 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 treatment decisions affecting the young person.

The fear held by a young person that health-care providers will insist on parental involvement may deter the young person from seeking treatment in the first place. The consequences of a failure to treat may be tragic.

There will 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, will be detrimental to the young person - for example, where parents alone have knowledge of their child's medical and treatment history.

The current law does not provide a solution to these difficult situations. For example, a very young but apparently mature young person may be treated without parental involvement. Also, however, a health-care provider may be reluctant to treat a 16 year old without parental involvement through fear of making a wrong decision about the young person's maturity and thus exposing himself or herself to criminal and/or civil liability for assault and battery.

CHAPTER 5

THE NEED FOR CONSENT

Subject to certain exceptions - for example, situations of emergency¹²⁸ or self-defence, jostling in a crowd or the normal incidents of contact sport - any voluntary touching 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 assault charge.¹²⁹

This general rule also applies to physical contact made during the treatment of any person unless there is a specific statutory provision to the contrary. The intention or motives of the health-care provider are irrelevant. The act of touching in the absence of an appropriate consent 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.¹³⁰ Cardozo J in *Schloendorff v Society of New York Hospital* described the principle as follows:¹³¹

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

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.¹³²

¹²⁸ See 100-103 below.

¹²⁹ *Criminal Code (Qld)* s245; *Collins v Wilcock* [1984] 1 WLR 1172, [1984] 3 All ER 374; *Horan v Ferguson* (Unreported, Court of Appeal Qld, CA No 85 of 1994, 23 September 1994). See 83, 96, 97 below.

¹³⁰ *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 per Mason CJ, Dawson J, Toohey J and Gaudron J at 233.

¹³¹ (1914) 105 NE 92 at 93.

¹³² *Marion's case* per Mason CJ, Dawson J, Toohey J and Gaudron J at 235.

The adult test for competency to consent to medical treatment is whether or not the adult is able to understand broadly the nature and consequences of the decision.¹³³

In Australia, consent by an adult which is sufficient to permit interference with bodily integrity must also be "real" consent.¹³⁴ For the purposes of an action for trespass to the person or of a criminal assault charge, a "real" consent is one which has not been obtained by fraud or by misrepresentation of the nature of the procedure.¹³⁵ 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.¹³⁶ Fleming comments:¹³⁷

Consent does not have to be 'informed' to be 'real'. The reason for this distinction lies less in doctrinal finesse¹³⁸ 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.

For adults in need of assistance in decision-making, a number of legal procedures have been adopted 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 is being examined in detail in the Commission's reference on *Assisted and Substituted Decisions*.¹³⁹

¹³³ In *Chatterton v Gerson & Anor* [1981] 1 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 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.

¹³⁴ 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 99 below.

¹³⁵ *Chatterton v Gerson* [1981] 1 QB 432 at 443; *Sidaway v Board of Governors of Bethlem Hospital* [1984] 1 QB 493 at 511.

¹³⁶ *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.

¹³⁷ Fleming JG *The Law of Torts* (Law Book Co 8th ed 1992) at 81.

¹³⁸ Such that the misapprehension relates to risk, not certainty, of injury.

¹³⁹ See the Commission's Draft Report on *Assisted and Substituted Decisions* February 1995.

Young people's competency to consent is examined in detail in Chapter 6 below. Basically, their consent to treatment is valid if they have sufficient understanding and intelligence to enable them to understand fully what is proposed.¹⁴⁰ In the absence of relevant competency in a young person to consent to his or her own treatment, the usual rule, established at common law, is that the young person's parents or 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.

¹⁴⁰ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112 at 189 per Lord Scarman (HL(E)).

CHAPTER 6

LEGAL COMPETENCE TO CONSENT TO TREATMENT

1. INTRODUCTION

In New South Wales and South Australia,¹⁴¹ a young person's capacity to consent to general medical treatment is regulated to some extent by statute. 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,¹⁴² parents and others to consent to the treatment 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*¹⁴³ (*Gillick's case*), have often been referred to by commentators on Australian law as being authoritative statements.¹⁴⁴ In 1992 the High Court of Australia endorsed the principles enunciated in *Gillick's case*.¹⁴⁵

2. THE LAW IN QUEENSLAND

(a) *Gillick's case*

(i) Facts

In *Gillick's case*¹⁴⁶ the Department of Health and Social Security (UK) issued to area health authorities a notice dealing with the organisation and development of a family planning service in which it was stated that family planning clinic sessions should be available to people, irrespective of their

¹⁴¹ See Ch 11 below.

¹⁴² Note s17(2) *Mental Health Act 1974* (Qld) under which people of 16 years of age and older are able to seek and consent to treatment for mental illness as a voluntary patient "notwithstanding any right to custody or control of that patient vested in any person". A current review of the Act has suggested that alternate consent mechanisms should be used to enable voluntary treatment of young people wherever possible (*Queensland Health Review of the Mental Health Act 1974 Green Paper* October 1994 at 41). Also, s11(2A) of the *Status of Children Act 1978* (Qld) 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.

¹⁴³ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112 (HL(E)).

¹⁴⁴ See, eg, Gamble H "Re-examining Children's Consent to Medical Treatment" (1992) 27 *Australian Journal of Social Issues* 194.

¹⁴⁵ *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218.

¹⁴⁶ [1986] 1 AC 112.

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 his or her 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 them 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 by writ 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 properly and effectively to 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 of committing 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 medical treatment as if he or she were an adult.¹⁴⁷ The Court in *Gillick* was therefore primarily concerned with young people up to and including 15 years of age.

(ii) First instance

At first instance Woolf J dismissed Mrs Gillick's actions.¹⁴⁸ Woolf J stated 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."¹⁴⁹

¹⁴⁷ *Family Law Reform Act 1969* (UK) s8. See 161-163 below.

¹⁴⁸ *Gillick v West Norfolk and Wisbech Area Health Authority* [1984] 1 QB 581 (QB:Div Ct).

¹⁴⁹ *Id* at 595.

As to the argument that the notice was inconsistent with the rights of the parents of the child and the ability of the parents properly and effectively to 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:¹⁵⁰

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.

Woolf J¹⁵¹ was influenced by the judgment of Addy J in the Ontario High Court case of *Johnston v Wellesley Hospital*¹⁵² and in particular the passage quoted from Nathan, *Medical Negligence* (1957):¹⁵³

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

¹⁵⁰ *Id* at 596.

¹⁵¹ As was Lord Scarman in the House of Lords ([1986] 1 AC 112 at 189).

¹⁵² (1970) 17 DLR (3d) 139.

¹⁵³ Written at the time when the age of majority was 21. In Australia, the age of majority is now 18.

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. 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 Appeal reversed Woolf J's findings¹⁵⁴ 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. From this examination the Court reached three conclusions:¹⁵⁵

¹⁵⁴ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112 at 116 to 150 (CA). (Court of Appeal decision set out in the same volume as the House of Lords decision.)

¹⁵⁵ For discussion 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 291 and Gerber P and Rahemtula A "Who has the Right to Advise Children on Birth Control" (1986) 144 *The Medical Journal of Australia* 419.

- (a) "That a child's guardian has a collection of rights in relation to a child - these rights could not be transferred."
- (b) "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."
- (c) "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 Lords¹⁵⁶ 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."¹⁵⁷ Thus, it would be wrong to say that a child 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 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.¹⁵⁸

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 certainty 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.

¹⁵⁶ The highest appellate court in England.

¹⁵⁷ *Gillick's case* per Lord Scarman at 184 (HL(E)).

¹⁵⁸ *Id* at 186.

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.¹⁵⁹

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.¹⁶⁰ 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 on certain specific and precisely formulated matters.

Lord Fraser emphasised:¹⁶¹

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.

¹⁵⁹ *Id* at 188-189.

¹⁶⁰ *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; that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer.

¹⁶¹ *Id* at 174.

(v) **Criticisms of House of Lords decision**

A number of criticisms have been levelled at the House of Lords decision. For example, it has been claimed that:¹⁶²

1. It ignores realities of everyday medical practice. It is doubtful if many adults would satisfy the criteria - let alone young people.
2. Much is likely to depend on the necessarily subjective judgment of individual doctors as to what are the best interests of the young person.
3. 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 only be infringed 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.
4. The decision does not indicate whether a legally competent young person is able to refuse treatment which is considered by competent professionals to be in his or her best interests.
5. The decision does not elaborate on whether a legally competent young person's consent to treatment determines the Court's power to sanction a treatment.
6. The decision does not elaborate on whether a doctor must independently assess what is in an immature young person's best interests before relying on parental consent to treatment 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 medical treatment of young people.¹⁶³

¹⁶² See, for example, Cretney SM 'Family Law' *All ER Rev* 1985 173 at 175.

¹⁶³ The English Court of Appeal has subsequently further considered the law relating to consent to medical treatment of young people in the context of refusal of consent - see Ch 8 below.

(b) Marion's case¹⁶⁴

In *Marion's* case the parents of a 14 year old young woman 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 parents could proceed with the sterilisation.¹⁶⁵ There was an appeal to the High Court brought by the Secretary of the Northern Territory Department of Health and Community Services 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.¹⁶⁶ That decision was remitted to the Family Court for its determination.¹⁶⁷

The High Court summarised the Australian common law in relation to the ability of young people to consent to medical treatment.¹⁶⁸

The common law in Australia has been uncertain as to whether minors under sixteen can consent to medical treatment in any circumstances. However, the recent House of Lords decision in *Gillick v West Norfolk A.H.A.*¹⁶⁹ 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:¹⁷⁰

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 recognized by law. The principle of the law ... is that parental rights are derived from the parental duty and exist

¹⁶⁴ (1992) 175 CLR 218.

¹⁶⁵ *Re Marion* (1991) 14 Fam LR 427 (Nicholson CJ, Strauss and McCall JJ).

¹⁶⁶ Not her real name.

¹⁶⁷ In *Re Marion* (No 2) (1992) 17 Fam LR 336 Nicholson CJ determined that sterilisation would be in Marion's best interests.

¹⁶⁸ *Marion's case* at 237.

¹⁶⁹ *Gillick's case* [1986] AC 112.

¹⁷⁰ *Id* at 183-184.

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'.¹⁷¹

This approach, though lacking the certainty of a fixed age rule, accords with experience and with psychology.¹⁷² 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 treatment is the strongest judicial authority to date on this aspect of the law. It was also an important step in the majority's reasoning since the possibility that an intellectually disabled young person might have the capacity to give a legally valid consent (or to withhold such consent) to medical treatment was a reason why Court approval in relation to sterilisation should be necessary as a procedural safeguard.

It is unclear why the High Court indicated that the common law is uncertain in relation only to those young people under 16 years of age.¹⁷³ The reference cited was Devereux's article in the *Oxford Journal of Legal Studies*.¹⁷⁴ Devereux (now a member of this Commission) noted various legislative provisions in Australia which attach some significance to the age of 16, but did not venture 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.

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, the approval of a State Guardianship body, 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

¹⁷¹ *Id* at 189.

¹⁷² The High Court referred to:

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 ...

¹⁷³ *Marion's* case at 237.

¹⁷⁴ Devereux J 'The Capacity of a Child in Australia to Consent to Medical Treatment - Gillick Revisited?' (1991) 11 *Oxford Journal of Legal Studies* 283.

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; and
- . significant risk of making the wrong decision either as to a child's present or future capacity to consent or about what are the best interests of a child 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: the turning off of life support, transplantation of organs for the benefit of a sibling; gender reassignment, and the like. 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, and applications in relation to profoundly handicapped neonates. The Family Court has recently given its approval for a 14 year old to undergo gender reassignment by the construction of male sexual organs.¹⁷⁵ At birth, the young person had been diagnosed as a female with masculinisation of the genitalia. The young person had undergone genital reconstruction to give her a feminine appearance but received inadequate hormone replacement treatment. Recurrent masculinisation of the young person's physical structures had occurred with a change in mental behaviour and attitude. The young person wanted to undergo the reassignment procedure but in this case the Court held that the young person was not mature enough to understand the nature and consequences of the procedure. As the procedure would require invasive, irreversible and major surgery, the young person's parents could not consent and Family Court approval was required.

¹⁷⁵ *In Re A* (1993) 16 Fam LR 715.

CHAPTER 7

YOUNG PEOPLE'S INVOLVEMENT IN THEIR HEALTH-CARE TREATMENT

1. INTRODUCTION

The inclusion of young people in personal health-care decision-making - for example, through access to information, or an active role in the decision-making process - may facilitate that treatment process and increase positive psychological adjustment.¹⁷⁶

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 is old enough to understand a procedure or the implications of an intervention, he or she should be consulted.¹⁷⁷

A number of submissions to this Commission's *Information Paper* also recognised the value in involving young people in the treatment 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. For example:¹⁷⁸

if the young person is in such a traumatised state and refuses the examination, then the examination must not take place. eg a girl of 12 or 13 years of age may refuse for a variety of reasons, and that person's wishes need to be respected.

¹⁷⁶ Weithorn L "Children's Capacities for Participation in Treatment Decision-Making" *Emerging Issues in Child Psychiatry and the Law* (ed by Schetky D and Benedek E, Brunner & Mazel New York 1985) 22 at 27-28.

¹⁷⁷ Health Rights Commission *A Code of Health Rights and Responsibilities* Discussion Paper November 1994.

¹⁷⁸ Submission 5. See discussion on medical examinations in cases of suspected child abuse at 128-139 below.

A further submission from a community based youth support service noted:¹⁷⁹

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.

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 which will affect them. The legal incompetence of a young person will not necessarily reduce the significance of his or her involvement. Section 64 of the *Family Law Act 1975* (Cth) provides that in proceedings in relation to the custody, guardianship or welfare of, or access to children, the Family Court is to consider any wishes expressed by the child and is to give those wishes some weight as the court considers appropriate in the circumstances of the case.¹⁸⁰

Some 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:¹⁸¹

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 parents he or she wishes to live with. Great importance shall be attached to the child's wishes.¹⁸²

It is most likely common practice for health-care providers to seek the views of even very young patients before proceeding with treatment. 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 treatment, is given some power or control in the situation.

¹⁷⁹ Submission 82.

¹⁸⁰ *Family Law Act 1975* (Cth) s64(1A) states that nothing permits the Court or any person to require a child to express his or her wishes (if any) in such matters. Note also *Children Act 1989* (UK) under which a court in exercising its powers to make welfare orders under the Act is obliged to take into account a young person's ascertainable wishes - see 163 below for discussion of this Act.

¹⁸¹ Ministry of Children and Family Services 1993, English translation.

¹⁸² *Children and Parents Act 1981* (Norway) s33 states 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.

One justification for adopting a paternalistic stance in relation to young people is that they may be more easily influenced than adults (perhaps because of a habit of obedience). Leng notes:¹⁸³

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. Thus the principle of paternalism described above relating to practices judged harmful does not come into play.¹⁸⁴

2. COGNITIVE DEVELOPMENT

Research indicates that by adolescence young people may be as competent as adults of comprehending the nature and consequences of proposed medical treatment - 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).¹⁸⁵ Weithorn suggests, from available empirical research:¹⁸⁶

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.

¹⁸³ Leng R 'Consent and Offences against the Person: Law Commission Consultation Paper No. 134' [1994] *Crim L R* 480 at 484.

¹⁸⁴ *Ibid.*

¹⁸⁵ Weithorn L 'Children's Capacities for Participation in Treatment Decision-Making' in *Emerging Issues in Child Psychiatry and the Law* (ed by Schetky D and Benedek E, Brunner & Mazel New York 1985) 22 at 29-30 citing Piaget, Grisso and Vierling.

¹⁸⁶ *Ibid.*

According to Piaget's¹⁸⁷ 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." 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 Fellin¹⁸⁸ note, a person's capacity for decision-making does not increase beyond that stage:

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,¹⁸⁹ however, that adolescents under age 15 may be too vulnerable to making deferential responses to those in authority:

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.

The psychological evidence is unclear as to the voluntariness of young people's treatment decisions. Grisso and Vierling conclude on the basis of research by Milgram (1971) Patel and Gordon (1960) Costanzo and Shaw (1966) and others that:

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.¹⁹⁰ She reminds the reader that to restrict a young person's capacity to consent to his or her own treatment by requiring parental involvement, or parental or Court decision-making,

¹⁸⁷ Piaget J and Inhelder B *The Psychology of the Child* (Van Nostrand, Bane Books 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.

¹⁸⁸ Croxton T, Churchill S and Fellin P "Counselling Minors Without Parental Consent" (1988) 67(1) *Child Welfare* 3 at 8.

¹⁸⁹ *Id* at 9.

¹⁹⁰ Morgan J "Controlling Minors' Fertility" (1986) 12 *Mon ULR* 161 at 193.

can only increase the feeling of "externality of control".¹⁹¹ 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.

Morgan concludes that:¹⁹²

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 to giving informed consent. We do not refuse adults medical treatment on these grounds.

3. INTERESTS TO BE TAKEN INTO ACCOUNT

Croxton, Churchill and Fellin identify three sets of interests which require attention and protection in relation to the medical treatment of young people.¹⁹³

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 privacy issues of the parents.

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.¹⁹⁴

¹⁹¹ *Id* at 194.

¹⁹² *Id* at 195.

¹⁹³ Croxton T, Churchill S and Fellin P "Counselling Minors without Parental Consent" (1988) 67(1) *Child Welfare* 3 at 10.

¹⁹⁴ *Id* at 11.

Croxton, Churchill and Fellin suggest that the tandem between 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:¹⁹⁵

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.

Croxton, Churchill and Fellin consider that, ideally, parents should be involved in treatment 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 professional provider, they recommended the following statutory language:¹⁹⁶

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].

4. CHRONOLOGICAL APPROACH

Devereux¹⁹⁷ in reviewing the research carried out by Gerber and Rahemtula,¹⁹⁸ 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:

¹⁹⁵ Ibid.

¹⁹⁶ Ibid.

¹⁹⁷ 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.

¹⁹⁸ Gerber P and Rahemtula A "Who has the Right to Advise Children on Birth Control?" (1986) 144 *Medical Journal of Australia* 419.

- * 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: a form of cosmetic surgery. 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 treatment should be placed before his capacity to consent to tattooing. Devereux gives it priority over smoking, drinking, driving, marriage and sexual intercourse.

A type of chronological approach has been used in several states in the United States of America, by giving "emancipated" young people legal status.¹⁹⁹ Wilkins²⁰⁰ 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. An "emancipated" young person is able to give consent to certain medical treatment. Evidence of "emancipation" usually consists of age, marriage, pregnancy or parenthood, military service, maintaining a separate residence from the parents, and 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 treatment.

¹⁹⁹ See 168-170 below for discussions of the position in the United States of America.

²⁰⁰ 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.

CHAPTER 8

REFUSAL OF TREATMENT

1. INTRODUCTION

In *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)*²⁰¹ 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*.²⁰²

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

Lord Donaldson of Lynton MR expressed a similar view in relation to an adult's right to refuse medical treatment in *In re T (Adult: Refusal of Treatment)*:²⁰³

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 treatment of young people, the question inevitably arises whether a young person's right to consent to treatment should be accompanied by a right to refuse any or all proposed treatment.

While the law in relation to the treatment of adults has emphasised a right to bodily integrity,²⁰⁴ the law in relation to the refusal of treatment by young people has developed with a different focus.

²⁰¹ (1992) 175 CLR 218 per Mason CJ, Dawson, Toohey and Gaudron JJ at 234 and per McHugh J at 310.

²⁰² (1914) 105 NE 92 at 93.

²⁰³ [1993] Fam 95 at 102. See also *Home Secretary v Robb* [1995] 1 All ER 677 at 680 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] 1 All ER 683 per Hoffmann LJ at 686 for a similar statement of the law.

²⁰⁴ See *Marion's case* per Mason CJ and Dawson, Toohey and Gaudron JJ at 233.

There is limited Australian case law in relation to the capacity of young people to refuse treatment. In *Marion's* case, the High Court made brief reference to two decisions of the English Court of Appeal²⁰⁵ which had dealt with that issue. Accordingly, the Australian position is best examined following a consideration of those English decisions.

2. THE ENGLISH POSITION

(a) The decision in *Gillick v West Norfolk and Wisbech Area Health Authority (Gillick's case)*²⁰⁶

While *Gillick's* case is authority for the proposition that a young person who has reached a level of understanding and intelligence to understand what is involved in a proposed treatment can consent to that treatment, the circumstances in which a young person can effectively refuse treatment are less clear. The issue of refusal has become confused by the interpretation in two decisions of the Court of Appeal²⁰⁷ of Lord Scarman's comments in *Gillick's* case.

In *Gillick's* case Lord Scarman observed in relation to the nature of parental rights:²⁰⁸

...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.

²⁰⁵ *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.

²⁰⁶ [1986] 1 AC 112. See 50-56 above for a discussion of this case.

²⁰⁷ *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.

²⁰⁸ [1986] 1 AC 112 at 188-189.

(b) The decisions of the Court of Appeal

The Court of Appeal subsequently interpreted Lord Scarman's comments in *Gillick's case*²⁰⁹ in a way which has removed any suggestion that a legally competent young person, under English law, has a right of refusal in relation to his or her treatment.

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

In *In re R (A Minor) (Wardship: Consent to Treatment)*²¹⁰ 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.

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

In particular, Lord Donaldson construed Lord Scarman's statement in *Gillick's case* in a way which has significantly altered the direction in which the English law in this area has developed:²¹¹

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 were concurrent powers to consent vested in both the *Gillick*-

²⁰⁹ See section 2(a) above.

²¹⁰ [1992] Fam 11.

²¹¹ *Id* at 23.

competent young person and his or her parent because both are, in his analysis, "keyholders". The effect of such concurrent powers of consent is as follows:²¹²

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.

This approach has been criticised by Bainham:²¹³

When in 1985 Lord Scarman said that the "parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his 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 M.R. 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 medical treatment, thereby enabling medical treatment to be lawfully administered.

Bainham has made the following further criticism of Lord Donaldson's approach:²¹⁴

It 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]**

²¹² *Id* at 26.

²¹³ Bainham A "The Judge and the Competent Minor" (1992)108 *LQR* 194 at 194.

²¹⁴ *Id* at 198.

It has been suggested that a doctor is obliged to treat in accordance with his or her best clinical judgment.²¹⁵ Further, the parental right to treatment of a young person must be exercised in the best interests of the young person,²¹⁶ and the decision of a legally competent young person may be overridden by the court if it considers the decision not to be in the best interests of the young person. 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 only act on a consent - be it from a parent or a young person - if the doctor considered the treatment consented to to be consistent with his or her clinical judgment.

However, it is possible for there to be responsible, but differing, medical opinions as to whether a proposed treatment is in a young person's best interests and Lord Donaldson's analysis does not assist in the resolution of such a dilemma. Douglas²¹⁷ recognises that there is often no single view as to what treatment is in the interests of a patient:

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 three 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 negligence²¹⁸ 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)*...²¹⁹

Accordingly, 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 treatment, both courses 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 parents can

²¹⁵ 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.

²¹⁶ Note the reference in *Gillick's* case per Lord Scarman at 184 that "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 *LQR* 194 at 195.

²¹⁷ Douglas G "The Retreat from *Gillick*" (1992) 55 *MLR* 569 at 576.

²¹⁸ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

²¹⁹ [1976] Fam 185.

consent to treatment, 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 parent and young person, either by treating, if the parents consent, or by refraining from treating, if they refuse treatment.

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.²²⁰

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:²²¹

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 no less if there are concurrent powers of consent vested in the young person and his or her parents. On Lord Donaldson's own view, a doctor would be 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.²²² One valid consent is sufficient to enable treatment to be lawfully administered.

In those circumstances, however, a doctor still faces the burden of having to make a correct judgment as to the young person's maturity. In the absence of parental consent, the doctor must, even on Lord Donaldson's view of the law, make that judgment and make it correctly. If the doctor 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 doctor may commit an assault if he or she proceeds to

²²⁰ There was no definitive statement to this effect in *Gillick's* case. See footnote 216 above. Lord Scarman referred to the parents' obligation to act in accordance with the child's welfare. Lord Fraser refers to the doctor's ability to treat on the consent of the young person when such treatment is in his or her best interests. 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 293-294.

²²¹ *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 at 24.

²²² *Id per* Lord Donaldson at 23.

treat the young person.

The only possible way for a doctor 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 doctor to treat only when he or she has the consent both of a parent and the young person, so that there would always be a valid consent from someone. That difficulty is not alleviated by holding that parents have an independent right to consent until their teenager turns 18, for unless the doctor seeks the consent of the parents, the doctor does not know whether or not 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 doctor's difficult decision regarding a young person's maturity 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 medical treatment, but has a mere power to consent to medical treatment, which is itself concurrent with a similar power vested in the young person's parents.

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

In *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)*²²³ the Court of Appeal again considered the question of refusal of medical treatment 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*²²⁴) jurisdiction and sought leave to treat W without her 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.²²⁵

Because W was 16 years of age, the decision of the Court of Appeal directly concerned section 8(1) of the *Family Law Reform Act 1969* (UK), which provides:

- (1) The consent of a minor who has attained the age of 16 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...

²²³ [1993] Fam 64.

²²⁴ See 36, 37 above for discussion on *parens patriae*.

²²⁵ *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 per Lord Donaldson at 76.

- (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).²²⁶

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 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 insofar as a right to consent simpliciter was concerned. The problematic issue, however, especially in light of the comments in *In re R*²²⁷ 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 section 8(1) conferred on a young person of 16 years or over the same right to decide whether he or she would submit to medical treatment (that is, to exercise a power of veto over one's own medical treatment), which the young person would have if he or she were an adult.²²⁸

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:²²⁹

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 and independent parental right to consent to treatment 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 medical treatment for the

²²⁶ *Id* at 76-77.

²²⁷ *In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11.

²²⁸ See 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 subsection 8(1) of the *Family Law Reform Act 1969* (UK) might mean that a 16 year old was put in exactly the same position as an adult with respect to treatment and therefore had the adult right to refuse treatment.

²²⁹ *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 at 76.

reason that, apart from the court, no-one but the young person would be able to consent to his or her treatment. Lord Donaldson rejected the argument that the words "as effective as it would be if he were of full age", which appear in section 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.²³⁰ The effect of that rejection is that:²³¹

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 Donaldson held:²³²

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".

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:²³³

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.

²³⁰ Id at 77.

²³¹ Id at 84.

²³² Id at 81.

²³³ Id at 83. Balcombe LJ made a similar comment at 84.

(c) 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.²³⁴
- Below that age, a young person can consent to his or her own treatment if he or she is legally competent i.e. passes the test in *Gillick's case*.²³⁵
- In either case (16 years of age or older, under 16 but legally competent), the consent of the young person cannot be overridden by those with parental responsibility, but can be overridden by the courts.²³⁶ 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.²³⁷
- Parents retain an independent right to consent to the medical treatment of their children until they attain their majority at 18 years of age. Accordingly, a doctor may lawfully treat a young person, even one over 16 years of age, if the person having parental authority consents to the treatment.²³⁸ The parental power to consent must, however, be exercised in the best interests of the young person.²³⁹

²³⁴ *Family Law Reform Act 1969* (UK) s8(1).

²³⁵ *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 per Lord Donaldson at 83-84.

²³⁶ *Ibid.*

²³⁷ See *In re T (Adult: Refusal of Treatment)* [1993] Fam 95 at 102; *Home Secretary v Robb* [1995] 1 All ER 677 at 680; and *B v Croydon Health Authority* [1995] 1 All ER 683 at 686.

²³⁸ *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.

²³⁹ *Gillick's case* [1986] 1 AC 112 per Lord Fraser at 173 and per Lord Scarman at 184.

- No young person has the power to refuse consent to treatment, so as to override a consent given by someone with parental responsibility or by the court.²⁴⁰
- In all decisions, parents are constrained by the limitation that consent to treatment of their child can only be validly given if the treatment is in the best interests of the young person. It is unclear whether doctors must also determine whether the proposed treatment is in the young person's best interests.

4. THE AUSTRALIAN POSITION

In *Marion's* case²⁴¹ the High Court made brief reference to the question of refusal of treatment by young people.

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.²⁴² That comment was accompanied by the following footnote:²⁴³

(75) 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 Donaldson of Lymington M.R. 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.

While it is clear that the majority of the High Court endorsed the maturity approach in relation to consent (as opposed to a fixed age rule), it is by no means clear that the High Court would embrace the Court of Appeal's interpretation of Lord Scarman's comments in *Gillick's* case in terms of concurrent powers of consent. Although their Honours made reference 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.

Indeed, their Honours cited the principle for which *Gillick's* case is authority in the following terms:

²⁴⁰ *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 per Lord Donaldson at 84.

²⁴¹ (1992) 175 CLR 218.

²⁴² *Id* at 237-238.

²⁴³ *Id* at 238.

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.²⁴⁴

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.

In *Marion's* case, McHugh J expressly criticised the decision of the Court of Appeal in *In re R*.²⁴⁵

[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 medical treatment by young persons will, or should, necessarily follow the English Court of Appeal decisions. On the contrary, the High Court seems unlikely, in light of the express and implied criticisms of *In re R* in *Marion's* case, to follow the reasoning of the English Court of Appeal.

5. THE ARGUMENTS IN FAVOUR OF AND AGAINST CONFERRING ON YOUNG PEOPLE A RIGHT TO REFUSE MEDICAL TREATMENT

(a) The arguments in favour of a right of refusal

(i) Right to autonomy

As noted above, the Court of Appeal held in *In re W* 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:²⁴⁶

²⁴⁴ *Id* at 237.

²⁴⁵ *Id* at 316-317.

²⁴⁶ Douglas G "The Retreat from *Gillick*" (1992) 55 *MLR* 569 at 573.

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 passed the maturity test established in *Gillick's* case²⁴⁷ 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 treatment and if so, what treatment. Indeed, Balcombe LJ noted in *In re W* that "[i]n logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment".²⁴⁸

From that perspective, the right to refuse treatment could be said to derive simply from having reached a level of decision-making capacity, in the same way that it does with legally competent adults, who can choose whether or not to agree to treatment.

(ii) Clinical advantage

In *In re W* Lord Donaldson touched upon an aspect of consent and refusal, which is important even in a "best interests" approach to the issue of consent and refusal:²⁴⁹

[Consent] has two purposes, the one clinical and the other legal. The clinical purpose stems from the fact that in many instances the cooperation 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 medical treatment (or any particular form of it), the young person will

²⁴⁷ 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 *LQR* 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.

²⁴⁸ [1993] *Fam* 64 at 88.

²⁴⁹ *Id* at 76.

have no capacity to choose one particular form of treatment over any others, as that necessarily involves the rejection of other forms of treatment and a refusal to submit to those other forms of treatment.

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. The concept of refusal is as fundamental to having any right to choose between treatments, as it is to the right to refuse all forms of treatment.

(b) The argument against a right of refusal

Refusal may not be beneficial to the young person

The principal argument against conferring on young people a right to refuse medical treatment 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* that section 8(1) of the *Family Law Reform Act 1969* (UK) did not confer a right to refuse medical treatment on young persons over the age of 16, Lord Donaldson had regard to the background to the introduction of that legislation, as found in the *Report of the Committee on the Age of Majority*²⁵⁰ (the Latey Committee Report). Lord Donaldson noted one particular mischief which the report had identified:²⁵¹

[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 who gave evidence, except the Medical Protection Society, that young persons 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 Committee's Report did not confer an express right of refusal.²⁵² The legislation only conferred an express right

²⁵⁰ (1967) Cmnd 3342.

²⁵¹ *In re W* [1993] Fam 64 at 77.

²⁵² *Id* at 77-78.

to consent.²⁵³ Lord Donaldson seemed to be suggesting that the purpose of the legislation was only to enable young persons access to medical treatment, which they might otherwise be denied. If that was the purpose of the legislation, it is perhaps understandable why Lord Donaldson should treat the issue of consent quite differently from the issue of refusal; consent is seen as something obviously for the benefit of the young person.

Indeed, Leng²⁵⁴ suggests that the reason for which 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 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 treatment is different from, and probably higher, than the level of maturity required in consenting to treatment.

6. RATIONALES FOR REFORM

Options for clarifying the law in relation to a young person's right of refusal depend on the particular approach adopted: whether the primary purpose of a model is to confer on a legally competent young person the right to make all his or her health care decisions (including the decision to refuse treatment), or whether it is only with a view to promoting the young person's health by enhancing the young person's capacity to secure treatment, by clarifying the circumstances in which a young person can provide a valid consent to treatment.²⁵⁵

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.

²⁵³ See *Family Law Reform Act 1969* (UK) s8(1).

²⁵⁴ Leng R "Consent and Offences against the Person: Law Commission Consultation Paper No. 134" [1994] *Crim L R* 480 at 484.

²⁵⁵ See Bainham A "The Judge and the Competent Minor" (1992) 108 *LQR* 194 at 196 and Chapter 12 for discussion or options for reform.

CHAPTER 9

LIABILITY IN THE ABSENCE OF CONSENT

1. LIABILITY FOR TREATMENT OR EXAMINATIONS WITHOUT CONSENT

If a health-care provider touches a patient without the patient's consent or without the appropriate substituted consent, the health-care provider could be accountable for the touching in a number of respects:

- (a) criminally liable for assault;
- (b) civilly liable for trespass to the person;
- (c) civilly liable in negligence; and
- (d) liable for professional disciplinary action;

(a) Criminal liability

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.²⁵⁶ Invariably 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. However, the application of force may be unlawful despite consent. Section 246 of the Code states:

- (1) An assault is unlawful and constitutes an offence unless it is authorised or justified or excused by law.
- (2) The application of force by one person to the person of another may be unlawful, although it is done with the consent of that other person.

²⁵⁶ "Assault" is defined in s245 of the *Criminal Code* (Qld) as:

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) The term "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.

A person can consent to what would otherwise be a simple assault but cannot consent to more serious injuries such as wounding being done to that person by another.²⁵⁷

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.²⁵⁸ It is unclear whether consent would be necessary for "treatment" which is of a minor nature such as minor first aid procedures to relieve pain and discomfort or the taking of common medicines to relieve other minor ailments.²⁵⁹

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)**

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) states:

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 -

²⁵⁷ 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.

²⁵⁸ See *Horan v Ferguson* (Unreported, Court of Appeal Qld CA No. 85 of 1994, 23 September 1994). 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 rationalization 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 at 72-73 per Lord Goff].

²⁵⁹ 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 at the trial of a right or where personal character is involved.

(Jowitt *The Dictionary of English Law* at 572).

- (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;

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 the section whether it is intended to apply in cases of emergency treatment.²⁶⁰ 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 52.²⁶¹

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.

²⁶⁰ See 100-103 below for discussion on emergency.

²⁶¹ *Parliamentary Debates Legislative Assembly (Qld)* 23 March 1976 at 2951.

The Health Department has observed in relation to this passage:²⁶²

Section 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.²⁶³

(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) states:

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.²⁶⁴ 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.²⁶⁵

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 Concise Oxford Dictionary as "manual treatment of injuries or disorders of the body, operative therapeutics, surgical work", and this would presumably

²⁶² Queensland Health *Review of the Medical Act 1939* Discussion Paper September 1994 at 82.

²⁶³ The Health Department also observed at 191:
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.

²⁶⁴ 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.

²⁶⁵ Fleming JG *The Law of Torts* (Law Book Co 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**]

include the work of people such as nurses, dentists, acupuncturists 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.²⁶⁶

The term "operation" is defined in the Butterworths *Medical Dictionary* (Second Edition 1978) as:

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

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:²⁶⁷

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.²⁶⁸

That, of course, suffices to protect many kinds of operations from the mundane and the exotic. Voluntary castration to overcome uncontrollable sexual urges could be excused on therapeutic grounds. The section could also protect a surgeon performing a prefrontal leucotomy to effect a change of personality in a mentally-ill patient. Some routine procedures pose more problems. Male circumcision for religious reasons seems to be outside the protection of the section. So, too, would tattooing and ear-piercing, were the legality of such operations not assumed in the *Health Act 1937*.²⁶⁹ Cosmetic surgery, although not medically necessary, may enhance the self-esteem of the patient, and the notion of therapeutic benefit might be just stretched to cover it. However, sterilisation for contraceptive purposes without any medical indication is not so readily

²⁶⁶ *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).

²⁶⁷ O'Regan RS "Surgery and Criminal Responsibility under the Queensland Criminal Code" (1990) 14 *Criminal Law Journal* 73 at 75.

²⁶⁸ *Id* at 75-76.

²⁶⁹ *Health Act 1937* (Qld) s100A. The *Skin Penetration Regulations 1987* (Qld) made under that section provide for the registration of premises where such operations are to be carried out and for various safeguards.

accommodated. In England the legality of such procedures was put beyond doubt by legislation, the *National Health Service (Family Planning) Amendment Act 1972*, but in Queensland the matter is governed solely by s282 of the Code, and that seems to be inapplicable. Even a sterilisation performed to prevent the transmission of genetic disease or to prevent a pregnancy likely to threaten the physical or mental well-being of another - a spouse or other sexual partner - would not be within the narrow protective ambit of the section, confined as it is to consideration of the benefit of the patient only. In the result, there is now no correspondence between the criminal law as enacted and the criminal law as enforced. Sterilisations of the kind referred to are now commonly performed without prospect of prosecution.²⁷⁰

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 states:²⁷¹

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.²⁷²

²⁷⁰ **Note:** New Zealand *Criminal Code* s61A which specifically states that a surgical operation that is performed for the purpose of rendering the patient sterile 'is performed for a lawful purpose.' A similar provision has been included in Queensland's Draft *Criminal Code*. See discussion in O'Regan at 76-77.

²⁷¹ *Id* at 82.

²⁷² 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.²⁷³

Its scope is uncertain in many respects. The relevance of consent should be made explicit and the extent of the section's application to abortion should be clarified. Furthermore, if the legislature is of the view that other procedures such as sterilisation, although arguably not for the benefit of the patient, should not, either generally or in specific circumstances, attract the sanctions of the criminal law, then specific legislative provision should be made for them.

The Queensland Criminal Code has recently been reviewed.²⁷⁴ The review has resulted in a draft Bill which has been circulated for public comment.²⁷⁵ The draft Bill proposes to expand section 282 to cover "medical treatment" as well as surgery and to specifically cover sterilisation procedures. It does not propose to significantly alter the existing provision.²⁷⁶

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

This provision indemnifies medical practitioners from criminal liability where they give blood transfusions to persons under the age of 18 where the parents or others in authority of the young person either fail or refuse 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.

Although section 282 of the *Criminal Code* (Qld) provides no relief from criminal responsibility in relation to the removal of blood or regenerative tissue from one person for the benefit of another, the *Transplantation and*

²⁷³ O'Regan RS "Surgery and Criminal Responsibility under the Queensland Criminal Code" (1990) 14 *Criminal Law Journal* 73 at 83.

²⁷⁴ Final Report of the Criminal Code Review Committee to the Attorney-General 1992 (Qld).

²⁷⁵ *Criminal Code Bill 1994: Draft for Public Consultation*, Department of Justice and Attorney-General Queensland.

²⁷⁶ Proposed cl 53 of the Draft Bill reads:

53(1) A person is not criminally responsible for performing or providing in good faith and with reasonable care and skill a surgical operation or medical treatment on a person for the patient's benefit, or on an unborn child to preserve the mother's life, if the performance of the operation or the provision of the medical treatment is reasonable, having regard to the patient's state at the time and all the circumstances.

(2) Surgical or medical treatment to sterilise a patient that is performed with the patient's consent is taken to be for the patient's benefit.

Anatomy Act 1979 (Qld) excuses a person who in good faith and without negligence and with the patient's consent removes blood for transfusion or for other therapeutic purposes or for other medical or scientific purposes.²⁷⁷ Parental consent in the case of a donor who is a child is also necessary.²⁷⁸

Section 20 of the *Transplantation and Anatomy Act 1979* (Qld) reads:²⁷⁹

(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.

(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

²⁷⁷ *Transplantation and Anatomy Act 1979* (Qld) s17.

²⁷⁸ *Id* s18.

²⁷⁹ *Transplantation and Anatomy Act 1979* (Qld) s46 also provides a defence for a medical practitioner who removes regenerative tissue for transplantation or for other therapeutic purposes or for other medical or scientific purposes. The operation must be performed in good faith and without negligence and the consent of the donor, if an adult, or of a parent, if the donor is a child, must be obtained. There are stringent safeguards to ensure that consent has been freely given.

child or a person having authority to consent to the administration of the transfusion.

(iv) **Other**

* **Health Act 1939 (Qld)**

The *Health Act 1939 (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.²⁸⁰
- . School children and others may be examined if suspected of being infected with a notifiable disease.²⁸¹
- . All pupils attending schools must submit to medical and dental inspections provided for by the Minister.²⁸²
- . A child²⁸³ who has presented itself 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.²⁸⁴
- . 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.²⁸⁵

²⁸⁰ *Health Act 1939 (Qld)* s36.

²⁸¹ *Id* s47(3).

²⁸² *Id* s47(5), (5A).

²⁸³ A 'child' for the purposes of s76L is defined in s76M as meaning a person under or apparently under the age of 17 years. See discussion on s76L at 132-133 below.

²⁸⁴ *Health Act 1939 (Qld)* s76L.

²⁸⁵ *Id* s130C.

* ***Children's Services Act 1965 (Qld)***

Section 143 provides:

For so long as the Director is guardian of an infant he shall be deemed to be guardian of the person and the estate of such infant.

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 he might lawfully do and give if he were the guardian of such child.

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 Children's Court must order such medical examinations as appear necessary or desirable.²⁸⁶ 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.

* ***Corrective Services Act 1988 (Qld)***

The *Corrective Services Act 1988 (Qld)* provides for corrective services and the release of prisoners on parole with respect to people 17 years of age or over or apparently 17 years of age or over.²⁸⁷

²⁸⁶ *Children's Services Act 1965 (Qld)* ss 49 and 61(3).

²⁸⁷ *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. Only people 17 years of age and older can be sentenced to prison. See *Juvenile Justice Act 1992 (Qld)*. Note also, the *Penalty and Sentences Act 1992 (Qld)* does not apply to a child within the meaning of the *Juvenile Justice Act 1992 (Qld)*.

- Subsections 48(1) and 48(3) of the *Corrective Services Act 1988* (Qld) permit the general manager of a prison, in certain circumstances, to authorise a medical officer, a registered nurse who is an officer of the Commission or a legally qualified medical practitioner to search the person of a prisoner and collect any substance or thing from the prisoner's body.
- The general manager of a prison may also order a prisoner to provide breath and urine samples,²⁸⁸ and authorise the taking of samples of the prisoner's blood, saliva or hair.²⁸⁹
- A medical officer, nurse or medical practitioner authorised pursuant to section 48 of the Act to do any act may use such force as is reasonable for that purpose.²⁹⁰
- A prisoner is also required to submit to any examination or treatment authorised by section 50 of the Act.²⁹¹ 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 is also to submit to psychological assessments ordered by the Corrective Services Commission.²⁹²

²⁸⁸ Id s48(4)(a).

²⁸⁹ Id s48(4)(b).

²⁹⁰ Id s48(7).

²⁹¹ Id s51.

²⁹² Id s53(1).

* **Criminal Code (Qld)**

Section 259 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";
- . "take samples of the person's blood, saliva or hair";
- . "require the person to provide a sample of the person's urine";
- . "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".

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";
- . "take samples of the person's saliva";
- . "take dental impressions from the person".

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 child, "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". Alternatively, the acts can be performed without consent if a stipendiary magistrate approves the doing of the act. 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"²⁹³ can consent to such procedures, albeit in the presence of a parent or other adult. No competency test is applied.

²⁹³ 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*.

* **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".²⁹⁴

The chief executive of a detention centre is authorised "despite any other Act or law" to give consent to any medical treatment of a young person in the chief executive's custody if.²⁹⁵

- (a) the medical treatment requires the consent of a guardian of the child; and
- (b) the chief executive 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 it is likely that a medical practitioner would 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.²⁹⁶

The Department of Family Services and Aboriginal and Islander Affairs²⁹⁷ involves parents in the Director's decision-making role in relation to young people in the Director's care whenever possible and considered appropriate. This is usually dependent on whether the custody of the young person is short or long-term. If the young person is remanded pending trial, then the parents' consent is obtained unless emergency treatment is required.

²⁹⁴ *Juvenile Justice Act 1992 (Qld)* s5.

²⁹⁵ *Id* s212.

²⁹⁶ The Australian Medical Association *Code of Ethics* July 1992 provides:
Respect your patient's rights ... to accept or reject advice and to make their own educated decisions about treatment or procedures.

²⁹⁷ The Director-General and his or her delegates have the same powers of guardianship as a parent. If the parents of the child are available, the policy of the Department is to emphasise the parents' involvement in any consent which is required. The Director-General's delegate is usually the regional manager in the region where the consent is required. (Informal discussion with Department of Family Services and Aboriginal and Islander Affairs, 10 March 1993).

For treatment considered routine, the Director normally consents to the procedure being carried out. If the procedure is more serious, such as an operation, parental consent is sought.

For young people in long-term custody, the Director or his or her delegate provides consent.

* **Traffic Act 1949 (Qld)**

Section 16A of the *Traffic Act 1949 (Qld)* allows for the testing of breath, blood and urine in certain circumstances without consent.

(b) Civil liability for trespass to the person

The principal civil remedies available to a person who has been the subject of medical treatment without his or her consent, are the torts of trespass to the person and negligence. Trespass to the person comprises three separate torts: battery, assault and false imprisonment. Each of these may have relevance in the provision of medical treatment.

(i) Battery

To subject a patient to a touching or physical treatment without the patient or an appropriate substitute decision-maker understanding or consenting to the general nature of what is to be done is battery.

Battery is committed when the defendant, intending or being in the position of foreseeing this result, does an act which directly and physically affects the person of the plaintiff. 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.²⁹⁸ Mistake of fact or law is usually no defence - however

²⁹⁸ McHugh J in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 at 309-310:

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 authorized, justified or excused by law ...

reasonable the mistake (for example, mistake as to age, competency or maturity). 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 battery.²⁹⁹

In the 1988 English Court of Appeal case of *T v T*, Wood J observed:³⁰⁰

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, at least operative procedures will be prima facie acts of trespass to the person. To hold otherwise could lead to the proposition that all medical procedures may lawfully be performed without consent. As Grubb has observed:³⁰¹

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, contacts between people which conform with accepted every day human behaviour do not amount to battery - at least if there is no indication that they would be resented.³⁰² Thus it would not normally be a

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. Other persons do not have the right to interfere with an individual's body unless he or she proves lack of consent to the interference.

²⁹⁹ See *Boughey v The Queen* (1986) 161 CLR 10 where, in the High Court, it was 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".

³⁰⁰ *T v T* [1988] 2 WLR 189 at 203.

³⁰¹ Grubb A "Medical Law" *All ER Rev* 1988 200 at 209.

³⁰² *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* (Unreported, Court of Appeal Qld CA No 85 of 1994, 23 September 1994).

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.³⁰³

In *T v T*, Wood J observed:³⁰⁴

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 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 hospitals fall within the phrases 'exigencies of everyday life' or 'the ordinary conduct of daily life.' [emphasis added]

(ii) Assault

An assault is committed if a person intentionally and directly causes the plaintiff to apprehend that he is going to commit a battery against the plaintiff. Usually, this tort and 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:³⁰⁵

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.

³⁰³ *Cole v Turner* (1704) 6 Mod 149; 87 ER 907. Also see 82-83 above.

³⁰⁴ *T v T* [1988] 2 WLR 189 at 202, summarising the analysis made by Goff LJ in *Collins v Wilcock* [1984] 1 WLR 1172.

³⁰⁵ Fleming JG *The Law of Torts* (Law Book Co 8th ed 1992) at 26.

(iii) False Imprisonment

There will be circumstances in which the treatment of a young person without an appropriate consent will amount to the tort of false imprisonment. The tort is committed when the voluntary conduct of one person directly subjects another to total deprivation of freedom of movement. Any restraint upon the personal liberty of an individual which is not warranted by law, is a false imprisonment.³⁰⁶ The justification for the tort has been described by Lord Griffiths as follows:³⁰⁷

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.

The concept of "deprivation" in the definition of the tort indicates that the limitation on movement must be against the person's will or without consent, even though the plaintiff is not aware of the restraint.³⁰⁸ Furthermore, the conduct of the defendant need not have been motivated by malice and may very well have been motivated by his or her understanding of what was in the best interests of the plaintiff.

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 test 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 between the psychologist and the young patient.

³⁰⁶ *Bridgett v Coyney* (1827) 1 Man & Ry KB 211 per Lord Tenterden CJ at 215-216.

³⁰⁷ *Murray v Ministry of Defence* [1988] 2 All ER 521 at 529.

³⁰⁸ "Intentional Torts" *Laws of Australia* (Law Book Co Ltd 1993) at 33-84. Lord Atkin in *Meering v Grahame-White Aviation Co.* (1919) 122 LT 44 at 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.

(c) Civil liability in negligence

In negligence, the plaintiff alleges that the defendant owed the plaintiff a duty of care, and by acting carelessly, breached that duty, causing damage. Although lack of consent is not an element of negligence, a doctor who treats a patient without consent may well be in breach of the duty of care owed to the patient.³⁰⁹ A possible defence to negligence is that the plaintiff voluntarily assumed the risk of harm, but this involves consent to the risk of harm rather than to the harm itself.

The High Court in *Rogers v Whitaker*³¹⁰ confirmed that a medical practitioner has a duty to warn the patient of a material risk inherent in the proposed treatment. A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. The principle of "informed consent" in the context of the law of negligence is outside the scope of the Commission's current terms of reference. Neither the law of negligence nor informed consent form part of the Commission's reference.

(d) Disciplinary action

A health-care provider may also be the subject of disciplinary action by his or her professional organisation if he or she treats a patient without the patient's or appropriate substitute decision-maker's consent. For example, registered medical practitioners are subject to the supervision of the Medical Assessment Tribunal established under the *Medical Act 1939* (Qld).³¹¹ 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 "infamous conduct in a professional respect." Other professional bodies may have disciplinary procedures for members who treat patients or clients without consent.³¹²

³⁰⁹ *Rogers v Whitaker* (1992) 175 CLR 479 at 490.

³¹⁰ (1992) 175 CLR 479.

³¹¹ *Medical Act 1939* (Qld) s33.

³¹² 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. See, eg. Australian Acupuncture Association *Code of Ethics* paras 2.8 and Ch 13 set out in Appendix 2 of this paper.

2. CONSENT TO EMERGENCY TREATMENT

(a) Introduction

In an emergency situation, where a young person is involved, the usual principles of consent do not apply. The parents may not be able to be located quickly and the young person may be unconscious or so traumatised that no coherent information is able to be obtained. The treatment will be required urgently and a decision must be made whether to administer treatment to save the life or address serious health problems of the young person.

In Queensland there are a number of statutory provisions which govern the provision of emergency treatment by some health-care providers. The common law applies to treatment which may be administered by anyone attending the scene of an emergency.

(b) Common law

At common law, when treatment is required as a matter of urgency, the question of consent is regarded as an exception to the general rule that a patient's consent must be obtained prior to treatment being administered.³¹³ The treatment can only be that which is reasonably required in the circumstances of the emergency.³¹⁴ In these circumstances there will be no common law action against the health-care provider unless the treatment is performed negligently.

Provided the treatment is in the best interests of the patient's health and the treatment is necessary, the health-care provider is justified "in taking such steps as good medical practice demands".³¹⁵

This exception at common law to the usual requirement of consent does not only apply to medical practitioners. It also applies to ordinary citizens who render assistance at the scene of an accident. In this case the citizen is regarded as a rescuer.

³¹³ *Wilson v Pringle* [1987] 1 QB 237 at 252. Lord Goff in *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 at 75 considered that the principle was one of necessity, not of emergency. He stated that "[e]mergency is ... not the criterion or even a pre-requisite, it is simply a frequent origin of the necessity which impels intervention". It is not clear in Australia that the courts would go so far as to say that consent may be dispensed with in other than emergency situations. It is clear, however, in Australia, that "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 authorized representative is available to give consent on his or her behalf": see *Marion's* case per McHugh J at 310.

³¹⁴ *In re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 per Lord Goff at 77.

³¹⁵ *T v T* [1988] 2 WLR 189 at 204 per Wood J. See also *Frenchay Healthcare National Health Service Trust v S* [1994] 1 WLR 601.

(c) Statutory protection

When a person is injured and assistance is provided at the scene of the accident, there is some statutory protection in certain cases. Section 3 of the *Voluntary Aid in Emergency Act 1973* (Qld) provides protection for a medical practitioner or nurse who assists the injured person. The practitioner or nurse will not incur liability for acts or omissions done in the course of rendering medical assistance if the act or omission is done in good faith and without gross negligence and is not performed for fee or reward. The assistance must also be at or near the scene of the incident or while the injured person is being transported from the scene.

Police officers are also protected where they act in good faith and without gross negligence in rendering assistance in an emergency under section 69B(1) of the *Police Act 1937* (Qld). The protection extends to the situation where the person is suffering from illness as well as injury.

Ambulance officers may take reasonable measures to protect persons from any danger or potential danger associated with an emergency situation and to protect persons trapped in a vehicle as well as to protect themselves or other officers or persons from danger, potential danger or assault.³¹⁶

Section 52 of the *Medical Act 1939* (Qld) is the main provision which has generally been referred to as governing the provision of medical treatment to a person by a medical practitioner in an emergency situation where the person is in a hospital or institution, although it does not mention "emergency" and its scope is not entirely apparent. It is not restricted to life-saving operations, but also covers operations intended to "prolong" the patient's life. The section only applies where the person is in a hospital or institution, the person is not capable of consenting by reason of a mental disability and the treatment which is to be administered is a surgical procedure.³¹⁷ There is no definition of what is to be classified as a "surgical procedure" and no definition of "mental disability" in the Act. The section also does not cover treatment by health-care providers other than medical practitioners.

It is unclear whether the term "medical disability" covers immaturity, unconsciousness or those persons unable to communicate.³¹⁸

³¹⁶ *Ambulance Service Act 1991* (Qld) ss5.2 and 5.3.

³¹⁷ The terms of s52 are set out on 83-84 above.

³¹⁸ But see 84, 85 above.

The section appears to extend the normal principles of consent in that it contemplates consent being given by a relative. Under the normal rules of consent, a relative of a young person, if that relative is not the parent or guardian of the young person, is unable to consent to treatment on behalf of the child. By including the reference to "relative" it would appear that, if a relative is available in situations contemplated by the section, then that relative may be able to give consent to the treatment.

When the Bill incorporating the proposed section 52 was introduced in Parliament in 1976, it was stated that consent in an emergency could be waived where the consent of the patient or the parents of a child could not be obtained.³¹⁹ However, it was also stated that sometimes "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 [or herself] is too confused owing to a [mental disability] 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 [or she] is not the doctor who will perform the operation."³²⁰ This latter statement would appear to indicate that the section would not only apply in emergency situations, but would also apply to a case where the person is temporarily unable to consent, but where the treatment was in the contemplation of the person.

A medical practitioner who provided treatment under section 52 would be relieved from criminal and civil liability, but would not be relieved from liability in negligence if the treatment were performed in a negligent manner.

There is further provision in section 20 of the *Transplantation and Anatomy Act 1979* (Qld) for a blood transfusion to be administered to a young person by a medical practitioner or any person acting in aid of the medical practitioner without the consent of a parent or against the refusal of a parent. The transfusion must be necessary to preserve the life of the young person and either a second medical practitioner or the medical superintendent must concur with the decision to administer the transfusion. The section relieves the practitioner from criminal liability and the transfusion is deemed to have been given with the consent of the parent of the young person.

Section 282 of the Queensland *Criminal Code* may also be applicable in an emergency situation. This section provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his or her benefit, if the performance of the operation is reasonable having regard to the patient's state at the time and to all the circumstances of the case. The section is wider than section 52 of the *Medical*

³¹⁹ *Parliamentary Debates Legislative Assembly (Qld)* 23 March 1976 at 2951.

³²⁰ *Ibid.*

Act 1939 (Qld) in that it is not restricted to medical practitioners, although it is limited to surgical operations. The section relieves the person from criminal liability only.

By contrast to the position in Queensland, the South Australian *Consent to Medical and Dental Treatment Act 1985* has specific provisions relating to consent to treatment in emergency situations for adults and for young people.³²¹ Section 6 provides that medical or dental treatment may be given to a young person without consent if the medical practitioner or dentist is of the opinion that the young person is incapable of consenting, no parent is available or willing to consent, and the medical practitioner or dentist carrying out the procedure is of the opinion that the procedure is necessary to treat imminent risk to the young person's life or health. This opinion should be supported by the opinion of another medical practitioner or dentist unless it is not reasonably practicable to do so having regard to "the imminence of risk to the minor's life or health".

(d) Conclusion

In all cases, whether it is at common law or under statute, there would appear to be protection for persons administering treatment without consent to an injured person in an emergency situation. In an emergency there is 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)³²² services which 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."

³²¹ *Consent to Medical and Dental Treatment Act 1985* (SA) s7 and the *Consent to Medical Treatment and Palliative Care Bill 1994* (SA) which is awaiting Royal Assent. Cl 13 of the Bill is in similar terms to s7 of the *Consent to Medical and Dental Treatment Act 1985* (SA). See Appendix 4. These provisions also cover people over the age of 16.

³²² *Health Rights Commission Act 1991* (Qld) Sch1 Pt 2 s4.

CHAPTER 10

THE NEED FOR REFORM

1. INTRODUCTION

The submissions received by the Commission in response to the Information Paper highlighted the uncertainty and confusion that has resulted from the current law in Queensland relating to the competency of young people to consent to medical treatment. The confusion results primarily from the fact that the law in this area is the common law and in the absence of relevant Australian case law, United Kingdom cases provide the only authoritative albeit unclear statement of the law.

From the health-care provider's perspective, it is unclear in what circumstance he or she is immune 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 treatment but does not wish to involve his or her parents the health care provider must determine whether or not the young person is mature enough to be capable of understanding the nature and consequences of the proposed treatment. It would seem that the treatment would also have to be in the young person's best interests. The common law provides no further guidance to the health care provider. The test of maturity and the best interests tests are objective ones - so if the health care provider is mistaken as to the young person's maturity, or mistaken as to what is best for the particular young person, he or she may be liable for assault for treating the young person without good consent.

It is also unclear what the effect of the common law (as found in *Gillick v West Norfolk and Wisbech Area Health Authority* (*Gillick's case*³²³)) is on the provision of advice or information or a non touching treatment (such as hypnosis or counselling) rather than treatment involving physical touching of 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.

The provision of particular advice to a young person, or the filling of a prescription, or hypnosis or the wide variety of other types of non-touching "treatments" may result in profound consequences to the young person. If the health-care provider need not obtain the young person's nor his or her parents' consent before providing advice or non-touching treatment, then there may be no or little protection for the young person from inappropriate treatment. It would seem that a consent requirement would be as appropriate in the case of non-touching advice and treatment - even though the effect of such a requirement would not be so much to protect the health-care provider from criminal or civil charges, or to protect

³²³ [1986] AC 112.

the young patient's bodily integrity as it would be to protect the young patient's psychological integrity and his or her right to be respected as an individual.

Gillick's case has been cited as authority for the proposition that as young people mature parental rights yield to the young person's right to make his or her own decisions in relation to proposed treatment. It is unclear, however, what role or "rights" are left to the parent once the young person is treated as capable of making his or her own decision. The *Gillick* test does not of itself prevent the treating health care provider from informing the young person's parents about the proposed treatment (although that would probably constitute a breach of the health-care provider's duty of confidence to the young person), nor does it require the health care provider to treat a "*Gillick*-competent" young person.

As noted in Chapter 8, *Gillick's* case says nothing about a "*Gillick*-competent" young person's right to refuse treatment to which his or her parents have consented. Given the variety of judicial opinions expressed in the House of Lord's case, it also is unclear whether it has anything authoritative to say about the ability of a "*Gillick*-competent" young person's parents to override a young person's consent or refusal of consent to treatment.

It is not clear whether treatment provided by health-care providers other than medical practitioners is covered by the principle(s) for which *Gillick's* case is claimed to be the authority.

The common law has not resolved the confusion which may result when parents differ in their opinion of what is in the best interests of the young person - apart from accepting that the Court, exercising its *parens patriae* jurisdiction³²⁴ could make such a determination (providing, of course, someone with sufficient interest in the matter takes the time and trouble and undergoes the expense to apply to the Court for an exercise of that jurisdiction). It is not clear whether health-care providers 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 consent to a particular treatment; one of his or her parents may insist that the treatment proceed; and, the other parent may be indifferent to whether or not the treatment is to 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 unclear what rights and responsibilities parents have, at law, in relation to the treatment of their children. Parents are under a duty to protect their children and to provide them with the necessities of life (including treatment when necessary). Their right to make decisions relating to their children, particularly medical decisions is severely limited. They are only able to make decisions which are, objectively, in the best interests of their children. They are also unable to make

³²⁴ See 36, 37 above.

decisions relating to treatment which is at law required to be authorised by a Court (eg sterilisation). When a young person is incapable by reason of his or her age, of making his or her own decision parents have assumed that role and their decision is usually respected unless there has been a judicial or medical determination that the decision made would not be in the best interests of their child.

The common law has not yet devised a definitive set of circumstances which would give the parent final decision-making authority in relation to his or her child. It cannot be said that parents now have the right to consent to or to refuse particular treatments for their child - particularly if there is a question of whether or not the young person is legally competent, or if there is a question whether or not the treatment would be in the child's best interests.

Most importantly, the law in its present state is unable to guarantee that a young person has the right to be treated to ensure his or her continued good health or to return him or her to a state of good health, by a health care provider willing to treat. If the young person is too young to be capable of understanding the proposed treatment his or her parents will usually assist by way of substituted decision-making. 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 is at no time automatically entitled at law to consent to treatment. The young person must first find a health-care provider willing to treat in the absence of parental involvement and, if the health-care provider is so prepared, he or she must submit the young person to a maturity and understanding test. The results of that test will inform the health-care provider whether or not he or she is able to proceed with treatment. If the health-care provider proceeds without giving the test or if he or she fails to interpret the results on an objective basis then he or she may be liable to prosecution under the criminal law for assault, and/or under the civil law for trespass to the person.

The maturity test pays no regard to the relative independence or emancipation of the young person.

There is a need for clarity in this area. 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)*.³²⁵

³²⁵ (1992) 175 CLR 218. See discussion at 57-59.

Since *Marion's* case the High Court has not had occasion to examine further issues relating to consent to medical treatment of young people.³²⁶

2. PARTICULAR TYPES OF TREATMENT

Although the Commission intends by this Discussion Paper to seek submissions on appropriate consent requirements for all treatments by all relevant health-care providers (other than for those treatments specifically excluded³²⁷) it is not possible to discuss what would be the appropriate consent requirements for each imaginable treatment. However, a number of particular types of treatment, which could provide a useful test for the Commission's preferred scheme outlined in Chapter 12, have been referred to the Commission by way of submissions to the Information Paper or by way of consultations with expert and/or interested individuals and organisations. A number of those treatments, particularly when performed on young people, are controversial and/or the subject of strong moral, religious and ethical debate. Nevertheless, access to appropriate health care should be facilitated as much as possible and, 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.

For purposes of certainty and clarity, whatever legislative consent requirement scheme is adopted should cover all treatments other than those specifically excluded. It should cover treatment for common, uncontroversial conditions such as for the cold or influenza as well as treatment for controversial conditions such as sexually transmitted diseases. Set out below is a discussion on a number of treatments discussed in the submissions on the Information Paper.

³²⁶ However, the High Court has determined the interaction of the Family Court's 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) 120 ALR 545 and 38, 39 above.

³²⁷ See Ch 1 above.

3. SEXUALLY TRANSMITTED DISEASES³²⁸

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.³²⁹ A system of laboratory based notification has been in place in Queensland since 1988.³³⁰

The sexually transmitted diseases currently notifiable in Queensland include: chancroid,³³¹ chlamydia,³³² donovanosis,³³³ genital herpes,³³⁴ gonorrhoea,³³⁵ hepatitis B,³³⁶ hepatitis C,³³⁷ human immunodeficiency virus,³³⁸ lymphogranuloma venereum,³³⁹ and syphilis.³⁴⁰

³²⁸ 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* and Queensland Health *Annual Report 1992/1993 Health in Perspective*.

³²⁹ *Health Act 1937* (Qld) s32A. For list of notifiable diseases see Notification and Schedule, *Queensland Government Gazette* 28 July 1990 at 1993-4.

³³⁰ 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.

³³¹ An infection by the organism *Haemophilus ducreyi* which is relatively rare in Australia.

³³² An infection by *chlamydia trachomatis* which is one of the most commonly reported sexually transmitted diseases in Australia.

³³³ A progressive, destructive disease caused by *calymmatobacterium granulomatis* which is endemic among the indigenous population of Northern Australia.

³³⁴ A common sexually transmitted disease caused by herpes simplex virus types 1 and 2.

³³⁵ A common sexually transmitted disease.

³³⁶ A virus infection transmissible through sexual intercourse and exposure to blood or bodily fluids.

³³⁷ 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.

³³⁸ A virus infection transmissible through sexual intercourse and through bodily fluids. May lead to Acquired Immune Deficiency Syndrome (AIDS).

³³⁹ A condition caused by serotypes L1, L2, L3 of *chlamydia trachomatis* usually found in the tropics.

³⁴⁰ Sexually transmitted disease caused by the spirochaete *treponema pallidum*.

The most common sexually transmitted diseases notified in Queensland include chlamydia, genital herpes, gonorrhoea, hepatitis B, hepatitis C and syphilis. The age group most likely to acquire these diseases is the 15 to 29 year group, except hepatitis B and C (although rates are relatively high in the 15-29 year groups, they peak in the 30-34 year old males and 30-39 year old age groups respectively).

Notifications of HIV in Queensland as at 31 December 1994 (cumulative) totalled 1,873 including 101 relating to people under the age of 20 years.³⁴¹ In the year ending 31 December 1994 there were 4 notifications relating to people under the age of 20 years and 65 notifications relating to people in the 20 to 29 year category.

AIDS notifications in Queensland as at 31 December 1994 (cumulative) totalled 689 including 14 relating to people under the age of 20 years.³⁴² In the year ending 31 December 1994 there were no notifications relating to people under the age of 20 years. It should be noted that a diagnosis of AIDS reflects an infection with HIV that occurred up to 10 years previously³⁴³ 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 1993 national rate was 55.8 per 100,000 population. The 1993 rate for Queensland was 87.6 per 100,000.³⁴⁴ For gonorrhoea the national rate for 1993 was 15.9 cases per 100,000 and for Queensland it was 20.9 cases per 100,000 (including a rate of 100.4 cases per 100,000 population in 20 to 24 year old males). For hepatitis B the national rate for 1993 was 38.8 cases per 100,000 population and for Queensland it was 51.6 cases per 100,000 population. For syphilis, the 1993 national notification rate was 13.1 cases per 100,000 population and the Queensland rate was 21.1 cases per 100,000 population (including a rate of 92.4 cases per 100,000 population in 15 to 19 year old females).

³⁴¹ 672 related to people in the 20-29 years age group and 678 related to people in the 30 to 39 years age group. Figures are cumulative since 1984. See AIDS Medical Unit, Queensland Health *HIV/AIDS Statistical Report Period Ending 31 December 1994* at 11.

³⁴² 137 related to people in the 20-29 years age group and 282 related to people in the 30 to 39 years age group. AIDS Medical Unit Queensland Health *HIV/AIDS Statistical Report Period Ending 31 December 1994* at 6.

³⁴³ *Id* at 2.

³⁴⁴ 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.

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 'tip of the iceberg' of sexually transmissible diseases in Queensland".³⁴⁵

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 most recent available information on sexually transmitted diseases in Queensland as follows:³⁴⁶

The sexual health of the Queensland population has shown few encouraging signs of improvement during the last six years, 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

³⁴⁵ McCall B "Surveillance of Sexually Transmitted Diseases in Queensland 1988 to 1993" (1995) 19 *Communicable Diseases Intelligence* 58.

³⁴⁶ *Id* at 67.

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 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 a sexually transmitted disease it may be out of fear of their identity becoming known. It might also be due to a cultural barrier which makes people feel shame and guilt when they contract such a disease. There is a genuine public interest in having sexually transmitted diseases treated.

The Commission would welcome comment on the restrictions, if any, which should apply to a young person's ability to seek advice and treatment for a sexually transmitted disease. Should a different test of competency to consent to treatment be applied to young people suffering from a sexually transmitted disease than to young people suffering from a less serious, non-controversial condition?

4. CONTRACEPTIVE ADVICE AND TREATMENT

(a) Contraceptive advice and treatment not involving a touching

There is no statutory restriction in Queensland on the sale or supply of contraceptives to people whatever their age.³⁴⁷ 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 could obviously form the basis of an action for trespass or assault.

³⁴⁷ Note, however, s106 of the *Health Act 1937* (Qld) which restricts the sale or supply of contraceptives by means of automatic machines or similar devices.

The consequences to the medical practitioner of "treating" without an appropriate consent may be difficult to define. In *Gillick's case*³⁴⁸ it was argued by Mrs Gillick that doctors advising her daughters on contraception would be committing criminal offences, as principals, of causing or encouraging unlawful sexual intercourse with a girl under sixteen contrary to section 28 of the United Kingdom *Sexual Offences Act 1956*, or of committing offences of being an accessory to unlawful sexual intercourse with a girl under the age of sixteen contrary to section 6 of the 1956 Act. Section 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 in the doctor's ad hoc care. In relation to the offence in section 6 of the United Kingdom Act, 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."³⁴⁹

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.³⁵⁰

³⁴⁸ See 50-56 above.

³⁴⁹ *Gillick v West Norfolk and Wisbech Area Health Authority* [1984] QB 581 at 595 [QB: Div Ct].

³⁵⁰ 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 treatment that is required. The young person must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment 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 treatment 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 treatment are long-term.

It is unlikely that a medical practitioner simply providing contraceptive advice or treatment to a young person under the "age of consent"³⁵¹ in Queensland could be seen as a party to a sexual offence under the *Criminal Code (Qld)*³⁵² for the same reasons used by Woolf J to reject such a suggestion in the *Gillick* case in relation to the United Kingdom.

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.

(b) Contraceptive³⁵³ treatment 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. Similarly, if a medical practitioner inserts an intra-uterine device into a female or performs a vasectomy on a male. Whether or not a young person is able to give an effective consent will largely depend on the ability of the young person to consent to such treatment on his or her own behalf.

(c) When should a young person be able to consent to contraceptive treatment?

Many submissions to the Information Paper identified contraceptive advice, treatment and supply in relation to young people as a significant and controversial area of concern.

³⁵¹ The age of consent to sexual intercourse in Queensland is sixteen. See s215 of the *Criminal Code (Qld)*.

³⁵² *Criminal Code (Qld)* s7 states:

- (1) When an offence is committed, each of the following persons is deemed to have taken part in committing the offence and to be guilty of the offence, and may be charged with actually committing it, that is to say -
- ...
- (b) every person who does or omits to do any act for the purpose of enabling or aiding another person to commit the offence;
- (c) every person who aids another person in committing the offence;
- (d) any person who counsels or procures any other person to commit the offence ...

³⁵³ In this context, we are referring to temporary, reversible contraception not involving surgical intervention and are excluding consideration of sterilisation and abortion procedures and the "morning after pill".

A number of parents, parents' organisations and religious organisations expressed the belief that parents should at least be made aware of, if not be able to veto the provision of, contraceptive advice and treatment proposed for or given to their children, irrespective of the age of the children. One parent expressed the concern of a number of respondents when she wrote:³⁵⁴

Young people should be encouraged to discuss contraception and sexually-transmitted diseases with their parents, it should not be left up to others to decide these issues for them or encourage them to keep these issues from their parents. Moral standards can only be taught at home.

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. A paediatrician wrote:³⁵⁵

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:³⁵⁶

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:³⁵⁷

If they are old enough to ask the questions and are sexually active or planning to be they should have access to this information.

³⁵⁴ Submission 126.

³⁵⁵ Submission 1.

³⁵⁶ Submission 6.

³⁵⁷ Submission 7. See also submission 8.

A counselling organisation observed:³⁵⁸

Young people of any age should be able to seek treatment regarding 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:³⁵⁹

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 organisation³⁶⁰ 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 is compulsory. They believe 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.

³⁵⁸ Submission 40.

³⁵⁹ Submission 53.

³⁶⁰ Submission 61.

A youth health service wrote:³⁶¹

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.

Other respondents were of the opinion that issues such as contraception, sexually transmitted diseases, abortions and psychiatric treatments should not be seen as being different from any other medical treatment. As one respondent noted:³⁶²

This is in keeping with an holistic approach to health-care.

Some respondents considered it appropriate for there to be a lower age limit for young people to be able to consent to contraceptive advice and treatment. A paediatric surgeon wrote:³⁶³

I believe parents or the designated caregiver should be informed that this is occurring in any child under the age of 15 years. Over the age of 15 years I believe that a child should be able to seek contraceptive or sexually transmitted disease advice and/or treatment without the consent or knowledge of their parents.

Similarly, another respondent wrote:³⁶⁴

Contraception [advice] should be made available to young people aged 13 and over without their parents and guardians' consent at the discretion of the physician.

Other respondents³⁶⁵ suggested that parents should be involved unless the child, of whatever age, is living independently of the parents.

If the Commission recommends that all young people over a particular age, say 16, should be able to consent to medical treatment, then the medical practitioner would be free of the remote possibility of being civilly or criminally liable for advising or treating such a young person without first obtaining the parents' consent. If, on the other hand, the Commission were to recommend that an objective maturity test be applied, as per *Gillick's* case, a medical practitioner may feel reluctant to give

³⁶¹ Submission 82.

³⁶² Submission 55. Also see submission 147.

³⁶³ Submission 3.

³⁶⁴ Submission 4.

³⁶⁵ For example, submission 101.

advice or treatment even where in his or her assessment it would be most appropriate in the circumstances, for fear of making a wrong judgment as to the young person's maturity.

(d) Is contraceptive treatment 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 etcetera, 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. 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 after advice and options in contraception they usually have little choice but to seek professional help, including a pharmaceutical prescription. To limit the ability of young women to seek such help 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 females.³⁶⁶

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/STD prevention 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 abortions 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 no such entitlement under the current law and it is debatable whether this is a legitimate function of the law or whether it is a private matter.

³⁶⁶ Submission 23.

The Western Australian Law Reform Commission³⁶⁷ observed that contraceptive advice or treatment to young women:

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 scheme³⁶⁸ 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.

The Commission would welcome comment on the restrictions, if any, which should apply to a young person's ability to seek contraceptive advice and treatment. Should a different test of competency to consent to treatment be applied to young people seeking contraceptive advice and treatment than to young people seeking less controversial advice and/or treatment?

5. 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 at any age.

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 was either non-existent or inadequate.

³⁶⁷ Law Reform Commission of Western Australia Discussion Paper *Medical Treatment for Minors* 1988 at paras 6.10 and 6.11.

³⁶⁸ *Id* at paras 5.9-5.22.

Evidence presented to the National Inquiry into the Human Rights of People with Mental Illness³⁶⁹ (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.³⁷⁰

Research into the prevalence of mental disorders among Queensland children 10-11 years of age has indicated that 23% suffered from mental health problems and 14% fitted a diagnosis of mental disorders.³⁷¹

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 18.³⁷²

It has been estimated that 75% of adults who commit suicide suffered from depression as teenagers.³⁷³

The prevalence of attempted suicide and suicide among young Australians highlights the need for ready accessibility to appropriate health-care services with as few legal or social impediments as possible. Although feeling suicidal does not necessarily imply being mentally ill, it does indicate the need for help.

(a) Suicide statistics³⁷⁴

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 (including over 2,000 deaths in each of the past 6 years). 78% of the total number of deaths by suicide since 1982 have been male.

³⁶⁹ Human Rights and Equal Opportunity Commission *Human Rights and Mental Illness* 1993.

³⁷⁰ *Id* at 604 referring to Sawyer M, Meldrum D, Tonge B and Clark J *Mental Health and Young People* (1991) at 14.

³⁷¹ Connell H 'Psychiatric Disorder in Queensland Primary School Children' (1982) 18 *Australian Paediatric Journal* at 177-180.

³⁷² Reiger D *The NIMH Epidemiological Catchment Area Program: Historical Context, major objectives and study population characteristics* (1984) Archives of General Psychiatry.

³⁷³ *The Courier-Mail*, 31 October 1994 at 7 referring to statements by George Patton, head of the Centre for Adolescent Health, Melbourne.

³⁷⁴ 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 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.

Between 1982 and 1992, on an age and sex standardised basis, there was an increase in the suicide rate of 7.5%. For males, the increase was 14%.³⁷⁵ Males in the 15-24 year group had a considerably higher age specific suicide rate in rural areas than in urban areas.³⁷⁶ 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.³⁷⁷

The rate of suicide in Australia is amongst the highest in the world³⁷⁸ and suicide is second only to car accidents as the most frequent cause of adolescent death in Australia.³⁷⁹ The suicide rate in Queensland has consistently been above the national average in all years between 1982 and 1992. In Queensland, suicide is the most frequent cause of adolescent death.³⁸⁰

Although suicide is rare for young people under the age of 15,³⁸¹ 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.³⁸² Aboriginal and Torres Strait Islander suicides are significantly younger.³⁸³ 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".³⁸⁴

³⁷⁵ For females, there was a downward trend over the same period of 15% below 1982.

³⁷⁶ 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.

³⁷⁷ Queensland Health *Suicide in Queensland 1990-1992 by Health Region 1992* at 3.

³⁷⁸ Kosky RJ *Breaking Out - Challenges in Adolescent Mental Health in Australia* AGPS 1992 at 92.

³⁷⁹ Human Rights and Equal Opportunity Commission *Human Rights and Mental Illness* 1993 at 637.

³⁸⁰ 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.

³⁸¹ In 1990-1992 only 6 people below 15 suicided (Queensland Health *Suicide in Queensland 1990-1992 by Health Region 1992* at 6).

³⁸² *Id* at 12.

³⁸³ Queensland Health *Suicide in Queensland 1990-1992 by Health Region 1992* at 19.

³⁸⁴ *Id* at 12.

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 100,000 population in the 16-20 year age group.³⁸⁵

(b) Risk factors

A variety of factors have been identified which 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.³⁸⁶ The majority of young people who attempt suicide receive medical (as opposed to psychiatric or psychological) treatment only.³⁸⁷

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.³⁸⁸ Alcohol was involved in 39% of suicides in Queensland in the period 1990-1992.³⁸⁹ It has been suggested that 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.³⁹⁰

³⁸⁵ 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.

³⁸⁶ 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.

³⁸⁷ Human Rights and Equal Opportunity Commission *Human Rights and Mental Illness* 1993 at 638 quoting Professor Tonge.

³⁸⁸ Weber R *Suicide Prevention at the Workplace*. Paper presented to 1994 National Occupational Stress Conference June 1994 at 10.

³⁸⁹ Queensland Health *Suicide in Queensland 1990-1992 by Health Region* 1992 at 26-27.

³⁹⁰ Human Rights and Equal Opportunity Commission *Human Rights and Mental Illness* 1993 at 640.

History of psychiatric illness, physical or sexual abuse. Depression was likely to be a factor 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 the suicides.³⁹¹

Excessive stress. As mentioned earlier, low self-esteem associated with youth homelessness³⁹² is a factor in youth suicidal behaviour. 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.³⁹³

Other risk 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.³⁹⁴ It has been stressed, however, that there is no reliable way to predict which individuals will commit suicide.³⁹⁵

(c) Difficulty in obtaining treatment

There are a number of obstacles that affect the health-care provider's ability to reach and assist suicidal adolescents. In general, there is ignorance about the prevalence of mental disturbance in adolescence, especially depression. This also applies to the family members and teachers.

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.

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.

³⁹¹ Queensland Health *Suicide in Queensland 1990-1992 by Health Region 1992* at 27-28.

³⁹² See Ch 2 above.

³⁹³ Queensland Health *Suicide in Queensland 1990-1992 by Health Region 1992* at 28.

³⁹⁴ Human Rights and Equal Opportunity Commission *Human Rights and Mental Illness 1993* at 638.

³⁹⁵ *Ibid.*

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).

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.

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.³⁹⁶

In an annotation on adolescent suicide,³⁹⁷ 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 medical treatment difficult.

(d) Health-care provider's role in suicide prevention

Although the percentage of young persons 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 the health-care provider and, in particular, medical practitioners, may have important opportunities to detect suicidal behaviour and intervene appropriately to prevent these tragedies.³⁹⁸

³⁹⁶ Keir N I *Can't Face Tomorrow* (Rochester Thorsons Publishing Group 1986).

³⁹⁷ Kosky RJ 'Annotation. Adolescent Suicide' *Australian Paediatric Journal* 1989; 25:257-8.

³⁹⁸ 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.

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.³⁹⁹ A focus on the early identification and treatment of depression may be the most effective means of preventing suicide in adolescents.

As mentioned earlier, many health-care providers will evaluate suicidal youth 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.⁴⁰⁰

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.

The submissions to the Information Paper 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:⁴⁰¹

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.

Similarly, a lay respondent wrote:⁴⁰²

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

³⁹⁹ Hawton K, Bladestock E "General Practice Aspects of Self Poisoning and Self Injury" *Psychol Med.* 1976; 6:571-5, and 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.

⁴⁰⁰ 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.

⁴⁰¹ Submission 1.

⁴⁰² Submission 5.

the assistance of the family support network may be needed to assist the young person through a crisis/crises.

A health-care facility wrote:⁴⁰³

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:⁴⁰⁴

We suggest young people of any age should be able to seek such treatment without the knowledge or approval of parents.

Although they expressed 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.

However, a student wrote saying how valuable confidential counselling in school could be:⁴⁰⁵

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.

⁴⁰³ Submission 6.

⁴⁰⁴ Submission 35.

⁴⁰⁵ Submission 106.

A family planning organisation wrote:⁴⁰⁶

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 treatment recommended:⁴⁰⁷

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.

However, a number of respondents were not in favour of young people receiving psychiatric or psychological counselling without the knowledge or consent of parents.

For example, one respondent wrote:⁴⁰⁸

The parental or guardian('s) prior knowledge and consent needs to be obtained except in circumstances of emergency where death or physical harm is probable. Counselling should avoid advising termination of pregnancy or artificial contraception.

⁴⁰⁶ Submission 40.

⁴⁰⁷ Submission 104.

⁴⁰⁸ Submission 78.

Similarly, a religious organisation wrote:⁴⁰⁹

We feel that eighteen years and not younger should be the age at which young people should be able to consent to such treatment without the knowledge or approval of parents. The very nature of their illness may make informed consent by such young people impossible.

Another respondent wrote:⁴¹⁰

Counselling and other treatments for emotional or behavioural problems must be made known to parents as they will have to support and comfort them during this period of time. The exception would be when a young person was living independently.

(e) 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)*⁴¹¹ which contrasts sharply to people 16 years of age and over. Section 17(2) reads:

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.

As a legal academic wrote:⁴¹²

I believe that under the provisions of section 17(2) of the *Mental Health Services 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.

⁴⁰⁹ Submission 86.

⁴¹⁰ Submission 101.

⁴¹¹ Submission 21 and Submission 157.

⁴¹² Submission 23.

Similarly, a youth organisation wrote:⁴¹³

Section 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.

However, in relation to people under the age of 16, the situation is not clear. Parents sign their consent form under section 17 and they are classified as voluntary patients. In reality, however, it appears they are treated as involuntary patients and may have their wishes overruled.

The Commission would welcome comment on the restrictions, if any, which should apply to a young person's ability to seek psychiatric or psychological advice and treatment. Should a different test of competency to consent to treatment be applied to young people seeking psychiatric or psychological advice and treatment than to young people seeking less serious advice and treatment?

6. MEDICAL EXAMINATIONS IN CASES OF SUSPECTED CHILD ABUSE

(a) Introduction

Upon an allegation being made to police, health 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.

⁴¹³ Submission 61. See also Submission 82.

However, where the parents or a guardian of a young person too young or immature to be able to consent to his or her own medical examination refuse consent to the examination taking place, it appears that the current law in Queensland may actually hinder the investigation of the alleged offence.

(b) Investigation of suspected abuse

In 1980 the Co-ordinating Committee on Child Abuse was established in Queensland. That committee has representatives from the principal government departments concerned with child abuse and neglect services. These are the Department of Family Services and Aboriginal and Islander Affairs, Queensland Health, Queensland Police Service, the Department of Education and the Department of Justice and Attorney-General.

The Co-ordinating Committee oversees a system of hospital-based Suspected Child Abuse and Neglect Teams (S.C.A.N. Teams) to ensure the co-ordination of responses to reports of child abuse and neglect. The core members of each S.C.A.N. team are authorised representatives from each of the three disciplines with responsibilities to respond to child abuse and neglect matters, that is, an officer of the Department of Family Services and Aboriginal and Islander Affairs, a police officer and a medical practitioner.

The S.C.A.N. Teams consider reported cases of child abuse and neglect and make recommendations about how to respond in a co-ordinated manner. The S.C.A.N. Team ensures that one of the represented departments takes responsibility for the case, and co-ordinates the involvement of others. An examination of the young person will be a priority.

(c) Examining the young person

In the legal as well as the medical context, information gained from the young person is preferable to "second-hand" interpretations from a parent or guardian.

The examination is also important to identify problems other than abuse which may account for the suspicion of abuse.

The medical examination is regarded, at least by the medical profession,⁴¹⁴ as being for the benefit of the young person and not primarily to collect forensic evidence to assist in the prosecution of an offender. However, the importance of the collection of such evidence to assist in prosecution cannot be ignored, particularly as cases of suspected child abuse are difficult to prove. In relation to suspected sexual abuse, a medical examination may lead to:

⁴¹⁴ See for example Dr J Harry *Vicspcan* Second Annual Conference June 1989 proceedings at 100.

1. detection of damage to the young person's genitals or anus requiring treatment;
2. detection of sexually transmitted disease;
3. confirmation or discounting of pregnancy;
4. forensic evidence (evidencing sexual assault);
5. reassurance to the young person and parent;
6. detection of other conditions not associated with sexual abuse (eg threadworms or thrush which may be the cause of the young person's genital symptoms).

There are a number of people who may be interested in the results of a medical examination of a young person suspected of being abused. This interest usually stems from a concern for the welfare of the young person and from the fact that the results and findings of such an examination will often form a part of the evidence in a subsequent court case.

The court case may involve allegations of a criminal offence. Alternatively, the case may be 'civil' in nature and involve the young person's future welfare and upbringing. For example, it may involve a dispute between the young person's estranged parents over custody and access. It might also involve the question of whether the young person should be removed from his or her parents.

(d) Refusal by the young person to undergo examination

Where a young person of any age refuses to be medically examined following allegations of abuse, it is generally considered inappropriate to force him or her to undergo the examination. The following comments were included in submissions received by the Commission:

I do not think that examinations for evidence of sexual abuse should be carried out against the objections of the young person.⁴¹⁵

[I]f the young person is in such a traumatised state and refuses the examination, then the examination must not take place - e.g. a girl of 12 or 13 years of age may refuse for a variety of reasons, and that person's wishes need to be respected. Efforts must be expended into eliciting the reason for refusal, where abuse is obvious.⁴¹⁶

⁴¹⁵ Submission 1 (medical practitioner).

⁴¹⁶ Submission 5.

[A young person] who can understand the nature and consequences of the examination or treatment ... should be able to refuse medical examination and treatment whether or not it is in her/his best interests.⁴¹⁷

Examination not to take place against young person's objections.⁴¹⁸

[The respondent] does not believe that examinations should be carried out against the wishes of a young person. This can only reinforce feelings of powerlessness and violation resulting from the original abuse. Sensitivity by health professionals will be paramount in this situation.⁴¹⁹

No matter what the circumstance, 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 were able to feel in control of the situation and understand the rationales for the examination. Any objections the young person has need to be addressed and considered.⁴²⁰

The reasons a young person may give for objecting to the conduct of medical examination if the young person has capacity to consent, must also be considered.⁴²¹

These concerns are reflected in the academic literature on child abuse. From the medical point of view, Gardiner observes:⁴²²

We believe children should never be forced to have an examination of their genitals. Very apprehensive children may find postponing the examination acceptable; they then have time to prepare themselves emotionally, and to become more familiar with the examiner and the setting.

Cashmore and Bussey observe:⁴²³

These examinations may be embarrassing to children and interpreted by them as meaning that there is something wrong with them. Although the child's consent may not be required legally for a medical examination, depending on their age,

⁴¹⁷ Submission 6 (Organisation concerned with family planning).

⁴¹⁸ Submission 7 (Registered Nurse).

⁴¹⁹ Submission 61 (Youth Organisation).

⁴²⁰ Submission 82 (Youth Welfare Organisation).

⁴²¹ Submission 108 (legal service).

⁴²² Gardiner J "The Medical Assessment of Sexually Abused Children: Mythology & Reality" in Hetherington P (ed) *Incest and the Community: Australian Perspective* (1991) 97 at 101.

⁴²³ Cashmore J and Bussey K "Disclosure of Child Sexual Abuse: Issues from A Child-Orientated Perspective" (1987) 22 *Aust Journal of Social Issues* 13 at 19.

such consent is important and should be sought regardless of the child's age so that their sense of control over their own body is not further violated. It is also important that children are provided with adequate information about the medical examination and its purpose to allay any fears or sense of guilt surrounding it.

In South Australia section 26(3) of the *Children's Protection Act 1993* (SA) enables a person who is to examine, test, assess or treat a young person in certain circumstances to do so despite the absence or refusal of consent of the young person's guardians, but the examining person is not obliged to proceed if the young person refuses consent. In most Australian jurisdictions if a young person refuses consent, an attempt is made to explain the relevance and procedure of the examination to the young person or to provide any counselling if necessary, but if consent is still not forthcoming from the young person, then usually the examination does not proceed. However, in some jurisdictions⁴²⁴ in the case of a very young person who may be traumatised by the abuse or any subsequent examination, the young person may be placed under sedation or general anaesthetic with the written consent of the young person's parents or guardian in order to carry out the examination (which, as indicated above, is not usually performed solely for forensic purposes, but within the context of determining the causes of any physical complaints and the appropriate treatment).

(e) Statutory consent where parents and/or young person refuses examination

In Queensland there are certain statutory provisions to facilitate the medical examination or treatment of a young person suspected of having been maltreated or neglected in the absence of consent by the young person and/or his or her parent.⁴²⁵ For example, section 76L⁴²⁶ of the *Health Act 1937* (Qld) provides that a medical officer-in-charge of a hospital (or other authorised person) may admit and/or detain a "child"⁴²⁷ suspected of being maltreated or neglected in hospital for up to 96 hours. The officer can also order the young person to be returned if he or she leaves or is removed from the hospital without the officer's permission.

⁴²⁴ Such as Western Australia and Victoria. Other jurisdictions such as Queensland and South Australia do not follow this practice. A general anaesthetic will only be administered for treatment purposes.

⁴²⁵ Queensland Cabinet has recently given its approval for the drafting of new child protection legislation which could affect the question of consent to medical examinations in the case of suspected child abuse victims: see "Violent Parents to be Forced to Leave Home" *The Courier-Mail* 14 March 1995 at 1 and *Child Protection Legislation Issues Paper*, Department of Family Services and Aboriginal and Islander Affairs 1993.

⁴²⁶ See Appendix 3.

⁴²⁷ "Child" is defined in s76M as meaning a person under or apparently under the age of 17 years.

A police officer can assist in detaining the young person in hospital and conveying the young person to hospital. A police officer can also "take into custody" a young person who has left or been removed from hospital, and convey him or her to the hospital. The police officer can use such force as may reasonably be necessary to do the above.⁴²⁸

Taking into custody and detention in the hospital for the specified period is deemed lawful under subsection 76L(3)⁴²⁹ despite the wishes of any parent, guardian or person claiming to be entitled to custody of the child, as is the subsection of the young person to necessary diagnostic procedures and tests, or treatment.

Subsection 76L(4)⁴³⁰ of the *Health Act 1937* relieves doctors who treat young people pursuant to section 76L and those assisting the doctors, from any liability at law arising by reason only that any parent, guardian or person having authority to consent to the administration of the treatment refused consent to the administration of the treatment or in prescribed circumstances such consent was not obtained. Those circumstances include: if the medical officer in charge of the hospital or other authorised person believed that the treatment was necessary in the young person's interests, and either: a second medical practitioner agreed with that belief after personally examining the young person but before the administration of treatment; or if the hospital medical superintendent, upon being satisfied that a second medical practitioner was not available and treatment was necessary in the young person's interests, consented to the treatment before its administration. It would seem from the terms of the Act that any examination performed would have to be in the course of determining or providing treatment - that is, a medical examination could not be carried out with impunity if it were conducted merely for forensic purposes.

Subsection 76L(5)⁴³¹ provides that treatment administered to a young person in accordance with section 76L is, for all purposes, to be deemed to have been administered with the consent of the parent or guardian or person having authority to consent to the administration of the treatment.

There is no mention in the section of the consent of the young person being sought - and no mention of a possible conflict between the wishes of the young person, the medical officer and/or the young person's parent(s).

⁴²⁸ *Health Act 1937* (Qld) s76L(2BA)-(2C).

⁴²⁹ See Appendix 3.

⁴³⁰ *Ibid.*

⁴³¹ *Ibid.*

There is also no reference made to any rights of privacy or self-determination of young people consistent with their growing maturity and autonomy.⁴³²

An alternative method of proceeding with a medical examination without the consent of the young person⁴³³ or his or her parents is for an authorised officer of the Department of Family Services and Aboriginal and Islander Affairs or any police officer to apply to the Children's Court under section 49 of the *Children's Services Act 1965* (Qld)⁴³⁴ for an order that the young person be admitted to the care and protection of the Director of Family Services. Where it appears to, or it is reasonably suspected by, the authorised officer or police officer that a young person may be in need of care and protection, the officer may take the young person into custody on the authority of the Act, although application must be made to the Children's Court as soon as practicable thereafter for an order placing the young person under the care and protection of the Director-General.⁴³⁵ The Court may determine who is to care for the young person pending determination of the care and protection application.⁴³⁶

Upon the making of an application, the Court may order any necessary or desirable investigations and medical examinations in relation to the young person, in which case the young person is remanded into the temporary custody of the Director. The Court also hears any objections to the application.⁴³⁷

If the Court is satisfied that a care and protection order is necessary, the Court has a number of options. It may order a parent or guardian of the young person to enter into a recognisance, with or without surety, on the condition that the parent or guardian exercise proper care, protection and guardianship in respect of the young person; it may grant the Director protective supervision over the young person; or if it appears to the Court that any other order is not appropriate, it may order that the young person be admitted to the care and protection of the Director. Costs orders may also be made with respect to the application or any investigation or assessment.⁴³⁸

⁴³² See *Child Sexual Abuse Task Force Report* (WA 1987) paras 6.87 and 6.89.

⁴³³ Although in practice if a child refuses consent to the examination, the examination will not proceed, despite the lack of statutory clarification of the matter.

⁴³⁴ See Appendix 3.

⁴³⁵ *Children's Services Act 1949* (Qld) s49(2).

⁴³⁶ *Ibid.*

⁴³⁷ *Id* s49(3).

⁴³⁸ *Id* s49(4).

If the Court is not of the opinion that the young person is in need of care and protection, it may refuse to make any order.⁴³⁹

Under sub-section 49(2) it might be possible for the person with custody of the young person to have the young person examined prior to an application being made for an order that the young person be admitted to the care and protection of the Director, as long as such examination could be said to be conducted in the young person's best interests.⁴⁴⁰ However, it is more likely that such an examination would only take place pursuant to an order under sub-section 49(3)(a).

Although there is nothing in section 49 to indicate what regard is to be had to the wishes of the young person vis à vis a medical examination, in practice, as in the case of section 76L, if the young person refuses to undergo a court-ordered medical examination that is usually the end of the matter.⁴⁴¹

(f) The practice in Queensland

In Queensland, if a young person refuses to undergo a medical examination, his or her wishes are usually respected although the Commission has been informally advised that some effort is usually made to convince the young person of the positive aspects of an examination.

If the young person consents to an examination taking place but his or her parents refuse, the practice has been adopted of proceeding with the examination - depending upon the maturity of the young person.

⁴³⁹ *Id* s49(4)(b).

⁴⁴⁰ S49(2) states, in part:

Pending determination by a Children's Court of such an application the child shall be cared for in a manner consistent with his best interests...

⁴⁴¹ Compare to *Children's Protection Act 1993* (SA) s26(3) which reads:

A person who is to examine, test, assess or treat a child pursuant to this section may do so notwithstanding the absence or refusal of the consent of the child's guardians, but nothing in this section requires the person to carry out any examination, test, assessment or treatment if the child refuses consent.

and *Children Act 1989* (UK) s43(8) which reads:

if the child is of sufficient understanding to make an informed decision he may refuse to submit to a medical or psychiatric examination or other assessment.

In most cases, it appears that police are able to negotiate the relevant consent from the young person's parents, often by making the parents or guardian aware of the options open to police if consent is not forthcoming, such as seeking a care and protection order.⁴⁴²

It is a common belief, supported by the language of the section, that an order under section 76L of the *Health Act 1937 (Qld)* only applies to suspected cases of abuse presented at hospitals. Invariably, such cases relate only to physical abuse - for example, where a young person has suffered a broken bone or other obvious injuries. Rarely, if ever, has an order under section 76L been made in relation to a suspected sexual abuse case.

Where a care and protection order has been made under section 49 of the *Children's Services Act 1965 (Qld)*, a medical examination can proceed against the wishes of the parents and, presumably, against the wishes of the young person, particularly those of a very young child. However, it appears from consultation with those working in the area that if a young person refused to undergo an examination, the young person's wishes would be respected. Exceptions would be where the young person was in need of medical treatment and an examination had to be performed in the course of providing such treatment, or in relation to very young children such as babies incapable of understanding the nature of the treatment involved.

In cases of alleged child sexual abuse, it is not uncommon for there to be very little, if any, physical signs of the abuse. Courts may be reluctant to grant an order without evidence that only a psychiatric or other detailed medical examination could provide. Further, if a young person refuses to undergo a court-ordered examination, it is unlikely that a Court would insist that the examination proceed.

(g) Other Australian jurisdictions⁴⁴³

From informal consultations with Police Services and child abuse workers in other Australian jurisdictions, it appears police rarely have difficulty in obtaining parental consent for the examination of suspected child abuse victims.⁴⁴⁴

⁴⁴² If a parent is suspected of being the abuser, and denies it, he or she may be persuaded to consent by an argument such as "if you did not abuse your child, obviously you would not object to the child being examined?".

⁴⁴³ See comparative table of legislation in other Australian jurisdictions in Appendix 3.

⁴⁴⁴ Informal consultation with Western Australian Police; Princess Margaret Hospital (Perth); Victoria Police (Child Exploitation Unit); Royal Children's Hospital (Melbourne); New South Wales Police (Major Crime Squad, Parramatta); Royal Children's Hospital (Sydney); Tasmania Police; Northern Territory Police; Sexual Assault Centre (Darwin); Australian Capital Territory Police; South Australian Police; Child Protection Unit (Adelaide).

The Australian Capital Territory,⁴⁴⁵ the Northern Territory⁴⁴⁶ and Western Australia⁴⁴⁷ have provisions similar to section 76L of the *Health Act 1937* (Qld). Victoria used to have such a provision - but the Commission has been advised it was repealed on the ground that it was fraught with difficulties such as giving doctors a wide discretion with no facility to oversee the doctor's actions. Further, hospitals did not want such powers, and cases of alleged sexual abuse were not as commonly observed in hospitals as they are now.

Until 1 January 1994, when the *Children's Protection Act 1993* (SA) came into operation, South Australia also had a provision similar to section 76L of the *Health Act 1937* (Qld).⁴⁴⁸ Such a provision was not re-enacted in the new Act, and the Commission has been advised that, as in Victoria, a number of problems were encountered under the former provision. Thus, if the parents or guardian of a young person detained in hospital appeared at the hospital and absconded with the young person, hospital staff could do nothing as there was no warrant officially detaining the young person. Moreover, the provision placed the nursing and medical staff in the position of guarding over the young person without any legal authority. It should be added that the former South Australian provision was much less specific than section 76L of the *Health Act 1937* (Qld), and lacked the backing of written orders and the availability of police assistance embodied in the Queensland provision.

In all jurisdictions except Queensland, Western Australia and the Australian Capital Territory⁴⁴⁹ there are statutory schemes in addition to care and protection proceedings, which enable suspected child abuse victims who have not been admitted to hospital, to be detained for examination, against the wishes of the

⁴⁴⁵ *Children's Services Act 1986* (ACT) s74 - power for hospital to detain young person for up to 48 hours before matter must go to court for care and protection application. Magistrate can order detention to continue for further 72 hours with weekly review thereafter. These periods are usually used for medical examinations (s76).

⁴⁴⁶ *Community Welfare Act 1983* (NT) s15 - person in charge of hospital who believes young person has suffered maltreatment can detain the young person for examination or treatment for a period of 48 hours.

⁴⁴⁷ *Child Welfare Act 1947* (WA) s29(3a) - children under 6 years of age admitted to hospital may be detained for 48 hours for observation, assessment or treatment if reasonable grounds exist to suspect the child is in need of care and protection. The Commission has been advised that the provision is rarely used.

⁴⁴⁸ *Community Welfare Act 1972* (SA) s94.

⁴⁴⁹ *Children's Services Act 1986* (ACT). Ss73-75 allow for the detention of a young person suspected of being abused for a maximum of 48 hours before being taken before a magistrate for an order extending detention for a maximum of 72 hours. The Act is silent as to the question of medical examination during this period, although the Commission has been informed that examinations are carried out during this time.

young person's parents.⁴⁵⁰ In most jurisdictions it appears to be rare for a young person to be examined against his or her express wishes,⁴⁵¹ although in some States in the case of young children who have been traumatised by the abuse, some medical examinations are conducted, with the parents' written consent, under sedation or general anaesthetic.⁴⁵² Within the context of any powers exercisable in relation to a young person under the *Children's Protection Act 1993 (SA)* the views of a young person who is able to form and express his or her own views as to his or her ongoing care and protection must be sought and given serious consideration.⁴⁵³

Protocols have been developed by the Health Commission in South Australia and the New South Wales Department of Health for medical examinations in cases of alleged child sexual assault.⁴⁵⁴ The New South Wales protocol sets out the following consent requirements:

Medical examinations should never be carried out against the expressed wish of the child.

- a. Children age **16 years and over** can legally give consent to or refuse medical examination.

⁴⁵⁰ In South Australia a child who is reasonably believed to be at risk may be removed by police or an authorised officer from the child's guardian or guardians under Division 2, *Children's Protection Act 1993 (SA)*, s26 of which provides that whilst a child is in the custody of the Minister after having been removed from any person, premises or place by a police officer or authorised employee of the Department under Division 2 of the Act, or in respect of whom an order authorising examination and assessment of the child by the Youth Court of South Australia is made under Division 4, the child may be taken to an authorised place of assessment, including admitting a child to hospital to be professionally examined, tested or assessed, without parental or guardian consent.

In Victoria *Children and Young Person's Act 1989 (Vic)* s271 provides for the Director-General to have a young person examined and treated pursuant to interim orders if parents refuse consent.

In the Northern Territory see *Community Welfare Act 1983 (NT)* s12. In New South Wales see *Children (Care and Protection) Act 1987 (NSW)* s23 (detention for up to 72 hours to carry out examination); in Tasmania see *Child Protection Act 1974 (Tas)* ss9,10 (detention for 120 hours extendable to 1 month - may carry out medical examination in this time under s17).

⁴⁵¹ *Children's Protection Act 1993 (SA)* s26(3) provides:

A person who is to examine, test, assess or treat a child pursuant to this section may do so notwithstanding the absence or refusal of the consent of the child's guardians, but nothing in this section requires the person to carry out any examination, test, assessment or treatment if the child refuses consent.

⁴⁵² Although this will usually only be carried out after an attempt has been made to counsel or calm the child if possible. Other jurisdictions do not undertake this practice, feeling that to do so would be to commit a further assault of the child, thereby adding to the child's disempowerment. The provision of necessary treatment requiring sedation or general anaesthetic, such as where the child is haemorrhaging as a result of the abuse, is a different issue involving other considerations such as determining the best treatment for the child.

⁴⁵³ *Children's Protection Act 1993 (SA)* s4(3).

⁴⁵⁴ South Australian Health Commission March 1990 *Guidelines for the Medical Evaluation of Sexually Abused Children*; Department of Health (NSW) April 1990 *Child Sexual Assault: Medical Protocol*.

- b. Children age **14-16 years** can legally give consent to or refuse medical examination. *Minors (Properties and Contractors) Act 1976* (sic). If possible, approval of parent or guardian should also be sought.
- c. Children **under 14 years** of age
 - i Consent in writing must be given by parent or guardian for medical examination.
 - ii Medical examination order - The Director-General of F.A.C.S. may service (sic) a notice requiring medical examination. *Children (Care and Protection) Act 1987* No 54 section 23.
 - iii New South Wales State Wards - Approval must be granted by a person delegated by the Director-General of the Department of Family and Community Services.

A consent form is an integral part of the protocol. The form includes a statement to be signed by the child, a parent, guardian or other person, in the following terms:

I hereby consent to a complete medical examination including genital examination, and to the recording of the findings. I also authorise the collection of all necessary specimens for laboratory tests and the taking of necessary photographs of injuries related to the reason for this examination.

I understand that a copy of the Sexual Assault Medical Protocol and any relevant laboratory reports will be released to the Department of Family and Community Services and may be released to the Police Department and the Office of the Crown Prosecutor, as requested, for medico-legal purposes. I understand that some of the laboratory specimens may be forwarded to a forensic laboratory.

The consent and the examination must be witnessed.

7. YOUNG PEOPLE AS PARENTS

(a) Introduction

In 1993, 3000 teenage females became parents in Queensland. This represented 6% of all births in the State for that year.⁴⁵⁵

The question arises whether the duties and responsibilities of parents who are under eighteen years of age (referred to as "young parents") vis à vis their children are or should be the same as adult parents, and in particular, whether such young parents have or should have the same power to consent to the medical treatment of their children, notwithstanding that they may not be legally competent to consent.

⁴⁵⁵ Australian Bureau of Statistics 1993 *Demography Queensland* (Cat. no. 3311.3) at 23.

The courts have drawn no distinction between those parents who are not legally competent (through minority or otherwise), and those who are legally competent, in defining the general duties and responsibilities of parents, including the ability to consent to medical treatment. However, the courts do not appear to have considered the question specifically.

The lack of clarity in the law in this area could place health-care providers in a dilemma: whether to assume a young parent has the legal competence of most adults to consent to the treatment of his or her child or whether to test the legal competence of the young person and to restrict the treatment of the child to what the young parent is specifically competent to consent to.

Initial consultations held by the Commission and submissions to the Information Paper indicate that in dealing with this issue in practice, health-care providers tend to treat young parents as adults and give their opinion and consent the same importance as that of adult parents. In practice, an assessment of the legal competency of a young parent would appear to be considered irrelevant and only in the rarest case would a health-care provider consider a parent incapable of making decisions for a child and decline to accept the parent's consent. The Commission has been informed that this usually occurs when the parent is experiencing other, perhaps more important, problems in caring for the child (such as through an inability to pay for food and lodgings or to care for the child alone).

The *Family Law Act 1975* (Cth) which recognises the status of parents as the guardians and custodians of children, and which vests in parents duties and responsibilities which are ordinarily the incidents of parenthood, draws no distinction between parents of different ages or legal competency, in its specific provisions or in adopting the common law position in its general grant of responsibilities.⁴⁵⁶ This approach is mirrored in other legislation which imposes specific obligations on parents irrespective of their age - such as the duty to provide a child with the necessities of life imposed by the *Criminal Code* (Qld).⁴⁵⁷

It follows that, in general terms, young parents would appear to possess the same duties and responsibilities as adult parents in relation to their children. No general distinction is drawn between parents over or under eighteen years of age, or between those parents who are legally competent and those who are not.⁴⁵⁸

⁴⁵⁶ *Family Law Act 1975* (Cth) s63E.

⁴⁵⁷ *Criminal Code* (Qld) s286.

⁴⁵⁸ Competency is relevant in that many young parents may not be legally competent in the sense that they cannot make decisions concerning medical treatment (i.e. they may not be *Gillick*-competent).

However, although a person may be under a duty to provide medical treatment and other "necessaries" for a young person, under certain circumstances the person may actually be liable for fulfilling the duty - for example, where the person does not have the ability to consent to the treatment; or where the proposed treatment is not in the young person's best interests. The person could be relieved from criminal liability for assault for performing the duty under section 31 of the *Criminal Code* (Qld).⁴⁵⁹ However, he or she could still be civilly liable for assault and/or false imprisonment, despite fulfilling a legally imposed duty. Fleming observes:⁴⁶⁰

Defences specified for criminal prosecutions under the statute are not necessarily applicable to civil actions. Excuse from criminal liability does not lessen the duty, which alone is the "given" for the purpose of civil liability.

If a young parent does not understand the nature and likely consequences of a particular treatment (that is, is not legally competent) and is thus unlikely to be able to assess the treatment and its alternatives properly, it is more likely that he or she may desire treatment which is not in the child's best interests.

More importantly, from a practical perspective, it is possible that a health care provider may simply refuse to act on the consent of a young parent, at least where that parent is not obviously legally competent in relation to the treatment in question, on the basis that it is unclear what is in the child's best interests given the lack of reliable direction from the parent in this regard. What is in a child's "best interests" is often dependent upon an objective evaluation of what are necessarily subjective factors (such as priorities, values, beliefs and the importance placed upon different elements of life and health). It follows that a health-care provider would to a large extent usually be guided by the attitudes of a child's parents in satisfying himself or herself that treatment should be proceeded with. In the case of the child of young parents, a health-care provider may be less able to rely on any guidance, if given at all, from the parents.

As legal competency is determined by reference to a particular treatment, a young person would not be generally precluded from acting for a child, unless the young person were clearly incapable of giving consent in any or nearly all circumstances.

A general limitation on young people's ability to consent to the treatment of their children has not been identified in case law to date. However, it would be highly unusual if a young parent were able to give a valid consent to the treatment of his or her child in circumstances where that parent did not understand the nature and

⁴⁵⁹ *Criminal Code* (Qld) s31 reads, 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].**

⁴⁶⁰ Fleming JG *The Law of Torts* (Law Book Co 8th ed 1992) at 189.

likely consequences of that treatment (and therefore was not legally competent in relation to that treatment) and would not even be capable of giving consent to the treatment being carried out on himself or herself. Whilst adults may consent to treatment of their children irrespective of whether or not they understand the nature of or likely consequences of the treatment (all that is required being a broad understanding of the nature of the treatment⁴⁶¹), they may also consent to such treatment being carried out on themselves. It would be wholly inconsistent if young parents, who are considered not capable of consenting to certain treatments on themselves could nevertheless consent to that treatment being given to another.

In considering whether such a restriction exists at common law, it is useful to consider the basis for the parental authority over children. In *Marion's case*⁴⁶² McHugh J identified three possible sources of the power of parents to consent to medical treatment on behalf of their children, including a parent's right of control over a child, a parent's duty towards a child (the power arguably a necessary corollary of this) and a child's right of advancement. As outlined above,⁴⁶³ a child's right of advancement is likely the only relevant basis for the current power, and in the Commission's view supports the suggested restriction on the power. However, the existence of the restriction would likely be inconsistent with both the first and second suggested bases.

(b) Mechanisms available to facilitate treatment of child of young parents

If a health-care provider is not prepared to treat a child on the basis of the consent of a young parent, the mechanisms in place to facilitate the child's treatment are arguably flawed or too onerous or cumbersome to be of any practical use. The available options are as follows:

(i) Children's Services Act 1965 (Qld)

If a young parent is unable, or is considered unable to consent to the treatment of his or her child, application may be made to the Director-General of the Department of Family Services and Aboriginal and Islander Affairs for either of the following:

- * **Assistance in making decisions concerning the treatment of the child (under Part V of the Act), for example, through the appointment of a substitute decision maker.**

⁴⁶¹ See Ch 5 above.

⁴⁶² (1992) 175 CLR 218 at 312.

⁴⁶³ See 27-29 above.

The Director-General has a general power to provide assistance to a family where it appears to him or her that the income or resources of the family are inadequate to care for the child or children of the family properly, or it appears from any other cause that such child or children are in need of assistance. The assistance may be in such form and for such period as the Director-General considers appropriate⁴⁶⁴ and therefore would appear to extend to assistance for decision making concerning medical treatment.

However, the provision of assistance does not affect the guardianship or custody of any person concerned, and thus would only create a concurrent power to consent to treatment.

- * **A declaration that the child is in need of care and protection, and thus should be placed in the care of the Director-General, who would make decisions concerning the treatment, or appoint a suitable person to do so.**

Under Part VI of the Act, application may be made to the Director-General to admit the child into his or her care and protection. The application may be brought by the parent, a guardian, a relative or a person of good repute.⁴⁶⁵ If the Director-General is satisfied that the child is in need of care and protection and that such care and protection cannot be secured by the giving of assistance under Part V of the Act, he or she shall declare the child to be admitted to his or her care and protection and the guardianship of the child shall vest in him or her.⁴⁶⁶ Similarly, the child may be admitted to the care and protection of the Director-General by an order of the Children's Court upon the application of the Director-General (where the declaration has expired⁴⁶⁷ or otherwise), or by an officer authorised by the Director, or a police officer.⁴⁶⁸

⁴⁶⁴ *Children's Services Act 1965 (Qld)* s41.

⁴⁶⁵ *Id* s47. A doctor or other health-care provider working with the child would be able to make such an application as "a person of good repute".

⁴⁶⁶ *Children's Services Act 1965 (Qld)* s55.

⁴⁶⁷ Note that a declaration of the Director-General cannot continue indefinitely, and where it has been made upon the application of the parent or guardian, it will expire one month after the application.

⁴⁶⁸ *Children's Services Act 1965 (Qld)* ss49, 50.

For the purposes of the Act, a child is considered to be in need of care and protection if one of a number of circumstances exist, including:⁴⁶⁹

(a) not having a parent or guardian who exercises proper care of and guardianship over him [or her], he [or she] is -

- (i) neglected; or
- (ii) exposed to physical or moral danger; or
- (iii) falling in with bad associates; or
- (iv) likely to fall into a life of vice or crime;

(b) he [or she] is in the custody of a person who is unfit by reason of his [or her] conduct and habits to have custody of the child...

(c) he [or she] is for any other reason in need of care and such care cannot be adequately provided by the giving of assistance under Part V of the Act.

A child with young parents may be considered in need of care and protection on one of the above grounds, if the parents are unable to make informed decisions regarding the child's medical treatment.

In his or her capacity as guardian of the child the Director-General would have the power to consent to medical treatment of the child. In doing so, he or she would be required to exercise that power to further the best interests of the child. Usually, in the process of a declaration being made, the child would be placed in the custody of another person by the Director and consent to treatments would be ancillary to such arrangements.

(ii) Application to the Court under its *parens patriae* jurisdiction

The Supreme Court is vested with jurisdiction (known as its *parens patriae* jurisdiction) to supervise parents and other guardians and to protect the welfare of children.⁴⁷⁰ As part of that jurisdiction, the court may make protective orders, either by imposing wardship,⁴⁷¹ or by making *ad hoc* orders otherwise leaving the guardianship and custody of the child intact.⁴⁷²

⁴⁶⁹ *Id* s46(1).

⁴⁷⁰ See *Johnson v Director-General of Social Welfare (Vict)* (1976) 135 CLR 92 and 36-39 above.

⁴⁷¹ *Fountain v Alexander* (1982) 150 CLR 615 per Gibbs CJ at 626.

⁴⁷² See *In re N (Infants)* [1967] Ch 512 at 531.

It follows that application may be made to the court by any interested party to determine the appropriateness of a particular medical treatment or the best way to determine treatment for the children on an ongoing basis. In exercising the jurisdiction, the court would only act in opposition to the wishes of the parent where the welfare of the child clearly required it.⁴⁷³

The Commission invites comments on the following:

- 1. Should all young parents be presumed to be legally competent for the purposes of consent to and refusal of treatment of their children?
or**
- 2. In relation to their ability to consent to treatment of their children, should young parents be subject to the same presumptions and restrictions currently imposed on young people's ability to consent to their own treatment?**
- 3. In relation to their ability to refuse treatment of their children, should young parents be subject to the same presumptions and restrictions currently imposed on young people's ability to refuse treatment for themselves?**

⁴⁷³ See also 36-39 above.

CHAPTER 11

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 - *Minors (Property and Contracts) Act 1970*

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 medical treatment.

Pursuant to section 49 of the *Minors (Property and Contracts) Act 1970* (NSW)⁴⁷⁴ people who give medical or dental treatment to a young person under the age of 16 are protected from actions for assault where a parent or guardian has consented. In the case of a young person 14 years of age or upwards, the consent of the young person would similarly be effective. These provisions were adopted from a 1969 Law Reform Commission of New South Wales' Report. The New South Wales' Commission recommended a provision in identical terms to section 49 of the *Minors (Property and Contracts) Act 1970* (NSW).⁴⁷⁵ The Commission explained the reason for its recommendations as follows:⁴⁷⁶

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 fact that the treatment will be by, or under the

⁴⁷⁴ This section is set out in Appendix 4 to this Paper.

The main purposes of the legislation were:

1. To remove the disability of a person aged between 18 and 21 to enter into contracts, to dispose of property and to participate in other acts relating to contractual obligations and proprietary rights;
2. To provide for a person under the age of 18 years to enter into such transactions and to dispose of property other than by will in the circumstances provided for in the legislation as to be binding upon him except, by reason of youth, he or she lacks the understanding necessary for him to participate in such matters.

(Attorney General *Parliamentary Debates* House of Assembly (NSW) 11 August 1970 at 5275 Introduction of Minors (Property and Contracts) Bill).

⁴⁷⁵ In clause 48 of the draft *Minority Bill 1969* (Appendix F to their Report).

⁴⁷⁶ New South Wales Law Reform Commission *Report on Infancy in Relation to Contracts and Property 1969* at 88.

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 had no firm views on medical treatment of young people which were ancillary to the object of the legislation but the Government agreed with the Commission's view that "there are obvious advantages in laying down standards which will remove the existing uncertainty."⁴⁷⁷

The New South Wales provision, on its face, enables young people "aged 14 and upwards" to seek medical or dental treatment whether or not they understand the treatment proposed. The effect of such consent would be to relieve the treating doctor or dentist from liability for assault or battery.

An immunity is provided to any practitioner who performs medical or dental treatment upon a child less than 16 years of age, with the prior consent of a parent.

The provision is limited to claims for assault and battery. Any false imprisonment or negligence claim brought on behalf of the young person is not affected. The section provides an immunity and does not affect the common law.

Section 49 does not empower a young person to consent to medical or dental treatment so much as it restricts rights of young people to sue for assault persons who, with their consent, have treated them.⁴⁷⁸ The provision does not take away a guardian's powers to withhold or refuse consent to treatment.

Helsham CJ in *K v Minister for Youth and Community Services* stated in relation to section 49:⁴⁷⁹

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 sterilization) 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 a 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

⁴⁷⁷ Attorney-General *Parliamentary Debates* House of Assembly (NSW) 11 August 1970 at 5275.

⁴⁷⁸ *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311 at 321.

⁴⁷⁹ *Ibid.*

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.

Thus, a parent would probably be entitled to seek a Court order prohibiting, in the interests of the child, performance of treatment to which a 14 or 15 year old had consented. The Court would then have to decide the dispute according to the principle that the interests of the child are paramount.

Conversely, upon Helsham CJ's view, the New South Wales provision deprives the child of the right to sue a doctor for battery, for treatment to which a parent, but not the child, had consented. Thus, a doctor could lawfully carry out treatment, such as cosmetic surgery on a patient under 16 in the absence of the patient's consent, if it were otherwise lawful.

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.⁴⁸⁰

(b) South Australia

(i) *Consent to Medical and Dental Treatment Act 1985*⁴⁸¹

South Australia has the most comprehensive legislative scheme relating to young people consenting to medical treatment. Although the legislation is about to be amended, it is apparent that it has worked well over the last 10 years to achieve some certainty in this area of law.⁴⁸²

The *Consent to Medical and Dental Treatment Act 1985 (SA)*⁴⁸³ defines consent in relation to the carrying out of medical or dental treatment as meaning informed consent.⁴⁸⁴

⁴⁸⁰ Weeks P "Family Planning and the Law" (1989) 8 *Healthright* 10 at 14 (fn 22) notes that s49 of the *Minors (Property and Contracts) Act 1970 (NSW)* deals expressly only with children aged 14-16 "so that the primacy of the wishes of children aged 16 and 17 is implied".

⁴⁸¹ Relevant sections of the Act are set out in Appendix 4. New legislation awaiting Royal Assent is discussed at 157-160 below and is set out in Appendix 4.

⁴⁸² Submission 22 (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"). 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).

⁴⁸³ Relevant provisions of the 1985 South Australian legislation are set out in Appendix 4. These provisions will be replaced when the new legislation commences.

⁴⁸⁴ *Consent to Medical and Dental Treatment Act 1985 (SA)* s4.

Section 6(1) of the Act provides that the consent or the refusal or absence of consent to medical and dental treatment can be given by a young person 16 years of age and older, as if the person were an adult.

Section 6(2) of the Act provides that a young person under the age of 16 years can consent to a medical or dental procedure as if he or she were an adult so long as the doctor or dentist is of the opinion that the young person is capable of understanding the nature and consequences of the procedure and that the procedure is in the best interests of the health and well-being of the young person.

If reasonably practicable to do so the doctor or dentist should verify his or her opinion with the written opinion of another doctor or dentist.⁴⁸⁵

The consent of a parent of a young person under the age of 16 is deemed to be a consent of the young person and to have the same effect as if the young person were an adult.⁴⁸⁶ "Parent" is defined in section 4 of the Act as including "a guardian of the minor or a person acting *in loco parentis* in relation to the minor".

If there is an imminent risk to the young person's life or health then a medical procedure or dental procedure can be undertaken without consent in prescribed circumstances under section 6(5) of the Act.⁴⁸⁷ Prescribed circumstances exist if:

- (a) the minor is incapable for any reason of giving an effective consent to the carrying out of the medical or dental treatment; and

⁴⁸⁵ Id s6(3). See Appendix 4.

⁴⁸⁶ Id s6(4). See Appendix 4.

⁴⁸⁷ Id s6(6). See Appendix 4. S7 provides for the treatment, in emergencies, of persons (including adults) 16 years of age and over who are unable to provide consent. Where such a treatment is carried out in prescribed circumstances the person shall be deemed to have consented to the carrying out of the procedure. Prescribed circumstances are defined in s7(2). Those circumstances exist if:

- (a) the person is incapable for any reason of giving an effective consent to the carrying out of the medical or dental treatment; and
- (b) the medical practitioner or dentist carrying out the treatment -
 - (i) is of the opinion that the procedure is necessary to meet imminent risk to the person's life or health; and
 - (ii) has no knowledge of any refusal on the part of the person to consent to the treatment, being a refusal communicated by that person to him [or her] or some other medical practitioner or dentist; and
- (c) unless it is not reasonably practicable to do so having regard to the imminence of the risk to the person's life or health, the opinion of the medical practitioner or dentist referred to in paragraph (b)(i) is supported by the written opinion of one other medical practitioner or dentist.

- (b) no parent of the minor is reasonably available in the circumstances, or, being available, the parent, having been requested to consent to the carrying out of the treatment, has failed or refused to do so; and
- (c) the medical practitioner or dentist carrying out the treatment is of the opinion that the treatment is necessary to meet imminent risk to the minor's life or health; and
- (d) unless it is not reasonably practicable to do so having regard to the imminence of the risk to the minor's life or health, the opinion of the medical practitioner or dentist referred to in paragraph (c) is supported by the written opinion of one or other medical practitioner or dentist.

Section 8 provides that consent given or deemed to be given under the legislation is 'effective' and that a physician will not incur any civil or criminal liability for reasonably appropriate treatment provided in good faith and without negligence.⁴⁸⁸

Despite the apparently wide ambit of the opening phrase and the definition of consent in section 8(2), when read in context it would appear that section 8 refers only to the treatment of young people or to emergency treatment.⁴⁸⁹ The legislation was only ever intended to remedy a perceived uncertainty in the common law about the legal effectiveness of consent by or on behalf of young people and emergency medical treatment.

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(1)). Because section 6(2),(4) provides that for young people under 16 (as with young people between 14 and 16 in New South Wales) the consent of either a parent or the young person is effective, parental rights to refuse treatment may have been preserved. Thus, a parent may be able to seek a Court order prohibiting, in the interests of the child, performance of treatment to which a person under 16 years of age had consented.⁴⁹⁰ The Court would then have to decide the dispute according to the principle that the welfare of the young person is paramount.

⁴⁸⁸ Id s8 set out in Appendix 4. See also *Consent to Medical Treatment and Palliative Care Bill 1994 (SA)* cl 16 set out in Appendix 4.

⁴⁸⁹ See discussion by Mack K "The Impact of the Consent to Medical And Dental Procedures Act (SA) on Common Law Principles of Informed Consent in South Australia" (1988) 11 *Adel LR* 448.

⁴⁹⁰ See *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311 per Helsham CJ at 321.

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 their child's opposition, Weeks has noted:⁴⁹¹

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.

(ii) **Background to the 1985 South Australian legislation**

The *Consent to Medical and Dental Procedures Bill* was introduced to the South Australian Parliament in 1984. The Bill was based upon a report of the South Australian Minister of Health's Working Party on Consent and Treatment in 1983. The Working Party considered 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 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 him or herself, is able to provide an effective consent to proposed treatment. 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 validly consent to treatment - but rather, that it was the young person's capacity to make a reasoned decision based on the information that was important.⁴⁹²

The Working Party concluded in relation to young people 16 years of age and older:⁴⁹³

generally 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 ... at sixteen years a minor will be able to assess the information, provided to him and by making a decision based on the information decide his own fate. This ... is of fundamental importance and priority should be given to

⁴⁹¹ Weeks P "Family Planning and the Law" (1989) 8 *Healthright* 10 at 12.

⁴⁹² *Report of the Working Party on Consent to Treatment* December 1983 at 21. See discussion on US emancipation legislation at 168-170 below.

⁴⁹³ *Id* at 23.

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 a number of jurisdictions which have legislated to permit people of 16 years of age and over to give an effective consent.⁴⁹⁴ 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 consent (without such legislative support) they could sue the medical practitioner for "assaulting" the young person.

Legislation enabling a sixteen or seventeen year old to give effective consent to treatment would clarify the rights and responsibilities of those presently involved in decision making of this nature:

Statutory provisions 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.⁴⁹⁵

The Working Party did not wish to completely disregard the role of parents in the decision-making process. The Working Party stated that:⁴⁹⁶

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 did not form the basis of a separate recommendation and were not specifically referred to in the legislation.

⁴⁹⁴ For example, *Minors (Property and Contract) Act 1970* (NSW) and the *Family Law Reform Act 1969* (UK).

⁴⁹⁵ *Report of the Working Party on Consent to Treatment* December 1983 at 24.

⁴⁹⁶ *Ibid.*

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 treatment. The capacity of such young people to consent should be dependent upon their level of understanding:⁴⁹⁷

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 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 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 for 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.⁴⁹⁸

The basic premise upon which the legislation was drafted was stated as:⁴⁹⁹

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 Minister further justified the Bill by noting:⁵⁰⁰

- * 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

⁴⁹⁷ Id at 25.

⁴⁹⁸ *Parliamentary Debates* Legislative Council (SA) 11 November 1984 at 1852.

⁴⁹⁹ The Hon JR Cornwall *Parliamentary Debates* Legislative Council (SA) 20 February 1985 at 2651.

⁵⁰⁰ *Parliamentary Debates* Legislative Council (SA) 11 November 1984 at 1852.

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 are able to consent to sexual intercourse, drive a motor vehicle, be employed and undertake most of life's roles and responsibilities.

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 the proposed procedure should be able to consent to the procedure:

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.⁵⁰¹

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.⁵⁰² 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 profession 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.⁵⁰³

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

⁵⁰¹ Ibid.

⁵⁰² Burdett JC *Parliamentary Debates* Legislative Council (SA) 4 December 1984 at 2018.

⁵⁰³ Ibid.

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 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 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.

Another concern was that the legislation enables young people to go behind their parents' back 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 were not given the power to give or withhold consent. Procedures which might be of particular concern to parents include: abortion, sterilisation and cosmetic surgery. However, the Honourable J R Cornwall noted⁵⁰⁴ that parental consent for treatment of an under 16 year old 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. 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 child.

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:⁵⁰⁵

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.

⁵⁰⁴ *Parliamentary Debates Legislative Council (SA)* 20 February 1985 at 2651.

⁵⁰⁵ *Ibid.*

However, that is the situation in the 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 to privacy to one area for a 15 year old, then it is perfectly legitimate ... to extend it across the board.

The question was raised as to who would be responsible for the cost of medical or dental treatment on young people where the parents had not been consulted or had not consented to the treatment. At common law "minors" are only responsible for the cost of necessities of life.⁵⁰⁶ In other cases, parents may be responsible. Doctors and dentists would, however, usually ensure that there is 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 16.⁵⁰⁷

(iii) 1985 legislation: young person's power to veto; role of Courts

The 1985 South Australian legislation provides that the refusal of consent of a young person 16 years of age or over has the same effect as if the young person were "of full age".⁵⁰⁸ This goes further than section 8 of the United Kingdom *Family Law Reform Act 1969* which only refers to the consent of a young person 16 years of age or older being as effective as it would be if he or she were of full age.⁵⁰⁹

As noted in Chapter 8 above, in the English case of *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)*⁵¹⁰ the Court of Appeal confirmed that section 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 consent. In *In re W*, it was made clear that the 'Gillick principle' does not confer upon a legally competent young person in the United Kingdom a

⁵⁰⁶ See the Queensland Law Reform Commission's forthcoming Draft Report on *Minors' Civil Law Capacity* (expected publishing date May 1995).

⁵⁰⁷ See footnote 46 above.

⁵⁰⁸ *Consent to Medical and Dental Treatment Act 1985* (SA) s6.

⁵⁰⁹ See 161-163 below.

⁵¹⁰ [1993] Fam 64.

power of veto over treatment and 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 refuse treatment with no proviso that such refusal must be in his or her best interests.

The *parens patriae* jurisdiction of the courts in South Australia would seem to be excluded for 16 and 17 year olds except perhaps where the young person is incapacitated by a factor other than age from consenting to the proposed treatment.

If the circumstances of *In re W* were to arise in South Australia in relation to a 16 or 17 year old, it is unlikely that the Court would be able to override a decision of the young person (assuming the young person was held to be legally competent) not to be treated for a condition such as anorexia nervosa even though such treatment might be life-saving or avoid 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 8, *In re W* may well not be followed in Australia.

(iv) New legislation

On 11 August 1994 the *Consent to Medical Treatment and Palliative Care Bill 1994* (SA) was introduced in the South Australian Legislative Council.⁵¹¹ The Bill has now passed both Houses of the South Australian Parliament, having undergone a number of significant amendments, and is currently awaiting Royal Assent.

The Bill seeks to repeal the *Consent to Medical and Dental Treatment Act 1985* (SA) and to introduce new legislation relating to the consent and medical treatment of young people.

The original version of the Bill would have been far more restrictive than the existing legislation and far more intrusive into the lives of young people than even the common law. This would have been despite the finding of a Parliamentary Committee responsible for an earlier lapsed Bill which stated that it 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.⁵¹²

⁵¹¹ Debate on the Second Reading of an earlier Bill - the *Consent to Medical Treatment and Palliative Care Bill 1993* - was adjourned on 7 September 1993. A subsequent general election in South Australia saw a new Government. The 1993 Bill did not propose as drastic a change to the existing law in South Australia as does the 1994 Bill.

⁵¹² The Hon MJ Evans *Parliamentary Debates* House of Assembly (SA) 18 February 1993 at 2118.

The Honourable D J Hopwood observed:⁵¹³

if one looks at the empirical evidence of what has happened since [1984-85] ... one sees that it does not seem to have changed very much. What evidence have we that 16 and 17 year olds are really flocking along to dentists or people who carry out termination of pregnancy, or people who perform surgical operations to remove an inflamed appendix or whatever else it might be? Whatever realms of freedom were opened up to 16 and 17 year olds at that time do not seem to have been taken up enthusiastically by those people since that time. To the extent that they have been taken up at all it does not seem to me that they have contributed materially to such social problems as we may have confronting us at this time.

The original 1994 Bill defined "child" as a person under 18 years of age.⁵¹⁴

Clause 11 of the original 1994 Bill read:

11(1) Subject to this Act, a medical practitioner must, before administering medical treatment to a child, seek the consent of a parent or guardian of the child.

(2) The medical practitioner may then administer medical treatment to the child if:-

- (a) the parent or guardian consents; or
- (b) the parent or guardian does not consent (or there is no parent or guardian reasonably available to make a decision) but 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 interests 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.

If this provision had been enacted it would have drastically altered the then current law in South Australia. 16 and 17 year olds would no longer have had the security of knowing that the confidentiality of their consultations with doctors and dentists would be maintained. The doctor would have been required to contact the young person's parents in every case where treatment was proposed to seek the parents' consent. The only exception appears to be if a parent or guardian is not "reasonably available to make a decision".

⁵¹³ *Id* at 2121.

⁵¹⁴ *Consent to Medical Treatment and Palliative Care Bill 1994 (No 5B) (SA) cl 4(1).*

The provision also paid no regard to the independence or emancipation of older teenagers. The fact that a 17 year old may have left home, be working and in a de facto relationship - and/or with a child or children of his or her own - was ignored. In every case, the young person's parents would have been required to be contacted.

If the young person passed the maturity test set out in the original clause 11(2)(b)(i) and the doctor's or dentist's opinion as to the young person's maturity was verified after a personal examination of the young person by at least one other doctor or dentist, then the young person's consent to treatment would have overridden the parent's refusal of consent. By then, however, parents would have been informed of the proposed treatment and this may very well have resulted in a strained relationship between parents and child.

The original version of the 1994 Bill was the subject of widespread criticism - primarily on the basis that it would have resulted in a number of practical problems for young people seeking necessary treatment - such as for sexually transmitted diseases. The Honourable Diana Laidlaw observed, for example:⁵¹⁵

A major concern is that raising the age to 18 would deter young people, who are taking responsibility for their own health care, from seeking medical advice. Health professionals working in the area of sexually transmitted diseases are particularly concerned about the implications of a shift to 18 years. Infection rates of young people for certain sexually transmitted diseases do not encourage complacency ... So, to seek to raise the age to 18 years, thereby making young people's access to health services more difficult, runs counter to Government and community emphasis on sexual responsibility and prevention of sexually transmitted diseases, HIV and AIDS. It establishes a large credibility gap for those services as a means of encouraging and facilitating access to young people.

Amendments to the Bill included a return to the recognition of the age of 16 years as the age when young people should be treated as adults for the purposes of medical treatment. Clause 6 now reads:

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.

This has the same effect as section 6(1) of the *Consent to Medical and Dental Treatment Act 1985 (SA)*.⁵¹⁶

⁵¹⁵ *Parliamentary Debates Legislative Council (SA)* 19 October 1994 at 492.

⁵¹⁶ See Appendix 4.

Clause 12 of the Bill is of similar effect to section 6(2) of the *Consent to Medical and Dental Treatment Act 1985* and reads:

A medical practitioner 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.

No guidance is given in the Bill on what to do if the parents disagree as to whether or not the proposed treatment should proceed. Presumably the medical practitioner need only have the opinion of one parent before proceeding with the treatment and can ignore a contrary opinion expressed by another parent.

Unlike the Bill, section 6(2) of the *Consent to Medical and Dental Treatment Act 1985* (SA) does not require the additional medical practitioner to personally examine the young person before verifying or otherwise the opinion of the treating practitioner as to the young person's capacity.

The new South Australian legislation will not alter the law relating to consent to medical treatment of young people in South Australia in any significant respect.

(c) The Northern Territory - Consent to termination of pregnancy for female under 16

Section 174(4)(b) of the Northern Territory *Criminal Code* states that where a girl is under sixteen years of age or is otherwise incapable in law of giving consent, the consent of her parents or guardian is necessary before a medical termination of pregnancy is carried out. This is an exception to the *Gillick* test.

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).⁵¹⁷ Section 8 reads:

(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) 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. Devereux⁵¹⁸ suggests that the section is "inherently ambiguous":

Sub-section (1) seems to suggest that, apart from that subsection, consent of a minor to medical treatment is ineffective. The third subsection, 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 consent (viz those sixteen and over).

It is arguable that section 8 only protects people from civil liability for trespass if they act on the consent of a young person of 16 years of age or over.⁵¹⁹ By comparison, the South Australian provision clearly offers protection from civil and criminal liability.

⁵¹⁷ (1967) Cmnd. 3342 at 116-118 (the Latey Committee).

⁵¹⁸ Devereux J "The Capacity of a Child in Australia to Consent to Medical Treatment - Gillick Revisited?" (1991) 11 *Oxford Journal of Legal Studies* 282 at 289.

⁵¹⁹ The Parliamentary debates upon the introduction of the *Family Law Reform Bill* (UK) did not discuss the question of immunity to health-care providers. Nor did the Latey Committee's Report (*Report of the Committee on the Age of Majority* 1967 CMND 3342) upon which the Bill was based. Subsequent Court decisions have tended to assume that s8 provides immunity from civil liability. See, eg, Lord Donaldson of Lynton MR in *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 at 76-77:

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 ...

In introducing the United Kingdom Bill the Attorney-General stated that subsection 8(3) covers consent by patients under 16 years of age where the common law would have permitted them to consent.⁵²⁰ Others have suggested that it covers consent by a parent for a patient aged 16 or 17 who has refused consent, or whose consent the medical practitioner has not sought. It has also been suggested that the subsection covers emergencies.⁵²¹ Samuels suggests:⁵²²

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 is protected. In practice, the doctor will seek to ascertain the age of the minor, and, if he believes the minor to be 16 or over, look to the minor for consent. In any event he would be most unlikely to act in the face of objection by the minor.

It is unlikely that at the time the provision was enacted, that is, prior to the House of Lords decision in *Gillick's* case, section 8(3) was intended to protect doctors acting solely on the consent of the minor under 16.⁵²³ It is apparent, however, that the section was intended to clarify the capacity of young people to consent to medical treatment by providing that anyone 16 years of age or over could give a valid consent.⁵²⁴

There was relatively little opposition expressed during the United Kingdom Parliamentary Debates on the *Family Law Reform Bill* (UK) provisions relating to consent to medical treatment.⁵²⁵ One concern related to treatment of 16 and 17 year old school boarders. Mr Eldon Griffiths⁵²⁶ 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.

⁵²⁰ Sir Elwyn Jones (Attorney-General), *Parliamentary Debates* House of Commons (UK) 9 July 1969 at 1420.

⁵²¹ *Ibid.* However, note the Alberta Institute of Law Research and Reform in its Report on *Consent of Minors to Health Care* 1975 at 4 considered this to be unlikely because the subsection speaks of consent, not of absence of consent.

⁵²² Samuels A "Can a Minor (under 16) Consent to a Medical Operation?" (1983) 13 *Family Law* 30.

⁵²³ *Id* at 31.

⁵²⁴ *Parliamentary Debates* House of Commons (UK) 17 February 1969 at 43.

⁵²⁵ *Parliamentary Debates* House of Commons (UK) 9 July 1969.

⁵²⁶ *Id* at 1409.

In response to this concern, Mr John Lee⁵²⁷ noted:

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 is 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 reference to the welfare checklist in section 1(3) of the Act. The first item in the checklist is the ascertainable wishes of the young person. This is not the court's sole consideration, nor the paramount one, but the court must nonetheless have some recourse to young people's wishes.

More specifically, in respect of Emergency Protection Orders, Child Assessment Orders, Interim Care and Supervision Orders and Supervision Orders generally no order as to medical examination, assessment or treatment can be made over a child "of sufficient understanding" who refuses consent to such examination, assessment or treatment. Commentators on the Act noted that such provisions were in accordance with the *Gillick* principle.⁵²⁸ Thus, at least in respect of young people who were the subject of suspected abuse or otherwise in need of state protection legally competent young people could validly refuse. Subsequent decisions of the Court of Appeal in England have deprived "not at risk" young people of this right.⁵²⁹

⁵²⁷ *Id* at 1414-1416.

⁵²⁸ Eekelaar J and Dingwell R *The Reform of Child Care Law* (Routledge, London 1990) at 86; Masson J "Children Act 1989" *Current Law Statutes Annotated 1989* (4) (Sweet and Maxwell, London 1990) at 41-99, 41-94. See *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (HL(E)).

⁵²⁹ See Ch 8 above.

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:⁵³⁰

Prior 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 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 ward, 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].

The 1991 legislation clarified a number of aspects of the law in Scotland after *Gillick's* case. While, under the general scheme of the 1991 Act, young people under 16 have as a general rule the capacity to enter into any legal transaction, an important exception is found in section 2(4), which reads:

A person under the age of 16 years shall have the legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.

Edwards notes⁵³¹ 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. Unlike in the South Australian provision there is no reference to the welfare principle.⁵³² The doctor is not required to assess whether the proposed

⁵³⁰ Edwards L 'The Right to Consent and the Right to Refuse; More Problems with Minors and Medical Consent' 1993 *The Juridical Review* 52 at 53.

⁵³¹ *Id* at 54.

⁵³² This is not an accidental omission. It was based on the conclusion of the Scottish Law Commission in its *Report on the Legal Capacity of and Responsibility of Minors and Pupils* (No 110 1987) paras 3.61-3.83 that a best-interests test was restrictive, unnecessary and logically incoherent 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

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:

1. It is not clear what the attributes are of a young person meeting the test of section 2(4) (or, elsewhere - what the attributes of a "*Gillick*-competent" young person are.)
2. It is still unclear whether the parental right to consent also continues in cases where the young person under 16 is competent under section 2(4) (or "*Gillick*-competent") or whether, as the young person's capacity begins, the parental right terminates.
3. *Gillick's* case, and section 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 child. So if a child refuses to consent to a medical procedure, can (or should) the Court have the power to override that refusal?

4. NEW ZEALAND

New Zealand 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) reads:

(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

never unequivocally in the young person's best interests.

- (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 girl of any age can consent to an abortion or refuse her consent to 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 section 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.⁵³³ If no such person can be found in New Zealand or is not capable of giving consent, a District Court Judge or the Director-General may give consent.⁵³⁴

⁵³³ *Guardianship Act 1968* (NZ) s25(3)(b).

⁵³⁴ *Id* s25(3)(b),(c).

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 Court, which may then, as guardian, grant the necessary consent.⁵³⁵ Thus the High Court of New Zealand can assume the powers of consent referred to in section 25,⁵³⁶ 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 Court's umbrella of protection once the application is commenced, and thus although strictly speaking no guardianship order may have been made, the Court's consent should be sought, particularly in emergency situations.⁵³⁷

The situation is different under section 25A. In *Re S*⁵³⁸ it was held that the Court had no power to override section 25A in pursuance of any other broader power. Thus section 25A, unlike section 25(3), is a code dealing with consent in the context of abortion.⁵³⁹

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 cannot communicate decisions in respect of such matters,⁵⁴⁰ 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 section 12(3) 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 it is in the young person's best interests to make the appointment. Such a guardian may consent to non-excepted forms of medical treatment.⁵⁴¹ The *Protection of Personal and Property Rights Act 1988* (NZ) falls within the terms of section 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 section 6(1) of the *Protection of Personal and Property Rights Act 1988* (NZ) and who was or had been married would fall within the jurisdiction of the Act, and

⁵³⁵ *Re V* [1993] NZFLR 369, *Director-General of Social Welfare v B* [1994] NZFLR 516.

⁵³⁶ *Director-General of Social Welfare v B* [1994] NZFLR 516 at 517.

⁵³⁷ *Re V* [1993] NZFLR 369 at 375, citing *W v Director-General of Social Welfare* [1990] 1 NZLR 378 at 383.

⁵³⁸ High Court, Wellington CP 430/91, 16 July 1991.

⁵³⁹ *Re V* [1993] NZFLR 369 at 376.

⁵⁴⁰ *Protection of Personal and Property Rights Act 1988* (NZ) s6.

⁵⁴¹ *Id* s18; see Grant E "Consent to Medical Procedures and the *Protection of Personal and Property Rights Act 1988*" (1989) 7 *Otago Law Review* 161 at 175.

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.⁵⁴²

5. UNITED STATES OF AMERICA⁵⁴³

The Supreme Court of the United States has supported young people's access to contraceptive devices and services.⁵⁴⁴

Some States have legislated to permit young people of particular ages independent access to other forms of treatment such as outpatient mental health-care, or treatment for substance abuse.⁵⁴⁵

Weithorn observes that there is a "patchwork" of State laws governing the mental hospitalisation of young people.⁵⁴⁶

Some States consider a "voluntary" admission of a minor voluntary only if the minor consents to the hospitalization. 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 consent laws regarding the ability of young people to consent to medical treatment vary and exceptions to the parental consent requirements tend to fall into four general categories:

1. Exceptions arising out of the jurisdictions of juvenile and family courts over abused and neglected young people.
2. Exceptions related to the status and characteristics of individual young people (that is, "emancipated" or "mature" young people).

⁵⁴² 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.

⁵⁴³ Information kindly provided to the Commission by the US Department of Health and Human Services. (Letter from Acting Deputy Assistant Secretary for Population Affairs 23 March 1993.) See also Office of Technology Assessment (US) "Consent and Confidentiality in Adolescent Health Care Decision Making" 1991 *Adolescent Health* at 111-123 and 111-155.

⁵⁴⁴ *Carey v Population Services International* (1977) 431 US 678.

⁵⁴⁵ Wilkins LP "Children's Rights: Removing the Parental Consent Barrier" 1975 *Arizona State Law Review* 31 at 92.

⁵⁴⁶ Weithorn L "Children's Capacities for Participation in Treatment Decision-Making" in *Emerging Issues in Child Psychiatry and the Law* (ed by Schetky D and Benedek E, Brunner & Mazel New York 1985) 22 at 24.

3. Exceptions for emergency situations.
4. Exceptions for specific health problems and services:
 - (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, 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 mandated parental notification in the national family planning program for such 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 health-care.⁵⁴⁷

About one half of the States have enacted 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.

⁵⁴⁷ Ala. Code ss22-8-4 (1984); Kan. Stat. Ann. ss38-123(b) (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).

These statutes explicitly state that emancipation under these statutes removes the disabilities of minority, including the requirement of parental consent to medical treatment. Young people emancipated under these statutes have the right to consent to medical treatment.

A substantial number of States have enacted statutes that authorise young people who have attained varying degrees of independence to consent to medical treatment, although they do not use the term "emancipation" or "emancipated" young people. Over one half of the United States have "independent" minor statutes that allow young people who are parents to consent to medical treatment for themselves and/or their children. About one half of the States have statutes that allow married young people to consent to medical treatment; 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 medical treatment.

6. CANADA

At least three Canadian jurisdictions have legislated in relation to consent to medical treatment of young people. Set out below is a brief summary of those enactments.

(a) Ontario

Ontario does not have specific legislation and for the most part the law in this area is the common law which is similar to the common law in force in Queensland.⁵⁴⁸ Thus, where a young person is able to understand the nature and consequences of the particular treatment, he or she can give a valid consent and parental consent is unnecessary.⁵⁴⁹ However, surgical operations in public hospitals can only be performed upon young people under the age of sixteen years with the consent of a parent or guardian.⁵⁵⁰ Where a parent or guardian refuses, or is unavailable to

⁵⁴⁸ *An Act Respecting Consent to Treatment* (SO 1992, c31) was assented to in December 1992 but is largely unproclaimed. S6 of that legislation provides that a person (not age specific):
 is capable with respect to a treatment if the person is able to understand the information that is relevant to making a decision concerning the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision
 (S6 unproclaimed).

⁵⁴⁹ *Johnston v Wellesley Hospital* (1970) 17 DLR (3d) 139 at 144 (Ont HC); *Booth v Toronto General Hospital* (1910) 17 OWR 118 at 120.

⁵⁵⁰ *Public Hospitals Regulations* RRO 1980 Reg 865 s50.

consent to the treatment of a child who requires medical treatment, the court may find that the child is in need of protection.⁵⁵¹

(b) Quebec

The *Public Health Protection Act*⁵⁵² provides that a hospital or doctor may provide care to a young person fourteen years of age or older, but the hospital or the doctor must inform the person having parental authority in the case where the young person is sheltered for more than twelve hours, or in the case of extended treatment. Sections 36 and 37 of that Act provide:

36. An establishment or a physician may provide the care and treatment required by the state of health of a minor fourteen years of age or older with his consent without being required to obtain the consent of the person having paternal authority; the establishment or the physician must however inform the person having paternal authority in the case where the minor is sheltered for more than twelve hours, or of extended treatment.

Where a minor is under fourteen years of age, the consent of the person having paternal authority must be obtained; however, if that consent cannot be obtained or where refusal by the person having paternal authority is not justified in the child's best interest, a judge of the Superior Court may authorize the care or treatment.

37. An establishment or a physician shall see that care or treatment is provided to every person in danger of death; if that person is a minor, the consent of the person having paternal authority shall not be required.

(c) British Columbia

The *Infants Act*⁵⁵³ enables young people of any age to consent to medical treatment, provided the young person understands the nature and consequences of the treatment and its benefits and risks, and provided the treatment is, in the health-care provider's opinion, in the young person's best interests. Section 16 reads:⁵⁵⁴

⁵⁵¹ Part XV "Children in Need of Protection" *Infants and Children* C.E.D. (Ont. 3rd).

⁵⁵² (1972, c 42) Assented to 21 December 1972.

⁵⁵³ (RSBC 1979, c 196) s16 of which came into effect on 1 January 1993.

⁵⁵⁴ 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 rules apply.

- 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 recent amendments to section 16 were explained as follows:⁵⁵⁵

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 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.

⁵⁵⁵ Kindly provided to the Commission by the Ministry of Attorney General, Province of British Columbia, 10 March 1995.

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 sterilization. By the same token minors cannot refuse treatment which is in their best interest, for example chemotherapy or immunization. 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) Alberta

The Alberta Institute of Law Research in its *Report on 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 considers four special situations - venereal disease, drugs and alcohol, contraception and pregnancy and its termination. The Institute stated:⁵⁵⁶

In every one of these four situations there is a special reluctance to inform parents and undoubtedly the minor will be harmed by the 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 in these four specific categories. Thus, the Institute recommended that there should be no minimum age of consent at all for these four particular categories of condition. Where there is venereal disease involved, where there are problems with alcohol or drugs, where it was a question of

⁵⁵⁶ *Consent of Minors to Health Care* Report No 19 1975 at 10.

contraception or abortion the urgency of the situation was such that there should be nothing that would prevent a young person seeking treatment and that, in consequence, if they felt inhibited by having to inform parents, they should be able to obtain treatment without any parental involvement at all. In other words, the Institute's final recommendation was that a young person of any age may consent to health care in connection with any communicable disease, drug or alcohol abuse, prevention of pregnancy and pregnancy and its termination. Also, where the young person is under the age of 16 years their power of consent under that recommendation would be an alternative to that of the parent or guardian. The Alberta Institute's recommendations are yet to be implemented.

CHAPTER 12

OPTIONS FOR REFORM

1. INTRODUCTION

The problems experienced in Queensland by young people, health-care providers and parents with the current law on consent to treatment are problems which have been shared by such people in many jurisdictions. The responses to the problems have varied greatly - from legislation governing who may consent under what circumstances, to a belief in the ability of the common law to cope with the issues. After reviewing the submissions to the Information Paper, and the situation in a number of other jurisdictions, the Commission recommends in this chapter a legislative scheme for consent to treatment of young people. The recommendations are preliminary only. Submissions received in response to this Discussion Paper will be most important to the Commission in its task of preparing final recommendations for the Attorney-General. Again, the Commission urges you to make your views known to the Commission by 31 August 1995.

2. LEAVE TO THE COMMON LAW

As noted earlier⁵⁵⁷ the common law has failed to provide the certainty required by health care practitioners, parents and young people in relation to the law governing the treatment of young people.

Very few criminal charges are brought against health care providers in Australia relating to the treatment of patients. 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 treatment provided to a young person without appropriate consent either from the young person (if legally competent) or from the young person's parents/guardian. Despite this, there is an obvious concern, at least within the medical profession, that health care providers are in a vulnerable position. The 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 have parental knowledge or involvement as a prerequisite for treatment of young people.

The Commission is also unaware of any reported Australian civil actions for trespass to the person (assault) or false imprisonment involving the provision of non-consensual treatment to young people.

⁵⁵⁷ See 104-107 above.

To date the common law has been primarily concerned with the protection of medical practitioners from liability under the criminal law and civil law when they treat young people. The common law has paid regard to the "best interests" of young people but has paid very little regard to the unfulfilled need some young people have for treatment irrespective of the wishes of others. Concepts such as self-determination and autonomy have played little or no part in the development of the common law to date.

The common law has also emphasised the need for physical contact to have occurred for there to be liability for non-consensual interference with the victim. However, interference with a person's psychological integrity can result in serious damage to the person.

It would be unrealistic to leave the development of the law in this area to the common law of Queensland.

3. FIXED AGE PRESUMPTION

The current law in Queensland provides that at 18 years of age, people are to be treated for all purposes as adults. People under 18 years of age attain particular adult rights and responsibilities at various ages (for example, the ability to work in full-time employment; the ability to drive motor vehicles; the ability to leave full-time education; the ability to engage in lawful sexual practices, etc.)

In Queensland a young person's ability to give an effective consent to a health care provider to proceed with proposed treatment, as has been described in earlier chapters, is not at all clear. A health-care provider might be reluctant to treat a young person upon the consent of a young person, for fear of being held criminally or civilly liable for assault. A health-care provider might also be reluctant to treat a young person upon consent of the young person's parents if there were indications that the young person was mature enough to make his or her own decision, and of a possible conflict between the young person and his or her parents over the issue of treatment. A young person might be reluctant to seek the treatment he or she needs, if he or she fears that the health-care provider will involve the young person's parents in the treatment decision.

Some jurisdictions have reacted to these types of situations by simply setting the age at which young people are to be treated as adults for the purpose of treatment decision-making, at an age lower than 18.⁵⁵⁸ Most statutory schemes reviewed by the Commission have set that age at 16. In addition, most schemes also enable people under the age of 16 to consent in certain circumstances. One exception to

⁵⁵⁸ See, eg, *Guardianship Act 1968* (NZ) s25 at 165-166 above.

this is the *Family Law Reform Act 1969* (UK).⁵⁵⁹ For young people under the age of 16 in England and Wales, the common law only applies.

A major limitation of simply setting an age of consent, is that it leaves the common law, with all its problems, untouched in relation to the treatment of people below the new age limit.

After reviewing the submissions received in response to the Commission's Information Paper, it would appear that many health care providers and lay people simply assume that by about 16 years of age, young people are able to consent to their own medical treatment. This belief may be as a result of what 16 year olds can already lawfully do at that age - such as work, sexual activity etcetera. But, it may also be as a result of a general acknowledgment that maturity comes with late adolescence, and that these young people have the ability to do certain things which younger people are less competent to do.

This is not to say that at 16, all people have the ability to comprehend fully a proposed treatment. Then again, there may be as many legally competent adults who are as equally confused about medical treatment decisions.

There is no one age at which we all become mature, intelligent, rational beings. Rather, there are stages when most of us are able to understand more about what is happening around us and to us, and later adolescence seems to be one of these stages.

At 16, people may be relatively independent in their decision-making processes, if not economically, and may be in need of advice and perhaps treatment which if not provided, could have a detrimental effect on their health and well-being.

The younger the person, the more likely it is that he or she is dependent on his or her parents for decision-making, and the more likely it is that he or she will seek parental assistance and accept parental guidance in matters such as health care.

There will, of course, be occasions when young people will need advice or treatment in circumstances in which they will be unwilling or unable to involve their parents. If the result of the current law is that health care providers are unable or unwilling to treat such children in the absence of parental consent, then it is imperative that the law be reformed.

In all cases other than an emergency, a health-care provider would be ill-advised to treat a young person without an appropriate consent either from the young person or from the young person's parents. It would also be inappropriate in anything other than the most exceptional circumstances, to require an application to be made to a court or tribunal for authority to perform what may be routine treatment.

⁵⁵⁹ See 161-163 above.

The Commission seeks comment on its preliminary recommendation that:

At 16 years of age a young person can consent to or refuse treatment as if an adult. A health-care provider can treat a young person upon that consent and is prevented from treating the young person if he or she refuses the treatment.

4. FIXED AGE AND LEGAL COMPETENCY APPROACH

A number of jurisdictions have reduced the age at which young people are to be considered as adults for the purposes of treatment decision-making, and have devised legislative schemes for determining whether or not a person less than that age is competent to consent to treatment.

The tests for determining legal competency vary. For example, the Scottish provision states that a person under 16 years of age can consent "where in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment".⁵⁶⁰ Under the current South Australian provision, a young person under 16 can consent if the medical practitioner or dentist believes the treatment is in the "best interests of the health and well-being of the minor" and that the young person is capable of "understanding the nature and consequences of the procedure" and, where practicable, the medical practitioner or dentist's opinion is supported by the written opinion of one other medical practitioner or dentist.⁵⁶¹

The South Australian model is the most comprehensive one reviewed by the Commission.

The legislation recognises that there is an age at which most young people can be presumed to be competent to make treatment decisions (that is, to consent to treatment and to refuse treatment). That age has been set at 16, which is consistent with the age at which young people can assume a number of other adult-type responsibilities.⁵⁶² It is also consistent with reforming legislation in

⁵⁶⁰ See 164 above.

⁵⁶¹ See 149-150 above. See also *Consent to Medical Treatment and Palliative Care Bill 1994 (SA)* cl 12 discussed at 160 above and Appendix 4.

⁵⁶² Such as driving, leaving school, commencing work, etc.

other jurisdictions.⁵⁶³

The requirement of a second opinion in South Australia may be impractical and unnecessary in many circumstances. This would be particularly so in relation to minor treatment, and in circumstances where there was not another appropriate health-care provider readily available. At common law, a legally competent young person can be treated upon his or her consent alone, provided the treating doctor has determined that the young person is legally competent.

The major difference between the common law and the South Australian model vis à vis persons under 16 years of age is the nature of the determination of legal competency. At common law it is an objective determination. Such a determination by a medical practitioner could be challenged in future proceedings and it is possible for the medical practitioner to be held liable for assault or trespass to the person, despite an honestly held belief that, at the time of treating the young person, the young person was legally competent and did in fact consent to the procedure taking place. In South Australia, the determination of legal competency is the subjective opinion of the medical practitioner or dentist.

There appears to be no absolute right in persons under 16 years of age to refuse treatment in South Australia. The common law, as confused as it is in this respect, would apply.⁵⁶⁴

There is also no lower age limit in the South Australian legislation, below which young people could not consent to medical treatment. Thus, it may be possible for a 9 year old to consent to quite serious medical procedures, without the knowledge or consent of his or her parents. Presumably the health-care provider would address his or her mind to the best interests of the young person, but it could be argued that, without discussing the matter with the parents, it would be very difficult to judge what would be in the young person's best interests.

The South Australian legislation is limited to treatment by medical practitioners and dentists. For every other health-care provider the common law applies. Thus, the legal consequences of a young person visiting a doctor and of another young person visiting, say, a psychologist, could be quite different. In relation to health-care providers, the medical practitioner would be immune from certain liabilities for treating a young person without parental involvement, while the psychologist may be liable for treating without the involvement of the parents. One would be making a subjective determination of the young person's maturity and best interests (for under 16 year olds), while the other would be making an objective determination which could be challenged at a future time. The result may be that the psychologist could be criminally or civilly liable for his or her "wrong" determination

⁵⁶³ England and Wales (161-163), Scotland (164-165), Canada (170-174).

⁵⁶⁴ See Ch 8.

while the medical practitioner was immune from such liability.

In relation to young people in need of treatment, they may be more willing and comfortable to visit a medical practitioner, knowing that he or she will protect their confidence, than to visit another health-care provider who may be more likely to involve parents in the decision-making process because of a desire to avoid civil and/or criminal liability.

The appropriate health-care provider for a young person in need of treatment will largely depend on the type of treatment required. Medical practitioners and dentists are only two of a large number of health-care providers who may be the most appropriate treatment provider for a young person. It might be appropriate to have a more objectively imposed limitation on the type of health-care providers who should be entitled to an immunity, such as restricting the availability of the immunity to health-care providers required to be registered pursuant to legislation. At least in that way there would be some additional protection to young people seeking treatment from unregulated and possibly (though not always) unqualified, non-professional health-care providers.

The South Australian legislation does not deal with the situation where parents of a young person disagree as to the appropriate treatment for their child. Nor does it deal with the situation of a conflict between a mature young person under the age of 16 and the young person's parent. Both may provide a valid consent. However, it is not clear whether a young person's (under 16) refusal will override the parent's consent. Nor is it clear whether a parent's refusal can override the child's consent.

Under clause 15 of the *Consent to Medical Treatment and Palliative Care Bill 1994* (SA)⁵⁶⁵ a medical practitioner has a duty to explain to his or her patient or to 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.

⁵⁶⁵ The Bill has passed both Houses of the South Australian Parliament and is awaiting Royal Assent. See discussion at 157 to 160 above and Appendix 4.

It does not appear that the young person has to actually understand the information but, as clause 12 states, he or she must be capable of understanding the nature and consequences and risks of the treatment.⁵⁶⁶ Here it seems, if the young person is not adequately informed of the nature, consequences and risks of the proposed treatment he or she can not give real consent to the treatment. This may lead to criminal assault charges against the doctor or dentist or to a civil action for trespass to the person. In an action for negligence, if relevant information is not provided to the patient, the doctor or dentist (or other health-care provider) may have breached his or her duty of care towards the patient and may be liable for damage resulting from the "uninformed decision" made by the patient.

A doctor or dentist in South Australia must be satisfied that the treatment of a young person under 16 years of age is in the "best interest of the child's health and well-being". Because the test covers "well-being" as well as "health", presumably the doctor or dentist can take into account lifestyle and emotional factors to determine if the proposed treatment is in the young person's best interests. Doctors and dentists would not be able to provide treatment which they believed was not in the best interests of the health and well-being of the young person. Some treatment may involve the well-being of a person but not his or her health - for example, some cosmetic surgery.

Even though a doctor or dentist may satisfy the obligations imposed by the South Australian legislation before treating a young person without parental consent, the doctor or dentist may still be criminally or civilly liable for performing the treatment if the treatment is not "in accordance with proper professional standards of medical practice".⁵⁶⁷ Some unorthodox treatments, over-servicing or radical treatment may not be in accordance with such standards despite being, in the doctor's or dentist's opinion, "in the best interest of the child's health and well-being". What are proper professional standards will need to be adduced from evidence presented at the relevant time, but this requirement does indicate an element of uncertainty about the ability of a person to consent to his or her own treatment. The provision applies to adults and to young people deemed to be capable of consenting as if adults. It is a general limitation on the capacity of anyone to consent to treatment which may not be "appropriate in the circumstances". No penalty is imposed on the doctor or dentist in such a case. Presumably the ordinary criminal or civil consequences of treating a person without the appropriate consent will flow.

It would seem more appropriate to leave to the law of negligence whether or not the treatment was in accordance with acceptable standards. What is more important for the purposes of the current discussion is whether, for persons under

⁵⁶⁶ See cl 12 set out in Appendix 4.

⁵⁶⁷ *Consent to Medical Treatment and Palliative Care Bill 1994* (SA) cl 16(c) and *Consent to Medical and Dental Treatment Act 1985* (SA) s8(1) set out in Appendix 4.

16 years of age, the treatment is in the young person's best interests. If, in all the circumstances, the treatment was inappropriate by accepted standards within the relevant profession, it may be that the health-care provider should be liable for any damages suffered by the young person, irrespective of the giving of a valid consent.

The Commission seeks comment on its preliminary recommendation that:

Young people under the age of 16 years can consent to treatment provided they understand the nature and consequences of the treatment. (This recommendation is subject to recommendations discussed below relating to a lower-age presumption, registration of health-care providers, the provision of information to the young person, a signed consent form and a best interests test).

5. LOWER-AGE PRESUMPTION

Of the legislative schemes reviewed by the Commission, only Quebec has legislated for a fixed age below which young people are presumed not to be competent to consent to treatment.⁵⁶⁸ Yet the younger a person is, the less likely he or she is to fully comprehend proposed treatment and the more likely he or she is to depend upon others to make significant decisions on his or her behalf.⁵⁶⁹

From the health-care provider's point of view, the younger a person is, the greater the likelihood that the health-care provider will be mistaken as to the young person's ability to understand the nature and consequences of proposed treatment. The fact that the health-care provider may have a statutory immunity

⁵⁶⁸ *Public Health Protection Act* (Quebec 1972 c 42) s36 provides, in part:

Where a minor is under fourteen years of age, the consent of the person having paternal authority must be obtained; however, if that consent cannot be obtained or where refusal by the person having paternal authority is not justified in the child's best interest, a judge of the Superior Court may authorize the care or treatment.

Note also New South Wales has provided that a person 14 years of age and older is able to provide an effective consent to treatment for the purpose of relieving doctors and dentists from liability for assault or battery - whether or not he or she understands the proposed treatment. At 16 a person can consent as if an adult. See 146-148 above and Appendix 4.

⁵⁶⁹ Huddart J in the British Columbia Supreme Court decision of *Ney v Canada (Attorney General)* (1993) 102 DLR (4th) 136 at 138 noted:

Few would suggest that any child under 13 is capable of consenting to the provision of significant health care.

from criminal or civil liability for treating a young person upon the health-care provider's subjective belief that the young person is competent to consent does not detract from that risk.

A young person's parents generally have exclusive decision-making authority vis à vis their child's treatment from birth to maturity. In the main, it could be presumed that those decisions are made in the best interests of the young person's health and well-being. It is also likely that parents will have a broader understanding of their child's circumstances than will the child - especially the younger the child is.

It is arguable that young children are more likely than older children to be swayed by the opinion of their peers or perceived authority figures such as medical practitioners. Prior to adolescence, it is also less likely that young people will be involved in risk-taking behaviour (thereby necessitating medical treatment) which is not known to their parents.

The Commission believes that in the vast majority of cases, the most appropriate advocates for young people, and the most appropriate substitute decision-makers for young people, are parents of the young people. This is particularly so, the younger a child is. Of course, in relation to some relatively minor conditions it is apparent that quite young people will be mature enough to understand and be competent to consent to proposed treatment. In any event, the efficacy of involving young people in the decision-making process should be acknowledged.

The Commission seeks comment on its preliminary recommendation that:

Health-care providers cannot treat a young person 12 years of age and younger without the consent of a legally competent parent unless a legally competent parent is not conveniently contactable or refuses consent to treatment which is in the best interests of the young person. In such a case the health-care provider can treat the young person upon the consent of a substitute decision-maker, or upon the authorisation of either the Supreme Court or the Family Court. In all cases, treatment must be in the best interests of the young person. (This recommendation is subject to recommendations discussed below relating to registration of health-care providers).

6. EMANCIPATION

About half the States in the United States of America have enacted legislation which provides for Court-ordered emancipation of young people or which specifies

that certain designated acts by a young person's parents, a young person, or both, constitute emancipation.

These Acts explicitly state that emancipation removes the disabilities of minority, including the requirement of parental consent to medical treatment.

A number of United States jurisdictions authorise young people who have attained varying degrees of independence to consent to medical treatment but do not use the term "emancipation" or "emancipated young people".

The test for emancipation varies but may include: living away from parents and managing one's own financial affairs; young people who are high school graduates or who are in the military or who are married.

The concept of emancipation implies that there will be young people who are not emancipated (who do not fulfil the test), but who are nevertheless mature enough to understand what is involved in relation to proposed medical treatment. In that respect, it seems that emancipation type legislation may be discriminatory unless it is only one of a number of ways by which young people can be deemed legally competent.

Nevertheless, Australia's Health Insurance Commission's⁵⁷⁰ policy of issuing separate Medicare cards to people under 15 years of age is based upon a concept similar to the emancipation principle. It appears that a 14 year old, who is living away from home and whose independence is verified, can obtain his or her own Medicare card. In some circumstances, this may be all that a doctor or health-care provider would consider necessary to justify treating the young person without parental involvement.

An option for reform to be considered by the Commission is:

Whether there are certain indications of a young person's "emancipation" which should entitle the young person to be able to consent to treatment as if he or she were an adult, irrespective of the age of the young person.

⁵⁷⁰ See footnote 46 above.

7. CONFIDENTIALITY FOR SPECIFIC TREATMENTS

There are a number of types of treatment about which young people may feel particularly reluctant to talk to their parents. They may also happen to be treatments for conditions which will harm young people if not undertaken or if delayed. The Alberta Institute of Law Research and Reform has identified the following conditions as falling within that category:⁵⁷¹ sexually transmitted diseases; drugs and alcohol; contraception; and pregnancy and its termination. It has been argued that age and competency to consent are irrelevant considerations when compared to the dangers inherent in not obtaining appropriate treatment.

In relation to *sexually transmitted diseases*, the Alberta Institute noted that prompt treatment is essential and that a requirement of parental consent might result in delay or even neglect of treatment. The consequences of failure to treat or delay in treating can be serious - for example, it may result in sterility. Further, "if a person is old enough to contract venereal disease he should have the capacity to attend to it.... There is a public interest in having them treated and treatment can scarcely be contrary to the minor's 'consent'."⁵⁷²

Drug and alcohol abuse was also seen to be so damaging and exceptional that young people should be able to access treatment without parental involvement. The Alberta Institute referred to a program in the University of Alberta Hospital for the treatment of young people who had taken drugs. Apparently there was some reluctance to attend the program because of fears that the hospital would inform legal authorities and parents. The Hospital decided to treat young people for drug-related problems without notifying parents. The volume of young people attending the program increased rapidly and considerably and stayed at the increased level for quite some time.⁵⁷³

The Institute considered *contraception* to be an exceptional treatment on the basis that the consequences of not obtaining contraception would be unwanted pregnancies. With regard to the issue of confidentiality in such cases, the Alberta Institute noted:⁵⁷⁴

⁵⁷¹ *Consent of Minors to Health Care* Report No. 19 1975 at 10-22. It is interesting to note that in South Australia during the debate on the *Consent to Medical and Dental Procedures Bill 1985 (SA)*, those four areas were specifically raised by church groups as reasons why parental involvement is essential.

⁵⁷² *Id* at 12.

⁵⁷³ Alberta Institute of Law Research and Reform, *Consent of Minors to Health Care* Report No. 19 1975 at 12-13. Although the Hospital observed confidentiality, the physicians in charge of the program did try to convince the patients of the benefits to be gained in the long run in voluntarily informing their parents, and offered to assist them in doing so.

⁵⁷⁴ *Id* at 19.

We accept the general proposition that it is better for minors to take their parents into their confidence. Our understanding is that the practice of physicians is to try to persuade young patients to do this. If the patient agrees there is no problem. The hard issue arises when the minor is adamant in refusing. We think that in these circumstances the usual obligation of confidentiality should apply.

The Institute considered medical treatment in relation to *pregnancy and its termination* to be exceptional on the basis that:⁵⁷⁵

Pregnancy is a trying experience for a young person, and especially one who is unmarried. It is best that the daughter should inform her parents and seek their help and support. The decision whether the pregnancy should continue to term or whether an abortion should be sought within the terms of the Criminal Code is a very important one, doubtless difficult. We think that the decision should be the girl's. Whichever it is it should not be subject to veto by a parent.

Of course the consequences of failure to treat a wide range of other conditions may have serious adverse consequences to the health and well-being of a young person.

The Commission seeks comment on its preliminary recommendation that:

A registered health-care provider can treat a young person of any age and irrespective of the young person's legal competency, upon the request of the young person, for conditions to be prescribed by regulation. In such cases, the health-care provider shall, subject to any statutory requirement to the contrary, respect the young person's wishes relating to confidentiality.

Example: A 12 year old girl is sexually active and seeks treatment for a sexually transmitted disease. She does not want her parents to know of her sexual activity or of her health needs. She will not continue with treatment if her parents are informed.

8. REFUSAL OF TREATMENT

The Commission has identified the following options relating to refusal of treatment. The Commission welcomes any suggestions for other options which should be considered.

⁵⁷⁵ Id at 20.

(a) **No right to refuse**

Whether or not a young person (under 18 years of age) has a right to consent to treatment, he or she should not have a right to refuse treatment which is in his or her best interests and which has been consented to by his or her parents or a Court.

This is presently the position under English law, where the Courts have interpreted section 8 of the *Family Law Reform Act 1969* (UK) to confer on a 16 year old young person a right to consent to treatment, but not a right to refuse treatment which is consented to on behalf of the young person. The right to refuse is only acquired when the young person attains his or her majority. This would obviously represent the most paternalistic approach.

(b) **Right to refuse if legally competent**

When a young person has the intellectual maturity to be competent to consent to treatment, he or she should also be competent to refuse treatment.

This would mean that once a young person reached a level of maturity at which he or she could validly consent to treatment on his or her own behalf, the young person would have the accompanying right to refuse any treatment, including treatment to which the young person's parents might be willing to consent.

This would give the young person the power to choose between different forms of treatment, or to refuse any form of treatment altogether, even if such a decision might not be held, on medical grounds, to be in the young person's best interests.

The young person would effectively have the same rights to bodily integrity and autonomy as an adult, except that it would be subject to the overriding jurisdiction of the Supreme Court under the *parens patriae* jurisdiction.⁵⁷⁶

⁵⁷⁶ See 36, 37 for discussion of the *parens patriae* jurisdiction.

Examples:

A 17 year old has terminal cancer. Doctors offer treatment which might prolong his life slightly, but which will not result in a cure. The young person does not wish to undergo further treatment, although his parents are understandably anxious to try any form of treatment. Should the young person, in circumstances where an adult could withhold consent, have a similar right to withhold consent and refuse treatment?

A 15 year old has a gangrenous foot, the consequence of an infection, and refuses amputation, knowing that she will almost certainly die. Should the young person have the right to make that decision?

(c) Right to refuse at specified age

If a young person is given the right to consent to treatment at a specified age, say 16, he or she should also be given the right to refuse treatment at that age.

This model has been adopted in South Australia,⁵⁷⁷ where the consent or refusal of a young person 16 years of age or older in respect of medical or dental treatment has the same effect as if the young person were of full age.⁵⁷⁸ Below that age, no right to refuse medical treatment is conferred.⁵⁷⁹

(d) Right to refuse certain treatment

A young person, if legally competent, or of a specified age, should be able to refuse some types of treatment and not others.

This would permit some compromise in terms of the young person's autonomy, if it were thought that the right to refuse should generally be vested in parents, but that there were some types of treatment, arguably in the best interests of the young person, which the young person should be entitled to refuse.

⁵⁷⁷ See 148-160 for discussion of the South Australian legislation and Appendix 4.

⁵⁷⁸ *Consent to Medical and Dental Treatment Act 1985 (SA)* s6(1). The *Consent to Medical Treatment and Palliative Care Bill 1994* cl 6 refers to a person 16 years of age or over being able to "make decisions about his or her own medical treatment as validly and effectively as an adult" which would include decisions to refuse treatment.

⁵⁷⁹ See *Consent to Medical and Dental Treatment Act 1985 (SA)* s6(2) and the *Consent to Medical Treatment and Palliative Care Bill 1994 (SA)* cl 12 which refer to a person under 16 years being able to "consent" to treatment in certain circumstances.

Examples:

The parents of a 16 year old who is hearing impaired want her to have a cochlear implant. She does not wish to have the operation. Should she be able to refuse treatment against the wishes of her parents?

A ten year old, who is comfortable with his appearance, does not wish to undergo cosmetic surgery, to which his parents could validly consent on his behalf. Should he be able to override the consent of his parents and refuse the surgery?

The Commission seeks comment on the following:

- 1. Whether a health-care provider should be able to treat a legally competent young person 13 years of age or older upon the consent of the young person's parents but over the refusal of the young person.**
- 2. Whether a young person 13 years of age or older should be entitled to refuse any treatment provided he or she understands the consequences of refusal.**

9. IMMUNITY TO HEALTH-CARE PROVIDERS

In Queensland health-care providers may be criminally or civilly liable for assault or false imprisonment, despite acting in good faith and without negligence, if they treat a young person on the basis of the purported consent of the young person or of his or her parents. This will be so where it eventuates that the purported consent was not a valid consent at law. There will not be a valid consent to treatment if the young person is not legally competent, even if the health-care provider makes an honest but wrong determination as to the young person's competency to consent. Health-care providers may also be liable if they act in good faith and without negligence upon the consent of the young person's parents, over the objections of the legally competent young person. Others involved in the decision-making process or in the treatment itself, such as parents, may also be liable.

One result of the confused state of the current law, is that some health-care providers are reluctant to treat some young people without parental or court involvement, even where it is obvious that treatment is necessary for the

improvement of or maintenance of the young people's health or well-being.

In some other jurisdictions health-care providers have been given an immunity from liability (other than for negligence) if they fulfil the requirements of the respective legislative scheme before treating a young person.⁵⁸⁰

If an immunity from liability were to be given to health-care providers in the scheme to be proposed by the Commission, consideration would have to be given to what, if any, limitations should be imposed upon the immunity. For example, should the immunity extend to all health-care providers or should it be restricted to health-care providers who are required to be registered under statute in Queensland?⁵⁸¹ Such a limitation would provide some assurance that health-care providers entitled to the immunity are from recognised professions, and subject to some degree of regulation. This may offer some additional protection to young people seeking treatment. Health-care providers who are not registered would then need to ensure that a young person is actually competent to consent to the particular treatment being proposed and would not be able to take advantage of any presumptions provided in the scheme to be proposed by the Commission. The legislation in British Columbia which enables health-care providers to treat young people without parental involvement, limits immunity from liability to "licensed, certified or registered" health-care providers.⁵⁸²

If an indemnity were to be provided to statutorily registered health-care providers, for example medical practitioners, should that indemnity also attach to non-registered health-care providers, for example acupuncturists, to whom the registered provider has referred his or her young patient? At this stage the Commission is of the view that such an indemnity should not automatically extend to health-care providers other than registered providers. Whether a young person is referred to a non-registered health-care provider, or consults such a person independently, the non-registered health-care provider should seek an effective consent from either the young person (if legally competent) or from an appropriate substitute decision-maker (for example parent or court) before treating the young person.

⁵⁸⁰ See, eg, *Consent to Medical and Dental Treatment Act 1985* (SA) s8 discussed at 150 above and set out in Appendix 4. Also, *Consent to Medical Treatment and Palliative Care Bill 1994* (SA) cl 16. Also, *Minors (Property and Contracts) Act 1970* (NSW) s49 discussed at 146-148 above and set out in Appendix 4.

⁵⁸¹ In South Australia and New South Wales the relevant legislation only applies to medical practitioners and dentists - both registered health-care providers in those States.

⁵⁸² *Infants Act* (RSBC 1979, c 196) s16(1). See 171-173 above for discussion on the British Columbia legislation.

The Commission seeks comment on its preliminary recommendation that:

An immunity from criminal and civil liability (other than for negligence) should be provided to statutorily registered health-care providers who fulfil the requirements of the scheme to be proposed by the Commission. Such immunity should extend to any person acting in aid of the registered health-care providers and under the registered health-care providers' supervision.

10. CONFLICT BETWEEN PARENTS

No statutory scheme reviewed by the Commission deals with the situation where the parents of a young person who is not legally competent disagree as to the need for, or the choice of, treatment for their child. It appears that a health-care provider can at least treat such a young person upon the consent of either parent.

If one parent only has custody of the child it is unclear if a health-care provider can treat a child upon the basis of the consent of the non-custodial parent.⁵⁸³

If parents disagree on the treatment of their child this may indicate uncertainty as to what is in the best interests of the child. Currently, it would be possible for a parent or other interested party to apply for an injunction from the Supreme Court (under its *parens patriae* jurisdiction) to prevent the other parent or to prevent a health-care provider from having a child treated in a particular manner. Although this is a matter which could be heard expeditiously, it may be costly and intimidating to the parties.

⁵⁸³ Under the *Family Law Act 1975* (Cth) s63E(1) only the person(s) who has or is granted custody of a child has the right and responsibility to make decisions concerning the daily care and control of the child. However, it also states that the guardian of a child (who may be a different person to the person having custody of the child) has responsibility for the long-term welfare of the child. It is unclear whether the guardian has responsibility for medical treatment other than of an immediate or urgent nature. See *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 at 235-236.

The Commission seeks comment on the proposal that:

Where parents of a young person disagree as to the need for or type of treatment required for their child then the proposed Assisted and Substituted Decisions Tribunal, the Supreme Court or the Family Court may be approached for resolution of the dispute. (The Commission has not made a recommendation on this matter).

11. YOUNG PEOPLE AS PARENTS

(a) Arguments for and against a presumption that young parents be treated as adults for the purposes of consent?

Whilst it would seem appropriate to give a legally competent young parent the same power to consent to medical treatment as an adult parent, it would be less appropriate for a young parent to possess that power if he or she were not even capable of giving valid consent to his or her own treatment.

More importantly, if young parents who are not legally competent are, in all cases, given the same powers as adult parents, there is a very real risk that decisions will be made concerning treatment of a child without a proper appreciation of the nature of the treatment and the immediate and future consequences of that treatment. As a result, the health and well-being of the child could be at risk.

(i) Arguments for the presumption

The arguments in favour of presuming the legal competence of young parents to consent to the treatment of their children include:

*** Corollary to having duties and responsibilities,**

Having assumed the role of parent and thus having certain responsibilities and duties to the child, the person, as a necessary corollary to this, should have the ability to determine the child's treatment. This may be more relevant when the child is totally dependent upon the young parent.

*** Maturity with childbirth**

By reason of giving birth to and raising a child, the person is necessarily more mature than a teenager of the same age who has not taken on such a degree of responsibility and is therefore capable

of making informed decisions.

If the legal competence of young parents were assumed, problems in finding an alternative mechanism for decision making would be overcome, except in the rarest cases where the parent was simply unable to consent (for example, through unconsciousness or other disability).

(ii) Arguments against such a presumption

The arguments against the presumption include:

*** Rights and responsibilities not based on duty to provide treatment**

The fact that parents have certain responsibilities to their children does not in itself justify the granting of an absolute power to parents to determine the medical treatment of their children. As described above⁵⁸⁴ such a grant would only be justified if parents had a specific duty to provide their children with medical treatment, the necessary corollary of which would be an unimpeded power to consent to treatments. Given that such a duty does not exist, the mere imposition of other indirectly related duties on a parent does not justify the grant of a general power in deference to the overriding objective of ensuring the health and well being of the child.

*** Parenthood does not always connote maturity**

The fact that a young person is sexually active does not indicate that the young person has undergone the complete process of maturation. It has indeed been observed that:⁵⁸⁵

In Australia, as in most Westernised societies, the physical and sexual development of our adolescents occurs before we feel comfortable with their psychosocial maturity.

There are certain developmental tasks that an adolescent must go through as part of the maturation process for healthy emotional development. These developmental tasks have been identified as follows:⁵⁸⁶

⁵⁸⁴ At 28-29 above.

⁵⁸⁵ Identified by Fleming S in "Adolescent pregnancy in Australia: perspectives and problems" *Modern Medicine of Australia* May 1990 64 at 66.

⁵⁸⁶ Id at 65.

- (i) developing intellectual skills
- (ii) developing a sense of one's identity
- (iii) developing a conscience and moral values
- (iv) achieving independence from parents
- (v) adjusting to sexual maturity and changing gender roles
- (vi) establishing new working relationships with age mates of both genders
- (vii) making educational and vocational choices which will lead to economic independence

It would appear that certain of those steps are hastened or omitted altogether as a result of parenthood, because, unlike other teenagers, the young parent must assume responsibility, must think of the needs of another, must plan ahead and experiences maternal instincts and a desire to nurture, usually not experienced by women until later in life. Important decisions must be made (if a young mother is single) such as whether to continue her relationship with the father and on what level, and whether to seek adoption or accept single motherhood. As a result, young parents generally mature faster than normal teenagers in certain respects. In particular, persons working with teenage parents have observed that parenthood immediately provides a person with a sense of identity and usually requires the early adoption of gender roles (tasks (ii) and (v) described above).

However, whilst a teenage parent may mature faster in certain respects, developmental steps unconnected with any aspect of parenthood must still be undergone for normal maturation like any other adolescent. For example, it has been observed that young parents still see issues in black and white, may be unable to appreciate the consequences of certain decisions, and, in many cases, sacrifice autonomy through a need to find love and affection, and often prefer the interests of their partner to their child.⁵⁸⁷ Many teenage parents who, due to parenthood, in fact omit or only partly undergo certain developmental stages, often suffer the consequences emotionally as well as socially and financially in years to come.

It has been observed that.⁵⁸⁸

Teenage single girls suffer the consequences of interruption to education, with subsequent loss of career options and financial difficulty. Early parenthood means an interruption to the normal processes of adolescence as a transition to adulthood.

⁵⁸⁷ Consultation with an academic in the nursing field who is involved in research in relation to young Queensland mothers (29 November 1994).

⁵⁸⁸ Thompson C and Liddy U "Adolescent Sexuality: Issues, Choices and Reproductive Rights" (Oct 92-Feb 93) *Transitions - the YANG Journal* 34 at 38.

It therefore cannot be assumed that a young parent necessarily has the requisite maturity to make an informed decision regarding the medical treatment of his or her child. In fact, the two aspects of maturation which a young person would appear to undergo on becoming a parent (relating to identity and assuming gender roles) have no bearing on a young person's ability to understand the nature and consequences of types of medical treatments. Development of intellectual capability leading to the ability to understand and foresee the consequences of events is more critical to the ability of a young person to provide informed consent. Yet this ability has been observed to be absent in many young parents. It follows that the fact that a young parent may be more mature in certain respects than other teenagers of the same age would not be sufficient reason alone to justify granting that parent the power to determine his or her child's treatment.

(b) Mechanisms for decision making on behalf of young parents

As outlined above, the mechanisms currently available to assist young parents in need of decision-making assistance are flawed in certain respects (in particular, by not clearly delineating the liability for decision making when the parent is unable to consent to treatments).⁵⁸⁹ They are onerous and cumbersome and have the effect that health-care workers only resort to them in obvious and extreme cases of need. Part of the problem would appear to be that the mechanisms are aimed at assisting young people in clear cases of need, where the most fundamental necessities of life might otherwise be lacking (such as food and lodgings). In this context, it would usually be necessary for alternative custody or guardianship arrangements to be made to cater for a wide range of needs of the child, and accordingly, strict procedures for the making of those arrangements are necessary to ensure that unwarranted intervention with normal family life does not occur.

In the case of young parents who are not legally competent, assistance with decision making concerning the medical treatment of their children may be the only form of assistance they require. It would therefore be appropriate to establish a mechanism whereby that assistance could be easily accessed with a minimum of cost and disruption to the family life of the child.

There is a perception held by individuals and organisations contacted by the Commission that there is a distinct lack of support available to young parents through government and private organisations.⁵⁹⁰

⁵⁸⁹ See 142-145 above.

⁵⁹⁰ Consultations with people working in programs with young mothers (29 November 1994, 8 December 1994).

As a group, pregnant teenagers frequently come from a deprived social and economic background, and often have a history of teenage pregnancy. They frequently come from families with single parents and have experienced a lack of affection throughout their lives.⁵⁹¹ An academic who has been conducting research into teenage mothers in Queensland, has observed that most of such young mothers with whom she had had contact could only name one person able to give them support and even then, only a small degree of support is identified.⁵⁹²

It has also been observed by others working with teenage parents that, even where support is available to the young mother from her own mother (the baby's grandmother), the grandmother of the child may often be the worst person to assist her daughter in making decisions regarding the child, due, for example, to the conflict which the grandmother may feel between the interests of her daughter and the interests of her grandchild, or because the grandmother may be aware of circumstances, such as incest, which resulted in the pregnancy.⁵⁹³

The experience of people consulted by the Commission who work with teenage parents is that the young mother is usually the best person to make decisions concerning herself and her child. This was put on the basis that no one cares more for a child than the parents. However, it cannot be ignored that a young mother may be unable to make an informed decision concerning treatment of her child because she does not have sufficient maturity.

The Commission seeks comment on its preliminary recommendation that:

Young people who are parents can consent to the treatment of their children by registered health-care providers, provided the young people understand the nature and consequences of the proposed treatment. In all cases, treatment can not proceed unless it is in the best interests of the child.

⁵⁹¹ Consultation 29 November 1994.

⁵⁹² Ibid.

⁵⁹³ Consultations 25 November 1994, 29 November 1994 and 8 December 1994.

12. EXAMINATIONS IN CASES OF SUSPECTED CHILD ABUSE

Child abuse, particularly child sexual abuse is often difficult to detect and difficult to prove. It is therefore essential that those seeking to protect young people from suspected abuse have the ability to remove children whom they reasonably suspect to be at risk and to keep them in some safe place until suitable action can be taken, during which time the young person may be examined and treated if necessary. At present in Queensland such power of removal is limited to section 49 of the *Children's Services Act 1965* (Qld), under which section a care and protection application must be made as soon as practicable after the child is removed, and section 76L of the *Health Act 1937* (Qld), which only applies if the young person has presented himself or herself, or has been presented at, a hospital.

After discussion with those working in the area in Queensland, the Commission is of the view that the 96 hour detention provision embodied in section 76L of the *Health Act 1937* (Qld) should be retained, particularly as it gives hospital authorities and members of S.C.A.N. teams the ability to negotiate with parents to obtain consent, or to act in cases where young people are in great need of medical treatment, and their parents or guardians refuse consent to the provision of such treatment. However, the powers contained within section 76L should be extended so as to include situations where a young person has not been presented at a hospital. Powers of removal and detention for a 96 hour period, perhaps preceded by a request to the parents or guardian as in New South Wales and Tasmania, should be granted to authorised officers (such as S.C.A.N. team members and police officers), without the need for prior court sanction or application for a care and protection order. The 96 hour period, whether the child is in hospital or some other safe place, should be extendable for a further 96 hour period upon application to the Children's Court. Application to the Court for a temporary care and protection order should be made within this time. Also during this time, power should be available to conduct a medical examination or administer necessary treatment without the parents' or guardian's consent, and without the need for instituting a care and protection application. The Director-General or his or her delegate could be granted custody or guardianship during this time solely for the purpose of conducting such examination or providing such treatment.⁵⁹⁴

In all cases of suspected abuse, and particularly if a young person makes complaint of abuse, clear guidelines should exist as to the age at which the young person's consent to medical examination or treatment is sufficient, despite the absence or refusal of parental or guardian consent. This is especially useful where "homeless" young people are involved or one or more parents are implicated in the

⁵⁹⁴ Queensland Cabinet has recently given its approval for the drafting of new child protection legislation for Queensland which may affect the issue of consent to medical examinations of suspected child abuse victims. See "Violent Parents to be Forced to leave Home" *The Courier-Mail* 14 March 1995 at 1 and *Child Protection Legislation Issues Paper*, Department of Family Services and Aboriginal and Islander Affairs July 1993.

abuse. One way of clarifying this is to prepare a written protocol for police, Family Services officers and medical practitioners which clearly sets out the guidelines relating to consent to medical examination and treatment. Above all, as in the South Australian⁵⁹⁵ legislation and the New South Wales protocol it should be made clear that an examination not proceed in the absence of the young person's consent, at whatever age.

The Commission seeks comment on the following proposals for reform of child protection legislation and practice:

A young person who is or is suspected of being at risk of abuse may be removed by authorised officers (such as Family Services officers and police) and kept in a place of safety for a 96 hour period, extendable for a further 96 hour period, during which time the Director-General or his or her delegate is deemed to have custody of the young person for the purposes of conducting a medical examination and providing necessary treatment. QUERY WHETHER removal should be preceded by a written request to parents or guardian to hand over the young person.

The power of hospital authorities to detain suspected victims of child abuse is to be retained, and made extendable for a further 96 hour period.

During the currency of the 96 hour order, the consent of the Director-General or his or her delegate to medical examination or treatment is sufficient in the absence of parental or guardian consent.

A written protocol is to be developed as to the obtaining of consent to medical examination and treatment of suspected victims of child abuse.

A medical examination is not to proceed over the refusal of the young person.

13. DECISION-MAKER OF LAST RESORT: DECISION-MAKING FOR YOUNG PEOPLE WHO ARE NOT LEGALLY COMPETENT WHEN PARENTS ARE NOT LEGALLY COMPETENT OR NOT AVAILABLE

The current options for substituted consent to treatment of young people who are not legally competent where parents are either not legally competent or not available, where the proposed treatment is not required as a matter of emergency,

⁵⁹⁵ *Children's Protection Act 1993 (SA) s26(3).*

and where statute law does not specifically waive the requirement of consent before treatment is undertaken are:

(a) Care and protection proceedings to make the young person a ward

It has been suggested to the Commission that there is some reluctance on the part of carers of young people to proceed in this way due to: the perceived stigma attached to being a ward; the cost and formality of court proceedings; the fear that such proceedings may hinder the reunification of parents and child.

(b) An application to the Supreme Court pursuant to its *parens patriae* jurisdiction

The principal objections to such a proceeding are the cost and formality in having the matter heard by the Supreme Court.

(c) An application to the Family Court

For some proposed treatments, in particular non-therapeutic procedures resulting in the sterilisation of young people, the authorisation of the Family Court must be obtained.⁵⁹⁶ The Family Court may also be approached for its authorisation to proceed with any other treatment considered to be in the best interests of children of marriages.⁵⁹⁷ The High Court of Australia has likened this welfare jurisdiction of the Family Court to the *parens patriae* jurisdiction:⁵⁹⁸

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.

Objections to having the Family Court authorise treatment are similar to the objections raised in relation to the Supreme Court's jurisdiction, although, following *Secretary, Department of Health and Community Services v JWB and SMB*

⁵⁹⁶ See 4-5 above. It is unclear at this stage what, if any, other types of treatment cannot be consented to by parents and must be authorised by the Family Court.

⁵⁹⁷ The *Family Law Act 1975* (Cth) s63(1) confers jurisdiction on the Family Court 'in relation to matters arising under this part'. S64(1) of the Act provides:

In proceedings in relation to the custody, guardianship or welfare of, or access to, a child ...
(c) ... the court may make such order in respect of those matters as it considers proper, including an order until further order.

⁵⁹⁸ *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 at 259.

(*Marion's case*), the procedures in the Family Court for handling applications for sterilisation authorisations have been streamlined and are likely to be further refined in the future. It may be possible that the procedures for applications for authorisation of other types of treatment on young people could also be streamlined. Until that happens, cost and formality are the major objections to having the Family Court determine these matters.

(d) Consent by others

There is no Australian juridical authority to suggest that people other than the young person, his or her parent, court-appointed guardian, or a court can consent to or authorise the young person's treatment.⁵⁹⁹

In New Zealand there is a provision enabling the person "who has been acting in the place of a parent" or (if no such person) the Director-General of the relevant Government Department or a District Court judge to give consent.⁶⁰⁰ Similarly, in South Australia, "parent" is defined as including "a guardian of the minor or a person acting *in loco parentis* in relation to the minor".⁶⁰¹ There is, however, no apparent mechanism in either jurisdiction to ensure that a person "acting in the place of a parent" is an appropriate or the most appropriate person to consent to the medical treatment of the young person.

Under the scheme proposed by the Commission in its Draft Report on *Assisted and Substituted Decisions*,⁶⁰² the spouse, parents, son or daughter or someone who has a close personal relationship with the person concerned and who maintains a personal interest in the person's welfare would be able to consent to any treatment of the person other than treatment requiring special consent (for example, sterilisation and termination of pregnancy).⁶⁰³

⁵⁹⁹ But see academic literature such as MacFarlane P *Health Law: Commentary & Materials* 1995 at 81 and CCH *Health & Medical Law Reporter* at 17-390. In *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112 Lord Scarman at 189 suggested that doctors may be able to treat without consent even in non-emergency situations:

Emergency, parental neglect, abandonment of the child, or inability to find the parent are examples of exceptional situations justifying the doctor proceeding to treat the child without parental knowledge and consent: but there will arise, no doubt, other exceptional situations in which it will be reasonable for the doctor to proceed without the parents' consent.

⁶⁰⁰ *Guardianship Act 1968* (NZ) s25. See 165-166 above.

⁶⁰¹ *Consent to Medical and Dental Treatment Act 1985* (SA) s4. The *Consent to Medical Treatment and Palliative Care Bill 1994* (SA) cl 4 defines "parent" as including a person *in loco parentis*.

⁶⁰² February 1995 at 140-145 and cl 113.

⁶⁰³ Only the proposed Tribunal could consent to treatments requiring "special consent".

Given that the Commission has, on a preliminary basis in this Paper, recommended that 16 and 17 year olds should be treated as adults for the purposes of being able to consent to treatment, it would be appropriate for 16 and 17 year olds who are not legally competent under the adult test of competency to make their own decisions, either with or without assistance, to be treated as adult patients for the purposes of the scheme proposed by the Draft Report on *Assisted and Substituted Decisions*.

The Commission seeks comment on its preliminary recommendation that:

Where a young person under the age of 16 years is not legally competent and does not have a parent who is easily contactable, legally competent or willing to consent to treatment which is in the best interests of the young person, an application can be made to the Assisted and Substituted Decisions Tribunal⁶⁰⁴ to appoint an appropriate person to make treatment decisions on behalf of the young person. QUERY whether the Children's Court would be an appropriate alternative body to make such appointments?

The substitute decision-maker would be subject to the supervision of the Tribunal but would not necessarily have to approach the Tribunal on every occasion a decision had to be made. For a young person living in an institution, the person in charge of the institution or a person having a particular interest in the welfare of the young person may be an appropriate person to appoint as substitute decision-maker.⁶⁰⁵

Young people 16 years of age and over who are not legally competent to make treatment decisions on their own behalf should be treated as adults for the purposes of the Commission's proposed Assisted and Substituted Decisions Legislation and Tribunal to be established thereunder.

14. EMERGENCIES

The general requirement of consent is not applicable to emergency situations where immediate treatment is necessary in order to save a person's life or to

⁶⁰⁴ See Queensland Law Reform Commission's Draft Report on *Assisted and Substituted Decisions* February 1995.

⁶⁰⁵ Note in New Zealand consent can be given by a "guardian" of the young person or if no guardian can be found with reasonable diligence or who is capable of giving consent, consent can be given by "a person in New Zealand who has been acting in the place of a parent". If no such person exists, a District Court Judge or the Director-General can consent. See 165-166 above.

prevent serious injury to his or her health. Thus, where a young person is not legally competent to consent to treatment and his or her parents are not available, or are unwilling or unable to consent to the emergency treatment, health-care providers can treat. They will not be criminally or civilly liable for treating other than for negligence. Additional statutory protection for some health-care providers has been referred to earlier.⁶⁰⁶

There is no apparent need to reform the law in this regard.

15. PARENS PATRIAE

In *Carseldine v The Director of the Department of Children's Services*⁶⁰⁷ McTiernan J observed:

As the equitable jurisdiction of the Supreme Court derives from a delegation of the prerogative of the Crown to the Court, that jurisdiction could only be taken away by a statute, if the statute does so expressly or by necessary implication.

As the Commission is of the view that it is in the interests of young people for the *parens patriae* jurisdiction of the Supreme Court to be retained,⁶⁰⁸ it would be prudent to include in any legislative model an express provision to that effect, so that potential arguments about an implied ousting of that jurisdiction can be avoided.⁶⁰⁹

⁶⁰⁶ See Ch 9.

⁶⁰⁷ (1974) 133 CLR 345 at 351.

⁶⁰⁸ This is consistent with the Commission's recommendation in para 3.8.6 of its Draft Report *Assisted and Substituted Decisions* February 1995 that, notwithstanding the recommendation for the establishment of a tribunal to make determinations about decision-making by and for people with a decision-making disability, the *parens patriae* jurisdiction provided a formal accountability mechanism, that its role was essential to the role of the Supreme Court as a superior court and that it should not be abolished.

⁶⁰⁹ In *Carseldine v The Director of the Department of Children's Services* (1974) 133 CLR 345 it was argued for the respondent Department that the *Children's Services Act 1965* (Qld) showed an intention to remove from the Supreme Court its jurisdiction with respect to the custody of children admitted to the care and protection of the Director of the Department. That argument was rejected by the majority of the High Court, reversing the decision of the Full Court of the Supreme Court of Queensland. See note in (1974) 48 ALJ 546.

16. THE COMMISSION'S PREFERRED SCHEME

Consent for all treatments

1. No one can treat a person under the age of 18 years unless there is a valid consent in accordance with the recommendations listed below or in an emergency situation where it is not practical to obtain consent. Treatment is to include treatment involving physical and/or non physical contact with the patient.

Treatment of young people 16 or older

2. At 16 years of age a young person can consent to or refuse treatment as if an adult. A health-care provider can treat the young person upon that consent and is prevented from treating the young person if he or she refuses the treatment.
3. The proposed Assisted and Substituted Decisions legislation and the jurisdiction of the Tribunal to be established thereunder should be extended to cover 16 and 17 year olds who are not legally competent to make treatment decisions or who are in need of assistance in making such decisions.

Treatment of young people 15 or younger

4. Where a registered health-care provider treats a young person 15 years of age or younger, the treatment must be, in the registered health-care provider's opinion [subjective test], in the young person's best interests. Where a non-registered health-care provider treats a young person 15 years of age or younger, the treatment must be [objective test] in the young person's best interests.

Treatment of young people 13 or older by registered health-care providers

5. At 13 years of age or older, a young person can validly consent to treatment by a registered health-care provider and a registered health-care provider can treat the young person upon that consent provided that:
 - (a) in the opinion of the health-care provider [subjective test], the young person understands the nature and consequences of the proposed treatment and of the consequences of not being treated;
 - (b) the young person has been provided with relevant information on advantages and disadvantages of the proposed treatment in a mode which the young person is likely to understand;

- (c) the young person has signed a written "consent to treatment" form;
 - (d) in the opinion of the health-care provider [subjective test], treatment is in the young person's best interests.
6. A health-care provider who is registered as a health-care provider pursuant to a Queensland statute or whose registration as a health-care provider in another jurisdiction is recognised in Queensland, acting in accordance with 5 (above) upon the consent of a young person 13 years of age or over is to be immune from criminal liability for assault or battery and from civil liability for trespass to the person or false imprisonment in relation to the provision of treatment consented to. Such immunity should extend to any person acting in aid of the registered health-care provider and under the registered health-care provider's supervision.

Treatment of young people 13 or older by non-registered health-care provider

7. At 13 years of age or older a young person can validly consent to treatment by a non-registered health-care provider and a non-registered health-care provider can treat the young person upon that consent provided that:
- (a) the young person understands [objective test] the nature and consequences of the proposed treatment and of the consequences of not being treated;
 - (b) the young person has been provided with relevant information on advantages and disadvantages of the proposed treatment in a mode which the young person is likely to understand;
 - (c) the young person has signed a written "consent to treatment" form;
 - (d) the treatment is in the young person's best interests [objective test].

Treatment of young people 13 or older upon consent of parent

8. A health-care provider can treat a young person 13 years of age or older upon the consent of a legally competent parent of the young person **BUT QUERY WHETHER** treatment should proceed over the refusal of a legally competent young person of that age.

Treatment of young people 13 or older upon consent of substitute decision-maker

9. Where a parent of a not legally competent young person 13 years of age or older is not himself or herself legally competent or conveniently contactable, or refuses consent to treatment which is in the best interests of the young person, the health-care provider can treat the young person upon the consent of a substitute decision-maker or upon the authorisation of the

Supreme Court or the Family Court.

10. A substitute decision-maker for a young person 13 years of age or older who is not legally competent may be appointed by, if and when established, the proposed Assisted and Substituted Decisions Tribunal. **QUERY** alternative of extending the jurisdiction of the Children's Court to make such appointments.

Refusal of treatment by young people 13 or older

11. **QUERY WHETHER**, at 13 years of age or older, a young person who is legally competent to consent to particular treatment should be entitled to refuse such treatment provided, in the opinion of the health-care provider [subjective opinion of registered health-care provider; objective opinion of non-registered health-care provider], he or she understands the consequences of refusal.

Treatment of young people 12 or younger

12. Health-care providers can treat a young person 12 years of age or younger upon the consent of a legally competent parent of the young person. Where a parent of a young person 12 years of age or younger is not legally competent or conveniently contactable, or refuses consent to treatment which is in the best interests of the young person, the health-care provider can treat the young person upon the consent of a substitute decision-maker or upon the authorisation of the Supreme Court or the Family Court.

A substitute decision-maker for the parent of a young person 12 years of age or younger may be appointed by, if and when established, the proposed Assisted and Substituted Decisions Tribunal. **QUERY** alternative of extending the jurisdiction of the Children's Court to make such appointments.

In all cases, a registered health-care provider cannot treat a young person 12 years of age or younger unless, in his or her opinion [subjective test], the treatment is in the young person's best interests. A non-registered health-care provider cannot treat a young person unless the treatment is in the young person's best interests [objective test].

13. A health-care provider who is registered as a health-care provider pursuant to a Queensland statute or whose registration as a health-care provider in another jurisdiction is recognised in Queensland, acting in accordance with 12 (above) upon the consent of the parent of a young person 12 years of age or younger or a substitute decision-maker is to be immune from criminal liability for assault or battery and from civil liability for trespass to the person or false imprisonment in relation to the provision of treatment consented to. Such immunity should extend to any person acting in aid of the registered

health-care provider and under the registered health-care provider's supervision.

Involvement of young people and parents in treatment decision-making

14. Health-care providers should be encouraged to involve young people in the decision-making process relating to proposed treatment irrespective of the age and legal competency of the young people.
15. Unless it is considered inappropriate, health-care providers should encourage young people seeking treatment to inform their parents prior to the treatment taking place.

Young people as parents

16. Young people who are parents can consent to the treatment of their children by registered health-care providers provided the young people understand the nature and consequences of the proposed treatment. In all cases, a registered health-care provider cannot treat a child of a young person unless in his or her opinion [subjective test] the treatment is in the child's best interests. A non-registered health-care provider cannot treat a child of a young person unless the treatment is in the child's best interests [objective test].
17. A health-care provider who is registered as a health-care provider pursuant to a Queensland statute or whose registration as a health-care provider in another jurisdiction is recognised in Queensland, acting in accordance with 16 (above) upon the consent of a young person, is to be immune from criminal liability for assault or battery and from civil liability for trespass to the person or false imprisonment in relation to the provision of treatment consented to. Such immunity should extend to any person acting in aid of the registered health-care provider and under the registered health-care provider's supervision.

Treatment of prescribed conditions

18. A registered health-care provider can treat a young person of any age and irrespective of the young person's legal competency, upon the request of the young person, for conditions to be prescribed by regulation. Those conditions may include sexually transmitted diseases and other serious communicable diseases. In such cases, the health-care provider shall, subject to any statutory requirement to the contrary, respect the young person's wishes relating to confidentiality.

Disagreement between parents

19. **QUERY WHETHER**, if the parents of a young person disagree as to the need for or type of treatment required for their child, then the proposed Assisted and Substituted Decisions Tribunal, the Supreme Court or the Family Court may be approached for resolution of the dispute.

Consent to examination of alleged victim of child abuse

20. A young person who is or is suspected of being at risk of abuse may be removed by authorised officers (such as Family Services officers and police) and kept in a place of safety for a 96 hour period, extendable for a further 96 hour period, during which time the Director-General or his or her delegate is deemed to have custody of the young person for the purposes of conducting a medical examination and providing necessary treatment. **QUERY WHETHER** removal should be preceded by a written request to parents or guardian to hand over the young person.

The power of hospital authorities to keep suspected victims of child abuse for a 96 hour period is to be retained, and made extendable for a further 96 hour period.

During the currency of a 96 hour order, the consent of the Director-General or his or her delegate to medical examination or treatment is sufficient in the absence of parental consent.

A written protocol is to be developed as to the obtaining of consent to medical examination and treatment of suspected victims of child abuse.

A medical examination is not to proceed over the refusal of the young person.

Ability to consent where legal duty exists

21. **QUERY WHETHER**, if a person or institution (the carer) is under a legal duty to provide treatment to a young person who is not legally competent and where, in the opinion of a registered health-care provider and the carer, a delay in treating the young person in order to locate legally competent parents or to obtain the appointment of a substitute decision-maker would prejudice the health of the young person, the carer should be able to consent to the treatment and should the registered health-care provider and the carer be immune from liability.

Retention of *parens patriae* jurisdiction

22. The *parens patriae* jurisdiction of the Supreme Court is to be specifically retained.

APPENDIX 1

LIST OF RESPONDENTS TO THE INFORMATION PAPER

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Anonymous
Dr D B Appleton
Aquinas College, Parents & Friends Assoc
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Mrs Badke
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Ms L Boshler
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Mrs W Brown
Dr Butt
Mrs B Campbell
Mr Col Campbell
Ms E Campbell
Ms R Carriere, Blackheath and Thornburgh College
Ms J Ciinker, Blackheath and Thornburgh College
Dr J Collie, Royal Women's Hospital
Ms Jocelyn Collins
R J Conway, Biloela Right to Life
Mr G Cook, Austrn Festival of Light (Qld)
Ms K Cooper, Youth Health Policy Unit Qld Health
Dr T F Coyle
Dr M Crawford, Child Protection Unit, Mater Misericordiae Hospital
Brian Cronin
Mr & Mrs Cutcliffe
Mrs Carol A Daley
Mrs Dolores de Roode
Mr I Douglas
Ms Jan Eastgate, National President, Citizens Commission on Human Rights
Mr Jason Fagg
Mr & Mrs Fairley
The Family Planning Association
M Fatur
Mr James Finn, Youth & Family Services
Mr J Fleming
Mr T Ford
Mrs L Fry
Dr & Mrs Fullerton
Sister D Gardiner RSM, Mission and Ethics, Mater Misericordiae Public Hospitals
Rev Dr K J Gardner, Clerk Assembly of the Presbyterian Church of Qld
Father Peter Gillam
Mr & Mrs Con Gleeson
Dr J Goldbaum
Ms Jan Grigg
Ms G Grimley, Qld Spastic Welfare League
Dr David Grundmann, Planned Parenthood of Australia
Mr & Mrs Ian Gunn
Ms J Hailstone, Qld Parents of People with a Disability Inc
Ms Vi Hall
Ms J A Hancock, Brisbane Girls' Grammar School
Drs Hanger & Sadler and Mr Ian Hanger Q.C.
Mrs C Hauff, Principal, Clayfield College
Mr John Hodgins, Director, Legal Aid Office (Qld)
"ILLEGIBLE"
Innisfail State High School
Ms M Jensen
Ms R Johnson & Ms K Woodford, Innisfail State High School
Ms Sue Johnston
Denis Jones, Secretary, Queensland Nurses' Union
Ms C Judd
Mr S J Keane
Mrs M Kelly
Ms P Lanes, Kilcoy State High School Parents & Friends Assn
Dr Di Lange, Chief Medical Officer, Queensland Health
Dr S Latham
Prof. S Laufer, Bond University
Prof. J F Leditschke, Royal Children's Hospital
Ms Nancy Leighton, Children by Choice Association
Mr & Mrs Trevor Lingard
Ms K Lister, St Mary's Home (Anglican)
Dr R B McCrossin
Ms J McDonald, Sandgate House Youth Emergency Services
Mr P J M MacFarlane
Dr McGuckin
Mrs Judy Mackenzie, Survivors of Abortion Assn
G J McMahon
Ms Jill McNelly

Mr R D McRae, Down Syndrome Assn of Qld
Mrs K McWhirter
Mrs C Mann
Mrs C Mayberry
Menstrual Management Research Team,
University of Queensland
Ms L Meyers
Noel Miller, The Queensland Branch of
Australian Medical Association
Ms C Milliner, Bundaberg District Toy Library
M/s C Mitchell
Mr M P Monsour
Mrs N Mullins, Our Lady of the Way School
Parents & Friends Assn
Ms Ann Murphy
Mr & Mrs Ron Murray
Mr P Naske
Ms Joanne Nehmer, Mereeba State High
School (Far North Queensland)
Mr M G O'Dowd, Assn of Catholic Parents
Mr Michael O'Meara
Mr Robert Osmak
Paediatric Surgeons Group, Brisbane
Mr & Mrs R M Patroni
Mr L Percy
Ms K J Petrie
Ms Renee Prescott, Somerset College
Mrs Wendy Priebe
Willie Prince, Queensland Advocacy
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Dr D M Purcell
Queensland Health, Brisbane North Region,
Queensland's Health Sector
Queensland Right to Life Association
Qld Right to Life, Tableland Branch
Ms R Rawula
Right to Life Australia
Ms Sally Russell-Hall, Redbank Plains State
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Ms D Ryan RN
Ms Jennifer Rylance
Dr T Sadler
Ms M Samuels, Unicare
Ms S Savage
Dr David Schultz, Australian Association for
Adolescent Health
Mr J Shanahan
Dr Ian Shellshear
Mr H Shepherd
Mr B Smith, The Assn of Independent Schools
of Qld
Mr G W Smith, Canegrowers, Invicta Area
Mrs C Sorenson
Ms Lyn Stephens
Mrs June Sultana
Mrs R Svendsen
Ms S A Tendo
P Thiedeman, Woody Point Special School
Mohammad Tomoum, President, Islamic
Council of Queensland
B Torkington, St Francis Primary School
Mrs L Utting
Mr/Ms D Wallace
Mr L Wallace
Mrs M Wallace
Ms Susan Waller
Mrs Mary Walsh, Australian Parent Advocacy
Ms A Warner MLA, Minister for Family Services
and Aboriginal and Islander Affairs
Ms M Weller
Mrs Shirley Whitton
Mrs Wickham
Ms V Wigg
Dr I S Wilkey
Ms S Wilkie, President, Association of Private
Practising Psychologists
A.M. Williams, Bundaberg Community Council
Incorporated
Dr George L. Wilson
Mrs M Wilson
Mr Tim Wilson, Youth Affairs Network of Qld Inc
R Wood
Mr & Mrs W D Zischke

APPENDIX 2

HEALTH-CARE PROVIDERS ETHICAL DUTY OF CONFIDENTIALITY: A SAMPLE OF DUTIES

AUSTRALIAN OSTEOPATHIC ASSOCIATION: CODE OF ETHICS

3.2 Confidentiality

An osteopath must consider as entirely confidential any information concerning patients under their care. They must not divulge such information to any third party except with the patient's full consent, or where compelled to do so under the law ...

AUSTRALIAN ACUPUNCTURE ASSOCIATION: CODE OF ETHICS

2.7 A practitioner owes a duty of absolute confidence to his [or her] patients, and shall not disclose any information coming to his [or her] attention through his [or her] professional relationship with the patient, except when -

- (i) required to do so by a rule of law;
- (ii) in an emergency ...;
- (iii) in consultation with other health care practitioners, for the purpose of better diagnosing or treating, or co-ordinating the treatment of the patient;
- (iv) the patient has consented ...;
- (v) the patient is living in a husband and wife relationship, and the practitioner, on reasonable grounds, believes that it is in the best interest of the patient to inform the patient's spouse to the extent necessary to promote or protect the patient's interest.

CHIROPRACTORS' ASSOCIATION OF AUSTRALIA: BASIC CODE OF ETHICS

2.1 Confidentiality

2.1.1 All information given to a chiropractor or a chiropractor's staff by a patient must be treated confidentially.

2.1.2 Information may only be divulged with the patient's permission or when legally required to do so.

2.1.3 A chiropractor must not convey confidential communications from related professions to a patient without written consent from the author of such communications.

AUSTRALIAN HYPNOTHERAPISTS' ASSOCIATION: THE ETHICS OF

I pledge myself to treat as confidential, information received by me from any patient.

AUSTRALIAN PSYCHOLOGICAL SOCIETY LTD: CODE OF PROFESSIONAL CONDUCT

Section B: Consulting Relationships

1. ... Information obtained in clinical or consulting relationships, or evaluative data concerning children, students, employees, or other clients, may be communicated only for professional purposes and only to persons legitimately concerned with the case ...
5. When working with minors or other persons who are unable to give voluntary, informed consent, psychologists must protect these persons' best interests and will regard their responsibilities as being directed to the parents, next of kin, or guardians, in accordance with the normal legal formulae.

FEDERATION OF NATURAL AND TRADITIONAL THERAPISTS: CODE OF ETHICS

- 4.1 A practitioner may not disclose information obtained in confidence from or about a patient unless consent has been given.

POLICIES OF THE AUSTRALIAN OPTOMETRICAL ASSOCIATION 1990

- 100 Optometrists must provide their patients with personal, confidential clinical care and the benefits of current clinical procedures and technology. *[emphasis added]*

PHARMACEUTICAL SOCIETY OF AUSTRALIA: CODE OF PROFESSIONAL CONDUCT

Code 5

A pharmacist shall respect the trust and confidentiality of professional relationships with patients.

AUSTRALIAN ASSOCIATION OF SPEECH AND HEARING: CODE OF ETHICS

5. Members shall not reveal to unauthorised persons any professional or personal information obtained from the client served professionally, unless required by law or unless necessary to protect the welfare of the client or the community.

AUSTRALIAN PHYSIOTHERAPY ASSOCIATION: ETHICAL PRINCIPLES**Ethical Principle 5**

1. Information about a patient/client shall not be communicated to another person and/or recording system not involved in the patient's/client's care, without prior consent of that patient/client or his/her legal agent ...

3. Information may be given if authorised by an appropriate legal authority, or if necessary, to protect the welfare of an individual or the community.

APPENDIX 3

AUSTRALIAN LEGISLATION RELATING TO THE EXAMINATION OF ALLEGED CHILD ABUSE VICTIMS

1. COMPARATIVE TABLE OF CHILD PROTECTION LEGISLATION

QLD	SA	NSW	VIC	WA	TAS	NT	ACT
Children's Services Act 1965 (Qld) Health Act 1937 (Qld)	Children's Protection Act 1993 (SA)	Children (Care and Protection) Act 1987 (NSW)	Children and Young Persons Act 1989 (Vic)	Child Welfare Act 1947 (WA)	Child Protection Act 1974 (Tas)	Community Welfare Act 1983 (NT)	Children's Services Act 1986 (ACT)
Requirement to present child for examination		Notice requiring young person (<16) who it is reasonably believed has been abused to be presented to a specified medical practitioner to be medically examined: s23.	Protective intervener may serve a notice requiring young person to be brought before Children's Court for hearing of protection application: s68. Once application made young person may be medically examined.		Authorized officer may require anyone having care of a young person to cause the young person to be taken to an assessment centre to be examined: s9.		

	QLD	SA	NSW	VIC	WA	TAS	NT	ACT
Removal of young person	<p>Authorized officer or police may take child reasonably suspected of being in need of care & protection into custody. Care & protection application must be made as soon as possible after child taken into custody: s49(2) <i>Children's Services Act 1965.</i></p>	<p>Young person at risk may be removed from parent/ guardian using reasonable force: s17.</p>	<p>If notice not complied with, search warrant may be issued: s24. Police may enter specified premises, search for the young person & remove & present young person to a medical practitioner: s23.</p>	<p>If notice not appropriate, intervener may with or without a warrant take the young person into safe custody pending hearing of the application: s69.</p>	<p>Young person in need of care & protection may be apprehended by police or authorized officer without warrant: s29.</p>	<p>If requirement cannot be complied with or is unlikely to be complied with, warrant may be issued authorizing police officer to remove young person & take him or her to a place of safety: s9(3).</p>	<p>Young person who has suffered maltreatment may be removed pursuant to warrant: s11(1),(2).</p>	<p>Authorized person may take young person reasonably believed to be at risk to a place of safety: s73.</p>

	QLD	SA	NSW	VIC	WA	TAS	NT	ACT
Examination after removal	Upon care & protection application being made, a court may order necessary investigations & medical examinations, in which case the child is remanded into the temporary custody of the Director: s49(3) Children's Services Act 1965.	After removal, custody rests in Minister for 1 working day. Medical examination possible where young person removed or by court order: s26.	Where s24 warrant, police or authorized officer may present young person to medical practitioner for medical examination. 72 hrs allowed for the examination: D-G deemed guardian for purposes of examination: s23.	Young person in safe custody must be brought before court for interim accommodation order: ss73 & 74. Whilst in safe custody, D-G may at any time order young person be medically examined: s271.	After apprehension, young person must be brought as soon as practicable to court to make care & protection order: s29(3). A medical examination may then be performed.		Young person in custody may be held for max 48 hrs, during which time must be brought before Justice for a holding order. Holding order authorizes young person to be held in place of safety for max 14 days: s11(3). Person taking child into safe custody may consent to urgent medical procedure or treatment: s12.	May be held for up to 48 hrs before action is brought before a magistrate. Magistrate may order detention for max 72 hrs: s75. Medical examination may be carried out during 48 or 72 hr periods.

QLD	SA	NSW	VIC	WA	TAS	NT	ACT
<p>Where young person presented at hospital & maltreatment is suspected, prescribed medical officer may order admission & detention of young person at hospital for max 96 hrs: s76L Health Act 1937.</p>				<p>Where young person <6 admitted to hospital is reasonably suspected of being in need of care & protection, medical officer or deputy in charge of the hospital may order the detention of the young person in the hospital for max 48 hrs: s29(3a).</p>	<p>Young person may be detained in a place of safety (including hospital) for a max 120 hrs: s9.</p>	<p>Person in charge of hospital who reasonably believes young person has suffered or will suffer maltreatment may detain the young person in hospital & conduct a medical examination during 48 hrs, & apply for a holding order max 14 days: s15.</p>	<p>If young person in hospital & it appears to authorized person that the young person may be at risk, then authorised person may order young person's detention in hospital in writing: s74. 48 hrs allowed before action must be brought before magistrate.</p>
<p>Detention of young person in hospital</p>							

	QLD	SA	NSW	VIC	WA	TAS	NT	ACT
Examination of young person without parental consent	During 96 hr period it is lawful for young person to undergo necessary diagnostic procedures tests, & treatment, despite lack of parental or guardian consent in certain circumstances: s76L(3)(4) Health Act 1937.	Examination & assessment orders valid for 4 weeks, extendable for further 4 weeks. Medical examination possible without parental/ guardian consent, but not over refusal of young person: s26(3).		Interim accommodation order may last for 21 days, extendable further 21 days. Includes accommodation in a hospital. D-G may consent to medical examination during order: s271.		Medical examination may be conducted where young person is in a place of safety: s17. During any period of detention the Child Protection Assessment Board may apply to a magistrate for a child protection order. Young person may then remain in a place of safety for 30 days, extendable for a further 30 days: s17.	Whilst child in hospital or safe custody, minister assumes responsibility for care, protection & maintenance of the child: s17. Minister may order medical examination & treatment of young person where in receipt of report of maltreatment: s16.	Court may authorise continued detention of young person for 7 days, extendable for 7 days: s76.
Consent for special examinations			Young person in a facility or residential care centre who has to undergo a special examination (vaginal, anal or penile): special consent required from parents & young people: s21.					

2. RELEVANT STATUTORY PROVISIONS

Queensland

Section 76L *Health Act 1937* (Qld):

- (1) In this section -

"prescribed medical officer" means the medical superintendent or other medical officer in charge of a hospital in question or any nominee (being a medical practitioner) of such medical superintendent or other medical officer (such medical superintendent or other medical officer being hereby authorised to make any such nomination as the person thinks fit).

- (2) Where -

- (a) a child has presented itself or been presented at a hospital; and
- (b) the prescribed medical officer suspects upon reasonable grounds the maltreatment or neglect of the child in such a manner as to subject or be likely to subject it to unnecessary injury, suffering or danger;

the prescribed medical officer -

- (c) may order in writing the admission of that child as a patient to, and the detention of that child in, that hospital for a period not exceeding 96 hours from the time of that presentation; or
- (d) if prior to the making of that order the child leaves or is removed from the hospital without the permission of the prescribed medical officer - may order in writing that the child be taken into custody and conveyed to such hospital as that officer directs and detained there for a period not exceeding 96 hours from the time of the making of the order.

- (2A) If whilst a child is a patient in a hospital the prescribed medical officer suspects upon reasonable grounds the maltreatment or neglect of the child in such a manner as to subject or be likely to subject it to unnecessary injury suffering or danger, the prescribed medical officer -

- (a) may order in writing the detention of that child in hospital for a period not exceeding 96 hours from the time of the making of that order; or
- (b) if prior to the making of that order or at any time within the duration of that order the child leaves or is removed from the hospital without the permission of the prescribed medical officer - may order in writing that the child be taken and conveyed to such hospital as that officer directs and detained there as a patient for a period not exceeding 96 hours from the time of the making of that order.

- (2B) Where the prescribed medical officer who makes an order in writing pursuant to either subsection (2) or (2A) is of the opinion that the assistance of a police officer is necessary for the purpose of enforcing the order, the medical officer may certify as to the medical officer's opinion by endorsement upon that order.
- (2BA) It shall be the duty of a police officer to whose notice that endorsement is brought to assist the prescribed medical officer as required and in accordance with this Act and a police officer so assisting may without other authority than this Act detain or assist in detaining in hospital, prevent any person from removing from hospital or take and convey or assist in taking and conveying to such hospital as the prescribed medical officer directs that child, for the purpose of enforcing that order.
- (2C) It is lawful for any police officer acting in accordance with any authority vested in the police officer by this section and all persons acting in aid of the police officer to use such force as is necessary to detain or assist in detaining in hospital, prevent any person removing from hospital or take and convey or assist in taking and conveying to hospital a child, for the purpose of enforcing an order made pursuant to this section with respect to that child.
- (2D) A justice who is satisfied upon the complaint of a police officer acting in accordance with authority vested in the police officer by this section, that there is reasonable cause to suspect -
- (a) that an order has been made by a prescribed medical officer in respect of a child pursuant to either subsection (2) or (2A); and
 - (b) that the child has left or been removed from the hospital without the permission of that prescribed medical officer;
- may issue a warrant authorising all police officers to search for that child and for that purpose to enter any place or premises and to take into custody that child and to convey the child to the hospital.
- (2DA) For the purpose of executing the warrant made pursuant to subsection (2D) the person executing the same -
- (a) may enter any place or premises wherein the person executing the warrant reasonably suspects that child to be; and
 - (b) may search that place or those premises; and
 - (c) may exercise therein the powers conferred upon a police officer by this Act; and
 - (d) may use such force as may reasonably be necessary to perform any of the things referred to therein.
- (2DB) For the purpose of gaining entry to any place or premises a police officer may call to the officer's aid those persons that the officer thinks necessary and those persons, while acting in aid of the officer in the lawful exercise by the officer of the officer's power of entry and search shall have a like

power of entry and search.

...

- (3) Notwithstanding the wishes of any parent, guardian or person claiming to be entitled to the custody of a child in respect of whom an order has been made in accordance with subsection (2) or (2A), it shall be lawful for -
- (a) the child to be detained in, or taken into custody and conveyed to and detained in, the hospital for the period specified in the order;
 - (b) the child to be subjected to such diagnostic procedures and tests as the prescribed medical officer considers necessary to determine its medical condition;
 - (c) such treatment to be administered to the child as the prescribed medical officer considers necessary in the interests of the child, subject to the conditions specified in subsection (4).
- (4) Where treatment is administered to a child pursuant to subsection (3)(c), neither the prescribed medical officer administering the treatment or in charge of its administration nor any person acting in aid of the prescribed medical officer and under the prescribed medical officer's supervision in the administration of the treatment shall incur any liability at law by reason only that any parent, guardian or person having authority to consent to the administration of the treatment refused consent to the administration of the treatment or such consent was not obtained if-
- (a) in the opinion of the prescribed medical officer the treatment was necessary in the interests 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 treatment; or
 - (ii) the medical superintendent of a hospital, being satisfied of the unavailability of a second medical practitioner to examine the child and of the necessity of the treatment in the interests of the child, consented to the treatment before it was administered (which consent may be obtained and given by any means of communication whatsoever).
- (5) Treatment administered to a child in accordance with this section shall, for all purposes, be deemed to have been administered with the consent of the parent or guardian or person having authority to consent to the administration of the treatment.

...

Section 49 *Children's Services Act 1965* (Qld):

- (1) An officer of the Department authorized in that behalf by the Director or a police officer may apply to a Children's Court for an order that a child be admitted to the care and protection of the Director.
- (2) An officer of the Department authorised in that behalf by the Director or any police officer may, without further authority than this Act, take into custody on behalf of the Director any child who appears or who such officer suspects on reasonable grounds to be in need of care and protection.

The person so taking a child into custody shall, -

- (a) forthwith upon such taking notify the Director of that fact; and
- (b) as soon as practicable after such taking apply to a Children's Court for an order that such child be admitted to the care and protection of the Director.

Pending determination by a Children's Court of such an application the child shall be cared for in a manner consistent with his best interests-

- (c) by a person chosen by the court; or
- (d) in the absence of such a choice, by the person who took the child into custody or by a person chosen by him,

and for this purpose the person entrusted with the child's care may retain custody of the child.

If under this paragraph the court chooses the Director to care for a child it shall remand the child into the temporary custody of the Director.

- (3) Upon an application made to it under this section a Children's Court shall -
 - (a) order to be made in relation to the child concerned such investigations and medical examinations as to the court appear necessary or desirable and, if it does so, the court-
 - (i) shall remand the child into the temporary custody of the Director; and
 - (ii) shall be furnished with reports of such investigations and examinations;
 - (b) hear any objection to such application;
 - (c) if it appears to such court that the best interests of such child require it, adjourn such application to another Children's Court whereupon it shall be deemed that such application was made in the first instance to such other Children's Court.

- (4) A Children's Court-
- (a) if it is satisfied that such child is in need of care and protection, may-
 - (i) order a parent or guardian (other than the Director) of such child to enter into a recognisance in such amount as the court fixes without a surety or with such surety or sureties as the court orders conditioned that such parent or guardian exercise proper care, protection and guardianship in respect of such child;
 - (ii) order that the Director shall have protective supervision over and in relation to such child;
 - (iii) subject to section fifty-two of this Act, order that such child be admitted to the care and protection of the Director;
 - (iv) make such order as to the costs of the application and of any investigation or assessment made in respect of such child pursuant to the court's order as the court thinks just.
 - (b) if it is not so satisfied, shall refuse to make any order.

South Australia

Section 26 *Children's Protection Act 1993 (SA)*:

- (1) While -
 - (a) a child is in the custody of the Minister pursuant to having been removed from any person, premises or place under Division 2; or
 - (b) an investigation and assessment order under Division 4 authorising examination and assessment of a child is in force,

an employee of the Department may take the child to such persons or places (including admitting the child to hospital) as the Chief Executive Officer may authorise for the purpose of having the child professionally examined, tested or assessed.
- (2) A medical practitioner or dentist to whom a child is referred under this section may give such treatment to the child as he or she thinks necessary for alleviating any immediate injury or suffering of the child.
- (3) A person who is to examine, test, assess or treat a child pursuant to this section may do so notwithstanding the absence or refusal of the consent of the child's guardians, but nothing in this section requires the person to carry out any examination, test, assessment or treatment if the child refuses consent.

- (4) A person to whom a child is referred under this section, or the agency for whom the person works, must, as soon as practicable after any examination, assessment, test or treatment of the child is completed, furnish the Chief Executive Officer with a written report on the examination, assessment, test or treatment.
- (5) A person who is required to furnish a report under subsection (4) does not, insofar as he or she has acted in good faith, incur any civil liability in respect of complying with the requirement.

New South Wales

Sections 23 and 24 *Children (Care and Protection) Act 1987* (NSW):

- 23.(1) If the Director-General or a member of the police force believes on reasonable grounds (which may consist wholly or partly of information received by that person) that a child who is under the age of 16 years has been abused, the Director-General or the member of the police force, as the case may be, may serve a notice, in such form as may be prescribed by the regulations:
 - (a) naming or describing the child; and
 - (b) requiring the child to be forthwith presented to a medical practitioner specified or described in the notice at a hospital or some other place so specified for the purpose of the child's being medically examined,on the person (whether or not a parent of the child) who appears to the Director-General or the member of the police force to have the care of the child for the time being.
- (2) A person who fails to comply with the requirement contained in a notice served on the person under subsection (1) is guilty of an offence unless it is proved that the person did not have the care of the child at the time the notice was served.
- (3) If a person fails to comply with the requirement contained in a notice served on the person under subsection (1), an authorised officer or a member of the police force may present the child in respect of whom the notice was served, or cause the child to be presented, to a medical practitioner at a hospital or elsewhere for the purpose of the child's being medically examined.
- (4) When a child is presented to a medical practitioner under subsection (1) or (3):
 - (a) the medical practitioner may carry out or cause to be carried out such medical examination of the child as the medical practitioner thinks fit, including examination at a hospital or place that is not the hospital or place specified in the notice referred to in subsection (1) in respect of the child;

- (b) the Director-General shall, from the time at which the child is presented to the medical practitioner until the expiration of:
 - (i) such period of time as is reasonably necessary for the child to be examined in accordance with paragraph (a); or
 - (ii) 72 hours,whichever period first expires, be deemed to be the guardian of the child for the purpose only of enabling the examination to be carried out; and
 - (c) the medical practitioner or other person by whom any such medical examination has been carried out shall prepare a written report of the examination for transmission to the Director-General.
- (5) No proceedings lie against an officer, medical practitioner, member of the police force or person employed at any hospital or other place at which a child is examined for or on account of any act, matter or thing done or ordered to be done by that person, and purporting to be done for the purpose of carrying out or assisting in carrying out the provisions of this section, if that person has acted in good faith and with reasonable care.
- ...
- 24.(1) An officer or member of the police force may apply to an authorised justice for a search warrant if the officer or member of the police force has reasonable grounds for believing that a person on whom a notice has been served under section 23(1) has failed to comply with the requirement contained in the notice.
- (2) An authorised justice to whom such an application is made may, if satisfied that there are reasonable grounds for doing so, issue a search warrant authorising an officer or member of the police force named in the warrant:
- (a) to enter any premises specified in the warrant;
 - (b) to search the premises for the presence of the child the subject of the notice under section 23(1); and
 - (c) to remove the child and to present the child to a medical practitioner under section 23(3).
- ...
- (6) An officer named in a search warrant, or a member of the police force, may, for the purpose of removing a child pursuant to the warrant, use all reasonable force.

APPENDIX 4

STATUTORY PROVISIONS RELATING TO CONSENT - OTHER AUSTRALIAN JURISDICTIONS

New South Wales

Minors (Property and Contracts) Act 1970

- 49(1) Where medical treatment or dental treatment of a minor aged less than sixteen years is carried out with the prior consent of a parent or guardian of the person of the minor, the consent has effect in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, the minor were aged twenty-one years or upwards and had authorised the giving of the consent.
- (2) Where medical treatment or dental treatment of a minor aged fourteen years or upwards is carried out with the prior consent of the minor, his [or her] consent has effect in relation to a claim by him [or her] for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, he [or she] were aged twenty-one years or upwards.
- (3) This section does not affect:
- (a) such operation as a consent may have otherwise than as provided by this section; or
 - (b) the circumstances in which medical treatment or dental treatment may be justified in the absence of consent.
- (4) In this section:
- "dental treatment"** means:
- (i) treatment by a dentist registered under the Dentists Act 1934 in the course of the practice of dentistry; or
 - (ii) treatment by any person pursuant to directions given in the course of the practice of dentistry by a dentist so registered; and
- "medical treatment"** means:
- (i) treatment by a medical practitioner in the course of the practice of medicine or surgery; or
 - (ii) treatment by any person pursuant to directions given in the course of the practice of medicine or surgery by a medical practitioner.

South Australia

Consent to Medical and Dental Treatment Act 1985

- 6.(1) The consent or the refusal or absence of consent of a minor who is of or above the age of sixteen years in respect of medical or dental treatment to be carried out on the minor or any other person has the same effect for all purposes as if the minor were of full age.
- (2) The consent of a minor who is less than sixteen years of age in respect of medical or dental treatment to be carried out on the minor has the same effect for all purposes as if the minor were of full age where, in the opinion of a medical practitioner or a dentist supported by the written opinion of one other medical practitioner or dentist, as the case may be -
 - (a) the minor is capable of understanding the nature and consequences of the treatment;and
 - (b) the treatment is in the best interests of the health and well-being of the minor.
- (3) The requirement under subsection (2) that the opinion of the medical practitioner or dentist be supported by the opinion of another medical practitioner or dentist does not apply in any circumstances where it is not reasonably practicable to obtain such an opinion having regard to the imminence of risk to the minor's life or health.
- (4) The consent of a parent of a minor who is less than sixteen years of age in respect of medical or dental treatment to be carried out on the minor shall be deemed to be a consent given by the minor and to have the same effect for all purposes as if the minor were of full age.
- (5) Where medical or dental treatment is carried out in prescribed circumstances by a medical practitioner or a dentist on a minor who is less than sixteen years of age, the minor shall be deemed to have consented to the carrying out of the treatment and the consent shall be deemed to have the same effect for all purposes as if the minor were of full age.
- (6) Prescribed circumstances exist for the purposes of subsection (5) if -
 - (a) the minor is incapable for any reason of giving an effective consent to the carrying out of the medical or dental treatment; and
 - (b) no parent of the minor is reasonably available in the circumstances, or, being available, the parent, having been requested to consent to the carrying out of the treatment, has failed or refused to do so; and
 - (c) the medical practitioner or dentist carrying out the treatment is of the opinion that the procedure is necessary to meet imminent risk to the minor's life or health; and

- (d) unless it is not reasonably practicable to do so having regard to the imminence of the risk to the minor's life or health, the opinion of the medical practitioner or dentist referred to in paragraph (c) is supported by the written opinion of one other medical practitioner or dentist.
- 7.(1) Where medical or dental treatment is carried out by a medical practitioner or a dentist on a person who is of or above the age of sixteen years without the consent of that person, the person shall, if prescribed circumstances exist, be deemed to have consented to the carrying out of the treatment.
- (2) Prescribed circumstances exist for the purposes of subsection (1) if -
- (a) the person is incapable for any reason of giving an effective consent to the carrying out of the medical or dental treatment; and
 - (b) the medical practitioner or dentist carrying out the treatment -
 - (i) is of the opinion that the treatment is necessary to meet imminent risk to the person's life or health; and
 - (ii) has no knowledge of any refusal on the part of the person to consent to the treatment, being a refusal communicated by that person to him or some other medical practitioner or dentist; and
 - (c) unless it is not reasonably practicable to do so having regard to the imminence of the risk to the person's life or health, the opinion of the medical practitioner or dentist referred to in paragraph (b)(i) is supported by the written opinion of one other medical practitioner or dentist.
- 8.(1) Notwithstanding any rule of the common law, but subject to the provisions of any enactment -
- (a) the consent of a person to the carrying out of medical or dental treatment on him is effective whatever the nature of the treatment provided that the treatment is reasonably appropriate in the circumstances having regard to prevailing medical or dental standards; and
 - (b) no criminal or civil liability shall be incurred in respect of the carrying out of medical or dental treatment on a person with his consent if -
 - (i) the treatment is reasonably appropriate in the circumstances having regard to prevailing medical or dental standards; and
 - (ii) the treatment is carried out in good faith and without negligence.

(2) In subsection (1) -

"consent" of a person means a consent as defined in section 4 given or deemed under this Act or any other Act to be given by a person where -

- (a) the person is of full age and is otherwise capable of giving an effective consent; or
- (b) the consent is deemed to have the same effect as if the person were of full age or were capable of giving an effective consent.

*Consent to Medical Treatment and Palliative Care Bill 1994*⁶¹⁰

- 6. 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.
- 12. A medical practitioner 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.
- 13.(1) Subject to subsection (3), a medical practitioner may lawfully administer medical treatment to a person (the "patient") if -
 - (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.

⁶¹⁰ As at 28 April 1995 this Bill had passed both Houses of the South Australian Parliament but had not received Royal Assent.

- (3) If -
- (a) the patient has appointed a medical agent; and
 - (b) the medical practitioner proposing to administer the treatment is aware of the appointment and of the conditions and directions contained in the medical power of attorney; and
 - (c) the medical agent is available to decide whether the medical treatment should be administered,
- the medical treatment may not be administered without the agent's consent.
- (4) If no such medical agent is available and a guardian of the patient is available, the medical treatment may not be administered without the guardian's consent.
- (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.
15. 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.
16. 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
 - (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.

APPENDIX 5

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APPENDIX 6

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Powys v Mansfield (1837) 3 My Car 359; 40 ER 964
R v Gyngall [1893] 2 QB 232

- R v Raabe* [1985] 1 Qd R 115
R v Watson [1987] 1 Qd R 440
R v Macdonald and Macdonald [1904] St R Qd 51; [1904] QWN 50
Re D (A Minor) (Wardship: Sterilisation) [1976] Fam 185
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Re V [1993] NZFLR 369
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Rogers v Whitaker (1992) 175 CLR 479
Schloendorff v Society of New York Hospital (1914) 105 NE 92
Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)
(1992) 175 CLR 218
Sibley v Milutinovic [1990] Aust Torts R 81-013
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and Health* (1991) 99 ALR 679
T v T [1988] 2 WLR 189
Tournier v National Provincial and Union Bank of England [1924] 1 KB 461
W v Director-General of Social Welfare [1990] 1 NZLR 378
W v Edgell [1990] Ch 359
Wilson v Pringle [1987] 1 QB 237

APPENDIX 7

TABLE OF LEGISLATION

AUSTRALIA

Queensland (Qld)

Age of Majority Act 1974
Ambulance Service Act 1991
Children's Services Act 1965
Corrective Services Act 1988
Criminal Code
Freedom of Information Act 1992
Health Services Act 1991
Health Act 1939
Health Rights Commission Act 1991
Juvenile Justice Act 1992
Medical Act 1939
Mental Health Act 1974
Nurses Act 1992
Penalty and Sentences Act 1992
Psychologists Act 1977
Skin Penetration Regulations 1987
Supreme Court Act 1867
Traffic Act 1949
Transplantation and Anatomy Act 1979
Voluntary Aid in Emergency Act 1973

Commonwealth (Cth)

Family Law Act 1975
Family Law Amendment Act 1983
Privacy Act 1988

Australian Capital Territory (ACT)

Children's Services Act 1986

New South Wales (NSW)

Children (Care and Protection) Act 1987
Guardianship Act 1987
Minors (Property and Contracts) Act 1970

Northern Territory (NT)

Community Welfare Act 1983
Criminal Code

South Australia (SA)

Children's Protection Act 1993
Community Welfare Act 1972
Consent to Medical and Dental Procedures Bill 1984
Consent to Medical and Dental Treatment Act 1985
Consent to Medical Treatment and Palliative Care Bill 1994

Tasmania (Tas)

Child Protection Act 1974
Criminal Code

Victoria (Vic)

Children and Young Person's Act 1989

Western Australia (WA)

Child Welfare Act 1947

CANADA**British Columbia**

Infants Act (RSBC 1979, c 196)

Ontario

An Act Respecting Consent to Treatment (SO 1992, c 31)

Public Hospital Regulations RRO 1980 Reg 865

Quebec

Public Health Protection Act (1972, c 42)

NEW ZEALAND

Criminal Code

Guardianship Act 1968

Protection of Personal and Property Rights Act 1988

NORWAY

Children and Parents Act 1981

UNITED KINGDOM

Age of Legal Capacity (Scotland) Act 1991

Children Act 1989

Family Law Reform Act 1969

Family Law Reform Bill 1969

Sexual Offences Act 1956

UNITED STATES OF AMERICA

Alabama Code (1984)

Kansas Statutes Annotated (1986)

Oregon Revised Statutes (1981)

Rhode Island General Laws (1985)

South Carolina Code Annotated (1985)

INTERNATIONAL CONVENTIONS

UN Convention on the Rights of the Child