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**CONSENT TO HEALTH CARE OF
YOUNG PEOPLE**

Report No 51

**Volume Two
The Commission's Legislative Scheme
for Consent to Health Care of Young People**

Queensland Law Reform Commission
December 1996

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The Commission's Legislative Scheme
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Queensland Law Reform Commission
December 1996

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Miscellaneous Paper	<i>Medical Examinations in Cases of Suspected Child Abuse</i>	(MP17, June 1996)

This Report is in three volumes:

Volume 1: The Law and the Need for Reform

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

Volume 3: Summary of the Commission's Report

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CHAPTER 9

A LEGISLATIVE SCHEME FOR THE AUTHORISATION OF HEALTH CARE FOR YOUNG PEOPLE

1. INTRODUCTION

As stated in the Discussion Paper⁷¹⁰ the problems experienced in Queensland by young people, health care providers and parents with the current law on consent to health care of young people have been experienced by such people in many jurisdictions. The responses to the problems have varied greatly - from legislation governing who may consent to health care under particular circumstances, to a belief in the ability of the common law to cope with and resolve particular issues as they arise.

After reviewing the submissions to both the Information Paper⁷¹¹ and the Discussion Paper and after discussing the reform options and issues with many people in urban and rural Queensland, the Commission has devised a legislative scheme for consent to health care of young Queenslanders. The Commission believes that this scheme will assist young people in need of health care, and will be more easily understood and accessible than the current law. The legislative scheme is based broadly on the preliminary recommendations made in the Discussion Paper, but also takes into account the many comments and suggestions made in relation to those recommendations.

The policy decisions of the Commission that underlie the scheme are discussed in the following chapters of this Report and the scheme is presented in the form of draft legislation in Chapter 17. The Office of the Queensland Parliamentary Counsel prepared the draft legislation upon the instructions of the Commission. That Office's professional assistance and highly relevant and constructive drafting suggestions have been greatly appreciated by the Commission.

The principal advantage of the Commission's legislative scheme is that it will enable many young people to seek health care in the knowledge that health care providers will be able to treat upon the consent of those young people.

The incentive for health care providers to comply with the scheme will be the increased certainty about their protection from criminal and civil liability for assault and/or battery.

The role played by parents in the protection of their children is recognised by the scheme and, in a number of respects, is enhanced under the scheme. Parents will

⁷¹⁰ Queensland Law Reform Commission, *Discussion Paper Consent to Medical Treatment of Young People* (WP44, May 1995) at 175.

⁷¹¹ Queensland Law Reform Commission, *Information Paper Consent by Young People to Medical Treatment* (MP2, May 1993).

usually be involved in health care decisions for their young children (under 12 years of age) unless the parents are themselves not legally competent or are not available to consent. This is not currently a requirement of the law. It is currently possible for a young person of any age - provided that he or she is of sufficient maturity and intelligence - to be treated for any condition without the knowledge of his or her parents. Parents should also be more confident that, under the scheme, their children will be able to be treated in circumstances where the delay associated with having to contact parents would seriously jeopardise their children's health.

2. AUTHORISATION OF HEALTH CARE

The Commission's scheme authorises health care to be performed upon young people in a variety of contexts. Once health care has been authorised pursuant to the scheme, health care providers will be protected from criminal and civil liability for assault and/or battery for providing the health care. The scheme applies to health care of all young people from birth to 18 years.

The scheme provides for a number of ways in which health care can be authorised. The types of authorisation of health care provided for under the scheme have been designed to acknowledge:

- the increasing maturity of young people as they approach adulthood;
- the need to protect very young children;
- the vital role parents and carers have in relation to the health care of children; and
- the overall importance of ensuring that the law does not hinder vulnerable young people's access to health care.

Irrespective of an individual young person's understanding of the nature and consequences of proposed health care the Commission believes it is a societal responsibility to protect young people, as a group, from their own inexperience and immaturity. The younger a child is the more vulnerable he or she is to making a wrong health care decision and to being taken advantage of because of his or her age and immaturity. The law should, wherever appropriate, facilitate the protection of young people from themselves and from the detrimental actions of others.

The Commission also acknowledges, however, the need to recognise the increasing autonomy of young people as they approach adulthood. Just as young people are generally given greater responsibility for their own welfare as they develop and mature, parents generally relinquish some of the control they have exercised over their children since birth as the children approach adulthood. The law should not hinder young people's efforts to exercise that responsibility or other people's efforts to ensure that young people receive the assistance they need.

By authorising health care of young people based on the criteria of competency and age, the Commission believes that it is able to address both the need to protect vulnerable young people and the need to respect the growing autonomy of young people as they approach adulthood.

The current procedures available for the authorisation of health care of young people are retained.⁷¹² The various means of authorising health care for young people under the scheme and under the current law are set out below.

(a) Authorisation by consent of a competent person

Under the Commission's scheme a young person will be able to authorise his or her own health care in a number of circumstances. The most significant circumstance will be where the young person is competent to consent to his or her own health care.

There will also be situations where a young person who is competent to consent to his or her own health care will be able to consent to health care for another - such as the young person's child or a child in the young person's care.

Parents and, in certain circumstances, carers of young people, will be able to consent to health care for young people. An adult's competence to consent will be according to the current common law competency test for adults - namely, that the adult has a broad understanding of the nature of the proposed health care.

A young person's competence to consent to his or her own health care or to the health care of another has been a more difficult concept to define. The common law test of a young person's competency to consent to his or her own health care - commonly referred to as the *Gillick* test - that the young person is intelligent and mature enough to be capable of understanding the nature and consequences of the proposed health care - has been addressed in Volume 1 of this Report.⁷¹³ The legislative scheme has attempted to improve on the *Gillick* test.

(i) Adult competency vs young person competency

The Commission considered the possibility of having different tests of competency for different age groups of young people within the legislative scheme, so as to reflect the developing maturity that most young people undergo on their way to adulthood, and the seriousness of certain health care decisions.

⁷¹² For example, the ability to apply to the Supreme Court of Queensland in its *parens patriae* jurisdiction or to the Family Court of Australia under its welfare jurisdiction. See 94-97 of this Report.

⁷¹³ See Ch 3 of this Report.

One suggestion considered was that 16 and 17 year olds be treated as adults for the purposes of consent to health care.⁷¹⁴ To be competent to consent to their own health care, and in certain circumstances, to the health care of others, they would have to satisfy the current common law adult test of competency - that is, that they have a broad understanding of the nature of the proposed health care.

Young people under 16 years of age would have to satisfy the *Gillick* test to be able to consent to health care. The *Gillick* test is a significantly more stringent test to satisfy than the current common law test applying to adults.

Although easier to fulfil than the *Gillick* test, the adult competency test pays little regard to the person's understanding or ability to understand the consequences of the proposed health care. It is so broad that it could almost be regarded as a presumption that adults are competent to consent to any health care option presented to them.

(ii) Nature of the *Gillick* test

The test adopted by the Commission in the legislative scheme has been developed from the *Gillick* test. The main elements of the *Gillick* test are discussed below.

Intelligence and maturity

The Commission considers the elements of "intelligence" and "maturity" in the *Gillick* test to be only two of a number of matters which may be relevant in the context of the health care provider's assessment of the young person's understanding of the proposed health care. Other factors, such as previous experience with the condition in need of treatment could be as relevant to the question of capacity to make a sound decision about health care.

A health care provider may be more concerned with assessing the young person's intelligence and/or maturity than in assessing what the Commission considers to be the most significant criterion for relying upon the young person's consent - the young person's understanding of the proposed health care. If a young person actually understands the proposed health care, then the young person's intelligence is only of incidental significance.

Ability to understand vs understanding

The *Gillick* test is framed in terms of the young person's "ability to understand" the nature and consequences of the health care. However, the Commission

⁷¹⁴ See 268-270 of this Report for a detailed discussion of this suggestion, and the reasons why the Commission has recommended a single competency test for all young people under 18 years of age.

believes that the critical issue for any competency test should be that the young person actually understands those matters, and is not merely capable of understanding them. It might be that a young person would be able to understand the nature and consequences of health care, but perhaps, through lack of information, does not understand those matters. For this reason, the Commission believes that a requirement that a young person understands various matters provides a greater degree of protection for a young person than requiring that a young person merely be able to understand various matters.

With a requirement that the young person understands certain matters, it would be less likely that a young person would be subjected to health care procedures that he or she did not understand, or to complications from the health care that he or she "could" have understood, but in fact did not understand before the health care was carried out.

A competency test based on the young person's actual understanding of the nature and consequences of the proposed health care may also encourage the health care provider to provide and explain relevant information to the young person. Of course, health care providers should adopt this practice with all patients, irrespective of the age of the patients, in order to avoid possible liability in negligence for failure to disclose material information.⁷¹⁵

Nature and consequences

Unlike the current adult test of competency, the *Gillick* test includes reference to the consequences of the proposed health care. During the consultation meetings following the release of the Commission's Discussion Paper, and in a number of submissions received in response to the Discussion Paper, health care providers stressed the significance of the young person's ability to understand the consequences of health care to which they purport to consent. A number of respondents discussed how difficult it is for many apparently intelligent and mature young people to appreciate being thirty years of age, let alone understand the long term consequences of certain treatments, or the risks involved in failing to undergo or sustain certain treatments. For example, the Commission was informed that it is difficult for some young people with diabetes to appreciate the long term consequences of failing to adhere to treatment regimes.

The Commission agrees that it is important for young people to have an understanding of the consequences of the health care to which they purport to consent. The Commission does not believe that this puts young people, particularly adolescents, in a worse position than adults. The protection afforded to young people by having to understand the consequences of the

⁷¹⁵ *Rogers v Whitaker* (1992) 175 CLR 479. See the discussion of this case at 240 of this Report.

health care they are about to undergo far outweighs the advantages, if any, that may accrue to them from being able to consent to health care which they may not understand and which may result in serious detrimental effects later in life.

Communication

The *Gillick* test does not address the situation of a young person who may have the ability to understand the nature and consequences of the proposed health care, but who has no means of communicating his or her decision to anyone else. The Commission believes that, in order for a young person to be able to give a valid consent, it should be essential for the young person to be able to communicate his or her decision about proposed health care in some way.

(iii) The Commission's recommendation

After lengthy deliberations the Commission recommends that all young people should be subject to the same competency test for the purposes of the Commission's legislative scheme.

For the reasons discussed above, the Commission prefers a competency test that requires a young person to understand the nature and consequences of the health care, and not merely be capable of doing so.

The Commission recommends that for the purposes of the legislative scheme a young person⁷¹⁶ should be able to provide a valid consent to health care if he or she:

- **understands the nature and consequences of the health care; and**
- **communicates his or her decision about the health care in some way.**

This recommendation is reflected in clause 20 of the draft legislation in Chapter 17 of this Report.

While this is a modification of the *Gillick* test, it retains the principal advantage of the *Gillick* test, namely, that competence is linked to understanding, rather than to the attainment of an arbitrary age, and is relative to the particular form of health care concerned. In this way, those young people who lack the

⁷¹⁶ For most health care the Commission has recommended that there be a lower limit of 12 years of age on a young person's capacity to consent to health care. The lower age restriction on the competence of a young person to consent to health care is discussed in Ch 10 of this Report.

requisite degree of understanding are protected from making possibly detrimental decisions about their health care. On the other hand, those young people who do have the requisite degree of understanding will, in many cases, be able to make their own health care decisions - a reflection of their developing maturity and increasing autonomy.

The Commission also recommends that the health care of a young person under 16 years of age may be authorised by the valid consent of a parent until the young person turns 16 years of age and is competent to consent exclusively to his or her own health care.⁷¹⁷ An adult should be able to provide a valid consent to health care of a young person if he or she has a broad understanding of the nature of the health care and communicates his or her decision about the health care in some way.

(b) Authorisation by circumstances

The Commission has identified a number of circumstances in which it would be appropriate for health care to proceed without the need for a valid consent - albeit with appropriate safeguards.

For example, there will be situations, short of an emergency, where a young person who is not competent is in need of health care without delay, and where either the delay associated with trying to contact a parent for a valid consent would jeopardise the health of the young person, or a parent is not able to be contacted. In such cases, it may be appropriate for the health care to proceed. The safeguards proposed by the Commission include:

- the health care should only be able to be carried out by certain specified types of health care providers;
- some types of health care should not be able to be carried out without a valid consent; and
- the health care should be in the best interests of the young person.

Other situations which should, in themselves, be justification enough for health care to proceed would include emergencies and certain minor health care.

The legislative scheme will also, in certain circumstances, authorise health care for sexually transmitted diseases and contraceptive health care for young people who are not competent - because of the very serious consequences to the young person if that health care is not provided.

⁷¹⁷ See Chs 10 and 11 of this Report. The competence of a young person who is 16 or 17 years of age to provide exclusive consent to, and refusal of, his or her health care is discussed in Ch 12 of this Report.

(c) Existing procedures for authorisation of health care

Where there is no person under the Commission's scheme with authority to consent to the health care of a young person, or if there is a dispute between people as to the health care to be provided to a young person, recourse will need to be made to the courts for appropriate orders. Further, any authorisation under the scheme will be subject to an appropriate court order, although it is anticipated that the Commission's legislative scheme will alleviate some of the need to have recourse to those procedures.

The Commission's proposed scheme will not affect the existing procedures for authorising the health care of a young person, namely:

- by the Supreme Court of Queensland;
- by the Family Court of Australia; or
- by the Director-General of the Department of Families, Youth and Community Care under the *Children's Services Act 1965* (Qld).

(i) The Supreme Court of Queensland

An application could be made under the *parens patriae* jurisdiction⁷¹⁸ for the Supreme Court to consent to the health care.⁷¹⁹ This jurisdiction stems from the Crown's direct responsibility for those who cannot look after themselves, including minors and those with a decision-making disability. According to the High Court in *Marion's case*,⁷²⁰ the Supreme Court can exercise this jurisdiction in cases where parents have no power to consent to health care, as well as in cases in which they do have the power.⁷²¹

Although mindful of the limitations of the Supreme Court in terms of cost and formality, the Commission is nevertheless of the view that its *parens patriae* jurisdiction provides an important safeguard in relation to the health care of young people.

(ii) The Family Court of Australia

An application could be made under the welfare jurisdiction of the Family Court

⁷¹⁸ *Supreme Court Act 1867* (Qld) s22.

⁷¹⁹ See 94-95 of this Report for a discussion of this jurisdiction.

⁷²⁰ (1992) 175 CLR 218.

⁷²¹ *Id per* Mason CJ, Dawson, Toohey and Gaudron JJ at 259.

for authority to consent to the health care of a young person.⁷²² This jurisdiction has been likened by the High Court to the *parens patriae* jurisdiction of the Supreme Court.⁷²³ An application can be made to the Family Court by anyone who has an interest in the welfare of the young person.⁷²⁴

Although much of the jurisdiction of the Family Court is delegated to Registrars,⁷²⁵ they do not have power to make orders in relation to the welfare of a child,⁷²⁶ except for interim orders, consent orders, and orders in undefended proceedings. Other matters arising under the welfare jurisdiction would have to be heard by a Family Court Judge.⁷²⁷

The Family Law Rules make provision for "special medical procedures" in Order 23B,⁷²⁸ whereby the Family Court may make an order declaring that a person is authorised to consent to the carrying out of a medical or surgical procedure for a young person.⁷²⁹ An application can be made by the young person's parent, guardian or custodian, or any other person who has an interest in the welfare of the young person.⁷³⁰ An application must be in the prescribed form and include an affidavit annexing medical reports setting out relevant information including the nature, purpose and effects of the proposed treatment.⁷³¹ The application is heard before a judge of the Family Court as soon as possible.⁷³²

⁷²² *Family Law Act 1975* (Cth) s67ZC. The jurisdiction also covers children whose parents have not married - see *Commonwealth (Family Law - Children) Act 1990* (Qld).

⁷²³ *Marion's case* (1992) 175 CLR 218 at 256.

⁷²⁴ *Family Law Act 1975* (Cth) s69C. See 97 of this Report.

⁷²⁵ *Family Law Act 1975* (Cth) s37A, *Family Law Rules* O36A.

⁷²⁶ *Family Law Act 1975* (Cth) s37A(2)(d), *Family Law Rules* O36A r2(1)(g). S 37A(2)(d) provides that a Registrar does not have the power to make an excluded child order (as defined in subsection (2A)). S 37A(2A) defines an "excluded child order" as including an order in relation to the welfare of a child other than an order until further order, an order made in undefended proceedings or an order made with the consent of all parties to the proceedings.

⁷²⁷ This is according to the Commission's informal inquiries of a Registrar of the Family Court in Brisbane. An order in relation to the welfare of a child, that is, in accordance with s37A, expressed to be an "order until further order" would be a matter arising under the welfare jurisdiction of the Family Court.

⁷²⁸ A copy of Order 23B is set out in Appendix 6 to this Report.

⁷²⁹ *Family Law Rules* O23B r2(1).

⁷³⁰ *Id* O23B r2(2).

⁷³¹ *Id* O23B rr3, 5.

⁷³² *Id* O23B r6.

Since *Marion's* case, the procedures in the Family Court for authorising health care have been streamlined. In Queensland, a protocol has been developed between the Family Court in Brisbane, the Brisbane Legal Aid Office and the Queensland Department of Families, Youth and Community Care for dealing with applications for sterilisation and other medical procedures in relation to intellectually disabled children.⁷³³

(iii) Director-General of the Department of Families, Youth and Community Care

An application can be made under the *Children's Services Act 1965* (Qld) for a care and protection order over a young person,⁷³⁴ which would allow the Director-General to make health care decisions for the young person.

If a young person is in need of care and protection an application can be made to the Director-General by the young person's parent, guardian, relative, or a person of good repute to admit the young person into the Director-General's care and protection.⁷³⁵ Alternatively, the Director-General, an officer of the Department, or a police officer can apply to the Childrens Court for an order that the young person be admitted to the care and protection of the Director-General.⁷³⁶ A young person is deemed to be in need of care and protection in a number of circumstances, including if he or she is neglected, deserted by his or her parent or guardian, or for any other reason.⁷³⁷

If a young person has been admitted to the Director-General's care and protection the guardianship of that young person passes to and vests in the Director-General,⁷³⁸ and the Director-General can lawfully consent to all medical examinations and treatments in relation to the young person.⁷³⁹

⁷³³ Practice Note 2/96 - Family Court of Australia (Northern Region) *Guidelines and Protocols - Approval of Special Medical Procedures for Children in Queensland (Order 23B of the Family Law Rules)*.

⁷³⁴ In this context the *Children's Services Act 1965* (Qld) uses the term "child", which is defined in s76M of the Act to mean a person under or apparently under the age of 17.

⁷³⁵ *Children's Services Act 1965* (Qld) s47(1).

⁷³⁶ *Id* s49.

⁷³⁷ *Id* s46(1).

⁷³⁸ *Id* s55(1).

⁷³⁹ *Id* s143. Note s55 makes the Director-General the guardian of a child over whom there is a care and protection order.

In the Discussion Paper⁷⁴⁰ the Commission sought comment on whether it would be appropriate for a mechanism to be provided for a substitute decision-maker to be able to be appointed to make health care decisions for a young person who was not competent to make such decisions, or a particular health care decision, and who lacked an available parent who was legally competent or willing to consent to the young person's health care.

In this Report the Commission has made two important recommendations that should alleviate the need in most cases to have a formal mechanism for appointing a person to make health care decisions for a young person who is not competent to make his or her own health care decision:

- the Commission has recommended a broad definition of "parent";⁷⁴¹ and
- the Commission has recommended that certain authorised health care providers should be able to treat a young person without a valid consent in circumstances where the health care is required without delay and a parent cannot be contacted.⁷⁴²

In light of those recommendations, the Commission is now of the view that it is unnecessary to develop further the concept of an appointed substitute decision-maker for a young person.

3. CATEGORISATION BY TYPE OF HEALTH CARE

Despite the limited legal remedies currently available to a person who, without a valid consent, has been treated in circumstances where there was no physical contact between the health care provider and the person, and the limited deterrence at law to health care providers willing to treat in such circumstances, there was widespread support by health care providers and others for the proposal made by the Commission in the Discussion Paper that there should be a statutory prohibition on treating patients (whether involving physical contact or otherwise) without an appropriate consent. Preliminary recommendation 1 in the Discussion Paper stated:⁷⁴³

⁷⁴⁰ Discussion Paper at 201.

⁷⁴¹ See the Commission's recommendation at 337 of this Report.

⁷⁴² See the Commission's recommendation at 292-299 of this Report.

⁷⁴³ Discussion Paper at 10.

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 practicable to obtain consent. Treatment is to include treatment involving physical and/or non physical contact with the patient.

A number of respondents to the Discussion Paper and a number of individuals involved in the consultation meetings commented on this proposal. Most agreed that a young person could be adversely affected by non-touching health care and that, ideally, a valid consent should be required before serious non-touching treatment is performed on a young person. A submission from a psychiatrist made the point that interference with a person's psychological integrity can result in serious damage to the person.⁷⁴⁴

Concerns with the proposal included the difficulty in distinguishing between those types of non-touching health care for which consent should be a requirement and other types of non-touching health care. For instance, a psychiatric team working with young people noted:⁷⁴⁵

[Some non-touching treatments should be subject to consent requirements. Some treatments result in deterioration before benefit (if at all), for example, some forms of psychotherapy.] However, it would be extremely difficult to distinguish such treatments.

A mental health service for young people noted:⁷⁴⁶

[We] agree that consent be obtained before treatment whether or not treatment involves physical contact ... However, [we are] concerned that in broadening the concept of consent to include non physical treatment this could be open to considerable interpretation when defining what is a health care procedure.

A number of respondents suggested that consent could be implied for a number of non-touching forms of health care. An association interested in public policy⁷⁴⁷ also proposed that consent to such health care should be presumed for certain classes of people, for example, a young person's school teacher, on the basis that parents in sending their child to school have given implied consent; a young person's priest, on the basis that in permitting their child's involvement in religious practices of a particular denomination, parents have given their implied consent; and the family doctor. The organisation suggested that if such consent is not implied for non-touching "treatment",

⁷⁴⁴ Submission 81: "There are increasing anecdotes appearing in the British press about stage hypnosis leading to serious psychological disturbance as a result of hypnotic suggestion being made to the individual, then being carried through into the normal waking state subsequently. In fact there is on record an account of a young man suddenly dropping dead following the instruction that he should imagine that he is being electrocuted by a power line. I would submit therefore that hypnotherapy can be an extremely powerful tool, which, whilst there may not be any actual physical contact between therapist and patient, the suggestion taking place during hypnotherapy can subsequently lead to serious consequences beyond the control of the subject."

⁷⁴⁵ Submission 57.

⁷⁴⁶ Submission 18.

⁷⁴⁷ Submission 3.

"much beneficial advice and counselling which is routinely given to children will cease to be conveniently available to them".

Although the Commission is concerned that certain forms of non-touching health care should not proceed without a valid consent,⁷⁴⁸ it agrees that the nature of much non-touching interaction between health care providers and young patients does not lend itself to the formality of a consent requirement and to an assessment of competence to consent. If, for example, simple advice given to young people were to be classified as health care for the purposes of the Commission's proposed scheme, it is likely that health care providers would be reluctant to assist immature or otherwise "non-competent" young people in valuable ways, such as providing advice on lifestyle choices or listening to personal problems - through fear that they may be liable for "treating" without a valid consent.

The Commission recommends a distinction between health care that involves a touching and health care that does not. Health care that does not involve a touching does not normally require a valid consent before it can be lawfully carried out. The Commission considers that generally this should remain the case, except in relation to some serious forms of non-touching health care, which may pose a significant risk to a young person (for example, some forms of psychotherapy).⁷⁴⁹ In those cases, there should be a valid consent before a health care provider will be protected from liability for assault and/or battery for performing the health care.

The Commission is of the view that Queensland Health and the Department of Families, Youth and Community Care would be the most appropriate bodies jointly to devise and review the list of non-touching health care that cannot proceed without a valid consent (whether from the young person, if competent, from a parent, or pursuant to a court order).

This recommendation is reflected in clause 8, clauses 1 and 2 of schedule 1, and schedule 2 of the draft legislation in Chapter 17 of this Report.

⁷⁴⁸ See clause 8 of the draft legislation in Ch 17 of this Report.

⁷⁴⁹ See 163-164 of this Report.

4. CATEGORISATION BY AGE

The Commission's legislative scheme is separated into three distinct parts according to the age of the young person who is to be the subject of a health care decision. Three age groups have been devised:

- under 12 years of age;
- 12 to 15 years of age; and
- 16 and 17 years of age.

The ability of a young person to authorise his or her own health care will be determined not only by the young person's competence to consent (as discussed above), but also by the young person's age at the time the health care is carried out.

The three age groups reflect the growing independence and autonomy of young people. They also assist in protecting young people who may exhibit some signs of maturity, but who are still vulnerable.

For young people under 12 years of age, the Commission has recommended that the authorisation of health care should, in the vast majority of cases, be the sole responsibility of parents. In all such cases the health care must be in the best interests of the young person.⁷⁵⁰

For competent young people between 12 and 15 years of age, the Commission has recommended that they should be able to consent to their own health care, and that parents should also be able to consent to their health care. Parents should not be able to override the consent of a competent young person to health care that is in the young person's best interests. Nor should a competent young person be able to refuse health care that has been consented to by a parent (provided, again, that the health care is in the best interests of the young person).⁷⁵¹

For competent young people 16 and 17 years of age, the Commission has recommended that they should be able to authorise their own health care, and that no one else (other than pursuant to a court order) should be able to do so. As with adults, there should be no restriction that they should only be able to consent to health care that is in their best interests.⁷⁵²

⁷⁵⁰ See Ch 10 of this Report in relation to health care for young people under 12 years of age.

⁷⁵¹ See Ch 11 of this Report in relation to health care for young people between 12 and 15 years of age.

⁷⁵² See Ch 12 of this Report in relation to health care for young people who are 16 and 17 years of age.

For non-competent young people between 12 and 17 years of age, the Commission is of the view that their parents should retain the ability to consent to, and refuse, health care, provided that that is in the young person's best interests.⁷⁵³

5. PROTECTION FROM LIABILITY FOR HEALTH CARE CARRIED OUT UNDER THE PROPOSED LEGISLATIVE SCHEME

In Queensland, a health care provider may be criminally and/or civilly liable for assault and/or battery, despite acting in good faith and without negligence, if he or she treats a young person without a valid consent.

A young person's consent to his or her own health care will be invalid if the young person is not legally competent. A health care provider could also be liable if he or she acts (albeit in good faith and without negligence) on the consent of a young person's parents, but over the objections of the young person if the young person is legally competent.

One consequence of the confused state of the current law in Queensland is that some health care providers are reluctant to treat a young person without parental involvement, even where it is obvious that the health care is in the best interests of the young person's health or well-being. The current state of the law is an impediment to some young people obtaining the health care that they require.

In some jurisdictions, health care providers are entitled to statutory protection from criminal and/or civil liability (other than for negligence) provided that they fulfil certain statutory requirements before treating young people.⁷⁵⁴ In the Commission's view, it is important to provide protection to health care providers who act in accordance with the Commission's proposed scheme and to those health care providers who believe they are acting in accordance with the scheme. That protection is an important part of the scheme; without it, some health care providers are likely, because of a concern for their potential liability, to continue to be reluctant to treat young people.

(a) Who should be protected from liability?

In the Discussion Paper, the Commission proposed that a health care provider should be protected from liability (other than for negligence) if he or she treated a young

⁷⁵³ See Chs 11 and 12 of this Report.

⁷⁵⁴ See, for example, *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* s16 (discussed at 168-179 and set out in Appendix 6 to this Report) which refers to the medical practitioner incurring "no civil or criminal liability for an act or omission done or made" in accordance with the South Australian scheme. See also *Minors (Property and Contracts) Act 1970 (NSW)* s49 (discussed at 166-168 and set out in Appendix 6 to this Report).

person in accordance with the proposed legislative scheme.⁷⁵⁵

The Commission also proposed that a distinction be drawn in the legislative scheme between “registered” and “non-registered” health care providers. The Commission suggested that only health care providers who were required to be registered under a Queensland statute should be protected.⁷⁵⁶ The Commission considered that this limitation would provide some assurance that health care providers entitled to the protection were from recognised professions and subject to some degree of regulation. It was considered that this would in turn offer some additional protection to young people seeking health care.

The current law was to continue to apply to health care providers who were not registered. Those non-registered health care providers would need to ensure that a young person was actually competent to consent to the particular health care being proposed; they would not be able to take advantage of the particular provisions in the Commission’s proposed scheme that were designed to protect health care providers who carried out health care in accordance with the scheme.

A number of respondents supported the Commission’s proposals. For example, a medical College noted:⁷⁵⁷

[we decry] the involvement of “people who profess to be in the business of health care” who are not formally registered practitioners of the recognised disciplines of the therapies, teaching or medicine, the latter term used in its broadest context which includes pharmacy, optometry and orthotics.

A society interested in public policy stated:⁷⁵⁸

Agreed in principle. The essential feature of professions to be granted such immunity is that they have a tradition of adherence to an ethical code. Examples would be doctors, nurses and dentists.

However, as a result of other submissions received in response to the Discussion Paper and views expressed during consultation meetings held by the Commission, the Commission is now of the opinion that it would be inappropriate for the scheme to distinguish between registered and non-registered health care providers.

⁷⁵⁵ Discussion Paper at 204.

⁷⁵⁶ *Ibid.* The relevant South Australian and New South Wales legislation applies only to medical practitioners and dentists who are both required to be registered in those States.

⁷⁵⁷ Submission 1.

⁷⁵⁸ Submission 3.

Registration is not a prerequisite for practice in some health care professions in some jurisdictions - for example, social workers in Queensland. Further, a number of States have disbanded registration by title for many health care providers. The current trend of governments in Australia appears to be towards deregulation, and favours self regulation of health care professions, although in Queensland it appears that there is still support for the retention of the regulatory scheme.⁷⁵⁹ In other jurisdictions, professions are being asked to develop effective non-statutory mechanisms to achieve the regulatory effects of registration. Registration of currently unregistered health occupation groups will only be considered where it can be proved firstly, that the public's health and safety may be at risk if the profession is not registered and secondly, that statutory regulation is the only valid mechanism to limit the risk.⁷⁶⁰ As one respondent noted:⁷⁶¹

[I]f the Commission considers that unregistered health practitioners should be required to adhere to a higher standard of professional ethics and conduct (viz consent matters and liability for non-consensual treatment), then it naturally flows that the Commission views unregistered health care practitioners as posing a greater risk to public health and safety than do registered health care practitioners. As statutory registration enables greater control by government over the practitioners and their practices, a more appropriate and relevant means of addressing the issue would be to recommend statutory registration of the currently unregistered professions.

...

Should the Commission be determined to recommend a two-level test for consent and immunity for practitioners, then the test should be based on the nature of the practices concerned and the degree of risk to public health and safety where treatment is applied without consent. In such a context, registered health care practitioners including medical practitioners, nurses, chiropractors, osteopaths and psychologists should be treated equally with acupuncturists.

Queensland Health noted:⁷⁶²

The differentiation between registered and non-registered health care providers has a great impact on allied health professions for which there is no registration process, for example, social work. Within the health system, treatment often involves a continuum of care provided by a range of health care providers. Within the mental health services, for example, a young person may require the services of an occupational therapist, nurse and/or social worker.

The Commission was also informed about numerous other health care providers who, although not registered, could not be assumed to be a greater threat to the well-being of young patients than registered health care providers, for example, dietitians and

⁷⁵⁹ See Queensland Health, Draft Policy Paper *Review of Medical and Health Practitioner Registration Acts* (September 1996).

⁷⁶⁰ Submission 45. This is consistent with the Australian Health Ministers' Advisory Working Group's *Criteria for Assessment of Regulatory Requirements for Unregulated Health Occupations*. These criteria are set out in Appendix 7 to this Report.

⁷⁶¹ Submission 45.

⁷⁶² Submission 62.

Aboriginal health workers (who provide important primary health care in remote areas of Queensland). Similarly, the Commission is not prepared to state that the health care provided by a non-registered health care provider is less beneficial to a young person than the health care provided by a registered health care provider. To limit a young person's access to any form of health care without good reason may have the effect of denying the young person access to beneficial health care.

Further, the fact that a health care provider is a member of a registered health care profession does not guarantee that his or her assessment of a young person's competence will be more accurate than an assessment by a health care provider who is not a member of a registered health care profession.⁷⁶³

The Commission's objective is not to limit the health care options available to a young person and his or her parents. There is no reason to believe that health care would be more likely to proceed without a valid consent or authorisation within some health care professions than within others (although those professions which adhere to a Code of Ethics or a Code of Conduct that contains material on the significance of consent may be more likely than others to respect and understand the significance of consent).

Accordingly, except where specifically recommended to the contrary,⁷⁶⁴ the recommendations of the Commission as to the protection of health care providers will apply to all health care providers, regardless of their registration under a Queensland statute.

(b) Nature of the protection

The Commission has considered the protective provisions in section 16 of the *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* and in section 49 of the *Minors (Property and Contracts) Act 1970 (NSW)*.

Section 16 of the *Consent to Medical Treatment and Palliative Care Act 1995 (SA)*⁷⁶⁵ provides that in certain circumstances, which include that treatment is administered "in good faith and without negligence", a medical practitioner or dentist:

incurs no civil or criminal liability for an act or omission made.

⁷⁶³ This opinion was expressed to the Commission during its consultation meeting with a psychiatrist and medical practitioner who both work with young people in need of psychiatric treatment (Consultation meeting 27). See also Consumers Health Advocacy, *My Body, My Health: The handling of Consumers health complaints* (October 1994) which suggests that registration does not necessarily by itself offer protection to people seeking treatment.

⁷⁶⁴ See the specific references to "an authorised health care provider" at 298-299, 307-308 and 312-313 of this Report.

⁷⁶⁵ The provision is set out in full in Appendix 6 to this Report.

On the other hand, section 49 of the *Minors (Property and Contracts) Act 1970* (NSW) protects a medical practitioner or dentist who carries out treatment in particular circumstances from:

a claim ... for assault or battery in respect of anything done in the course of that treatment

...

The Commission prefers the more specific provision in the New South Wales legislation to the broader provision in the South Australian legislation. Accordingly, a health care provider who carries out health care in accordance with the requirements of this scheme will be protected from criminal and civil liability for assault and/or battery.

In Chapter 16 the Commission has recommended that it be an offence for a person, without lawful excuse, to carry out on a young person health care that is not authorised by the legislative scheme or by another law. The Commission has also recommended the creation of a statutory cause of action to enable a young person to recover damages in respect of unauthorised health care.⁷⁶⁶

A person who carries out health care in accordance with the requirements of this scheme should also be protected from the new forms of criminal and civil liability created by the scheme.

In the recommendations that follow in this Report, reference is made to “protection from liability for assault”. “Liability for assault” for the purposes of this Report means:

- civil liability for assault or battery;
- criminal liability for assault; and
- the new categories of civil and criminal liability created by the legislative scheme.

(c) Protection for mistaken belief as to existence of requirements for authorisation

In the chapters that follow, the Commission sets out in detail the proposed statutory requirements for authorisation of health care of young people in each of the following age groups: under 12 years of age; 12 to 15 years of age; and 16 and 17 years of age.

The Commission has considered whether it would be appropriate for a person who carries out health care in the mistaken belief as to the satisfaction or existence of the proposed statutory requirements nevertheless to be protected from liability for assault.

⁷⁶⁶ See 344 of this Report.

Any protection to be afforded to health care providers in such circumstances must always be balanced against the protection that is sought for the young person who is to be treated (whether on the consent of a parent or of the young person). It is, therefore, important to consider whether there is sufficient protection for the young person if the health care provider is required, in order to be protected, merely to have held the mistaken belief honestly, honestly and reasonably, in good faith, or, indeed, in some other kind of way.

(i) **Opinion**

In Scotland, legislation protects a medical practitioner from liability where, in the *opinion* of the medical practitioner, the young person has the relevant capacity.⁷⁶⁷ Similarly, South Australian legislation provides that a medical practitioner or dentist may treat a young person if, in addition to certain other matters, he or she is of the *opinion* that the young person is capable of understanding the nature, consequences and risks of the treatment.⁷⁶⁸ No guidance is given in either Act as to the manner in which the health care provider's opinion is to be formed.⁷⁶⁹

It is clear that under the Scottish and South Australian provisions a health care provider is less likely to be liable for an honest, but wrong, assessment of capacity than he or she would be at common law. It is less clear, however, what restrictions, if any, the courts would impose on a health care provider in forming his or her opinion.⁷⁷⁰

The submissions to the Discussion Paper were mixed in their responses to the Commission's preliminary recommendation that a health care provider should be protected if he or she treats a young person upon the young person's own consent if the health care provider *believes* that the young person is mature enough to understand the nature and consequences of the proposed health care, whether or not his or her beliefs were in fact correct.⁷⁷¹

A number of submissions expressed concern that by providing protection to a

⁷⁶⁷ *Age of Legal Capacity (Scotland) Act 1991* s2(4). See 182-184 of this Report for a discussion of this legislation.

⁷⁶⁸ *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s12(b). A number of restrictions are imposed - for example, the need for a second opinion agreeing with the health care provider's determinations of competency and best interest. See 168-179 of this Report for a discussion of this legislation.

⁷⁶⁹ It has been stated that "if a man is to form an opinion, and his opinion is to govern, he must form it himself on such reasons and grounds as seem good to him" (*Allcroft v Lord Bishop of London* [1891] AC 666 per Lord Bramwell at 678).

⁷⁷⁰ The Scottish provision was intended by the Scottish Law Commission to provide immunity from liability where a doctor makes a wrong but honest mistake as to a young person's capacity (Scottish Law Commission, *Report on the Legal Capacity and Responsibility of Minors and Pupils* (No 110, 1987) at paras 3.72 - 3.77).

⁷⁷¹ Discussion Paper at 10 and 203 (Recommendation 5(a)).

health care provider simply on the basis of his or her opinion as to the existence of relevant factors such as the young person's competence, would allow a health care provider's own prejudices to influence his or her decision regarding the young person's competency.⁷⁷²

The Commission regards these as valid concerns. When the Commission recommended in the Discussion Paper that a health care provider should be protected from liability for treating a young person upon the basis of his or her (mistaken) opinion that the young person understood the nature and consequences of the proposed treatment, it did so in the context that such a recommendation (which is considerably more relaxed than the common law) would apply only to registered health care providers.

However, in light of submissions to the Discussion Paper regarding the distinction between registered and non-registered health care providers, the Commission has now recommended that its proposed scheme should apply to all health care providers.⁷⁷³ The result of that recommendation is that the Commission's scheme will now be considerably broader in its application.

In view of the more expansive definition of health care provider that has been adopted by the Commission in this Report, the Commission is now of the view that the circumstances in which a health care provider should be protected in respect of health care carried out on a young person should be slightly more restrictive.

(ii) Honest belief

It has been held by the Privy Council in the case of *Royal Brunei Airlines v Tan*⁷⁷⁴ that "honesty" is an objective standard. Lord Nicholls defined honesty as follows.⁷⁷⁵

Honesty... does have a strong subjective element in that it is a description of a type of conduct assessed in the light of what a person actually knew at the time, as distinct from what a reasonable person would have known or appreciated.... However, these subjective characteristics of honesty do not mean that individuals are free to set their own standards of honesty in particular circumstances. The standard of what constitutes honest conduct is not subjective. Honesty is not an optional scale, with higher or lower values according to the moral standards of each individual.

⁷⁷² Submissions 43 and 63 and Consultation meeting 17.

⁷⁷³ See the definition of "health care provider" in Ch 1 of this Report and in clause 19 of the draft legislation in Ch 17 of this Report.

⁷⁷⁴ *Royal Brunei Airlines v Tan* [1995] 2 AC 378.

⁷⁷⁵ *Id* at 389.

In most situations there is little difficulty in identifying how an honest person would behave. Nor does an honest person ... deliberately close his eyes and ears, or deliberately not ask questions, lest he learn something he would rather not know, and then proceed regardless.

Similarly, there is both a subjective and an objective element in the duty of an officer of a company to act “honestly” in the exercise of his or her powers and the discharge of his or her duties under section 232(2) of the *Corporations Law*. An officer must act in good faith and for proper purposes, both of which provide an objective threshold of reasonableness.⁷⁷⁶ Therefore the belief by an officer that he or she is acting in the best interests of the company will not satisfy the duty to act honestly unless it is a belief that a reasonably careful and diligent officer could hold.

(iii) Honest and reasonable belief

The Commission is concerned that a court may not impute an element of reasonableness into the formation of a health care provider’s belief unless specifically directed to by legislation.⁷⁷⁷

Given this uncertainty, it may be desirable, and also of assistance to health care providers, to specify in the proposed legislative scheme exactly what limitations should apply to the formulation of the beliefs that should be held by a health care provider in order to secure protection.

The Commission is now of the view that an element of reasonableness would, in addition to the element of honesty, constitute an important restraint on the formation of a health care provider’s belief, and would serve to protect young people from health care providers who may hold unorthodox views.

Section 24 of the *Criminal Code* (Qld), which provides a criminal defence to a person acting under a mistake of fact, has been of assistance to the Commission in devising an appropriate protection provision for the legislative scheme. That section provides:

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

⁷⁷⁶ The court needs to be satisfied that the belief was *bona fide*, that is, it is justifiable on some objective basis (*Harlowe’s Nominees Pty Ltd v Woodside (Lakes Entrance) Oil Co NL* (1968) 121 CLR 483; *Permanent Building Society (In Liq) v Wheeler* (1994) 11 WAR 187). It has been stated that *bona fide* is another way of saying that the power must be exercised for the purpose for which it was conferred (*Australian Metropolitan Life Assurance Co Ltd v Ure* (1923) 33 CLR 199 per Isaacs J at 217; *Provident International Corporation v International Leasing Corporation Ltd* [1969] 1 NSWLR 424 per Helsham J at 436).

⁷⁷⁷ The case of *Royal Brunei Airlines v Tan* [1995] 2 AC 378 was decided in a different context and the principle for which it is authority may not necessarily be transposed into the context of consent to health care.

exist.

- (2) The operation of this rule may be excluded by the express or implied provisions of the law relating to the subject.

Under the Commission's legislative scheme a health care provider who carries out health care on a young person under an honest and reasonable, but mistaken, belief as to the existence of relevant matters, will be protected not just from criminal liability for assault under the *Criminal Code* (Qld), but also from criminal liability proposed by the legislative scheme,⁷⁷⁸ from civil liability for assault or battery under the general law, and from civil liability under the cause of action proposed by the legislative scheme.⁷⁷⁹

(d) Protection for a supervised health care provider

The Commission has considered the position of a health care provider who carries out health care on a young person under the supervision of another health care provider.

As described above, a supervising health care provider will be protected from liability if certain requirements under the proposed legislative scheme have been fulfilled. He or she will also be protected if he or she honestly and reasonably, but mistakenly believes in the fulfilment of those requirements.

The Commission is of the view, generally, that where a health care provider carries out health care on a young person under the supervision of another health care provider, the supervised health care provider should be protected from liability for assault if the supervising health care provider would be protected under the scheme.

The Commission is of the view, however, that in limited circumstances, the supervised health care provider should lose that protection, notwithstanding that the supervising health care provider would still be protected under the scheme. This is where the supervised health care provider knows, or could reasonably be expected to know, that the health care is not authorised by the scheme.

For example, one of the recommendations of the scheme is that a young person of 16 or 17 years of age can provide an effective refusal of health care, including emergency health care. A health care provider who is being supervised by another health care provider might treat a young person, who is known to the supervised health care provider to be 16 years of age, over the young person's refusal. The Commission does not believe that the supervised health care provider should be protected, merely because the supervising health care provider would be protected if he or she did not

⁷⁷⁸ See 345 of this Report and clause 23 of the draft legislation in Ch 17 of this Report.

⁷⁷⁹ See clause 22 of the draft legislation in Ch 17 of this Report.

know, or have reason to know, the young person's age. If the supervised health care provider were to be protected in these circumstances, it would permit the supervised health care provider to flout the provisions of the scheme.

If the supervised health care provider knows, or could reasonably be expected to know, that the health care is not authorised by the scheme, the supervised health care provider should not be protected.

This recommendation is limited to a health care provider who is working under the supervision of another health care provider. It does not apply to a health care provider who carries out health care upon a referral from another health care provider. The health care provider to whom a young person may be referred will be in the same position as the referring health care provider. If the requirements of the scheme are not fulfilled, the health care provider to whom the young person has been referred will be protected from liability for assault only if he or she honestly and reasonably, although mistakenly, believes that the requirements of the scheme have been fulfilled.

(e) The Commission's recommendations

The Commission makes the following recommendations regarding protection for health care providers:

- (a) A health care provider⁷⁸⁰ who carries out health care of a young person in accordance with the proposed scheme should be protected from liability for assault.

"Liability for assault" for the purposes of the proposed scheme means:

- civil liability for assault or battery;
- criminal liability for assault; and
- liability under the new categories of civil and criminal liability created by the scheme.⁷⁸¹

- (b) If a person⁷⁸² carries out health care of a young person with an honest and reasonable, but mistaken, belief in the existence of any state of things, the person's liability for assault should be decided as if the real state of things had been such as he or she believed to exist.

- (c) A health care provider who carries out health care of a young person under the supervision of another health care provider should also be protected from liability for assault if the supervising health care provider would not incur that liability for carrying out the health care.

However, the supervised health care provider will continue to be liable if he or she knew, or could reasonably be expected to have known, that the health care was not authorised by the scheme.

These recommendations are reflected in clauses 43, 44 and 47 of the draft legislation in Chapter 17 of this Report.

⁷⁸⁰ Note the definition of "health care provider" at 21 of this Report.

⁷⁸¹ See 344 and 345 of this Report.

⁷⁸² The proposed legislative scheme authorises a person who may not be a health care provider to carry out certain health care in limited circumstances. See, for example, the Commission's recommendations in relation to minor health care at 299-301 of this Report.

6. A BRIEF OUTLINE OF THE COMMISSION'S SCHEME

Although the Commission's recommended legislative scheme is explained in greater detail in subsequent chapters of this Report, a brief outline of the scheme is set out in the following tables to enable readers to gain an overall impression of the scheme. The legislation reflecting these recommendations is set out in Chapter 17 of this Report. The summary of the main recommendations set out in each Table is subject to the list of qualifications which immediately follows Table 4.

Young people under 12 years of age

- As per Table 1 below.

Young people between 12 and 15 years of age

- As per Table 2 below.

Young people 16 or 17 years of age

- As per Tables 3 and 4 below.

LEGEND

The following meanings and abbreviations apply in Tables 1, 2, 3 and 4:

Competent means, in relation to particular health care, that the young person understands the nature and consequences of the health care, and communicates a decision about the health care in some way.

Parent is a reference to the broad definition of "parent" recommended by the Commission in Chapter 15 of this Report.

HCP means health care provider.

Authorised HCP means a registered medical practitioner, registered dentist, registered nurse, or such other health care provider as may be prescribed by a regulation made under the proposed legislative scheme.

Health care generally, unless otherwise stated, is a reference to all touching health care and certain forms of serious non-touching health care to be regulated by the proposed scheme.

Health care required without delay does not include:⁷⁸³

- (a) emergency health care;
- (b) a termination of pregnancy;
- (c) contraceptive health care;
- (d) health care for a sexually transmitted disease; or
- (e) a blood transfusion.

Minor health care means:⁷⁸⁴

- (a) first aid;
- (b) a non-intrusive examination for diagnostic purposes; or
- (c) the administration of a pharmaceutical drug if-
 - (i) a prescription is not needed to obtain the drug; and
 - (ii) the administration is for a recommended purpose and at a recommended dosage level.

All four tables list the consent requirements for health care, as well as the circumstances in which the proposed legislative scheme authorises particular types of health care to be carried out without consent.

⁷⁸³ See the Commission's recommendations about "health care required without delay" at 298-299 of this Report.

⁷⁸⁴ See the Commission's recommendations about "minor health care" at 301 of this Report.

TABLE 1: UNDER 12 YEARS OF AGE

Type of health care	Person protected under scheme	Competency of young person	Consent by	Restrictions
Consent requirements				
1.1 Health care generally ⁷⁸⁵	Any HCP	Not applicable	A parent	Health care must be in young person's best interests. A parent cannot, without court authorisation, provide a valid consent to a sterilisation that is not medically necessary.
1.2 Health care for a sexually transmitted disease ⁷⁸⁶	An authorised HCP	Competent	A parent; or Young person	Health care must be in young person's best interests.
		Not competent	A parent	
1.3 Contraceptive health care ⁷⁸⁷	An authorised HCP	Competent	A parent; or Young person	Health care must be in young person's best interests. A parent's consent is not effective if the young person objects to the health care.
		Not competent	A parent	
Exceptions to the need for consent				
1.4 Emergency health care	Any person	Not applicable	No consent requirement	Health care must be urgently required to meet imminent risk to young person's life or health. Health care must be in young person's best interests. Health care can be given over the refusal of a parent.

785 This excludes health care for a sexually transmitted disease, contraceptive health care and emergency health care. The Commission has made specific recommendations for each of those types of health care. See 1.2, 1.3 and 1.4 of this Table.

786 See 1.7 of this Table for when health care for a sexually transmitted disease can be carried out without consent.

787 See 1.8 of this Table for when contraceptive health care can be carried out without consent.

1.5	Health care required without delay	An authorised HCP	Not applicable	No consent requirement	Health care must be required without delay. The delay associated with taking reasonable steps to contact a parent for his or her consent would not be in the young person's best interests, or, if the authorised HCP has taken reasonable steps to contact a parent, no parental consent to, or refusal of, the health care is given. Health care must be in young person's best interests. Health care cannot be carried out under this provision if a parent has previously indicated in similar circumstances that the health care should not be carried out, and since then the parent has not indicated otherwise.
1.6	Minor health care	Any person	Not applicable	No consent requirement	Health care must be in young person's best interests.
1.7	Health care for a sexually transmitted disease	An authorised HCP	Not competent	No consent requirement	Health care must be in young person's best interest. Health care cannot be carried out under this provision if young person objects to it. ⁷⁸⁸
1.8.	Contraceptive health care	An authorised HCP	Not competent	No consent requirement if the young person requests the health care.	Health care must be in young person's best interests.

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The Commission has recommended that s36 of the *Health Act 1937* (Qld) be amended to ensure that it authorises health care for a notifiable disease of a young person who is not competent to consent to any "reasonable examination" etc and, therefore, presumably not competent to provide a refusal of health care, or whose parent refuses the health care of the young person. A young person who objected to health care for a sexually transmitted disease would be treated under s36 of the *Health Act 1937* (Qld) as amended.

TABLE 2: FROM 12 TO 15 YEARS OF AGE (INCLUSIVE)

Type of health care	Person protected under scheme	Competency of young person	Consent by	Restrictions
Consent requirements				
2.1 Health care generally ⁷⁸⁹	Any HCP	Competent Not competent	A parent; or Young person A parent	Health care must be in young person's best interests. Neither a parent nor a young person can, without court authorisation, provide a valid consent to a sterilisation that is not medically necessary.
2.2 Health care for a sexually transmitted disease ⁷⁹⁰	An authorised HCP	Competent Not competent	A parent; or Young person A parent	Health care must be in young person's best interests.
2.3 Contraceptive health care ⁷⁹¹	An authorised HCP	Competent Not competent	A parent; or Young person A parent	Health care must be in young person's best interests. A parent's consent is not effective if the young person objects to the health care.
Exceptions to the need for consent				
2.4 Emergency health care	Any person	Not applicable	No consent requirement	Health care must be urgently required to meet imminent risk to young person's life or health. Health care must be in young person's best interests. Health care can be given over the refusal of a parent.

789 This excludes health care for a sexually transmitted disease, contraceptive health care and emergency health care. The Commission has made specific recommendations for each of those types of health care. See 2.2, 2.3 and 2.4 of this Table.

790 See 2.7 of this Table for when health care for a sexually transmitted disease can be carried out without consent.

791 See 2.8 of this Table for when contraceptive health care can be carried out without consent.

2.5	Health care required without delay	An authorised HCP	Not competent	No consent requirement	Health care must be required without delay. The delay associated with taking reasonable steps to contact a parent for his or her consent would not be in the young person's best interests, or, if the authorised HCP has taken reasonable steps to contact a parent, no parental consent to, or refusal of, the health care is given. Health care must be in young person's best interests. Health care cannot be carried out under this provision if a parent has previously indicated in similar circumstances that the health care should not be carried out, and since then the parent has not indicated otherwise.
2.6	Minor health care	Any person	Not competent	No consent requirement	Health care must be in young person's best interests.
2.7	Health care for a sexually transmitted disease	An authorised HCP	Not competent	No consent requirement	Health care must be in young person's best interests. Health care cannot be carried out under this provision if young person objects to it. ⁷⁹²
2.8	Contraceptive health care	An authorised HCP	Not competent	No consent requirement if young person requests the health care	Health care must be in young person's best interests.

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The Commission has recommended that s36 of the *Health Act 1937* (Qld) be amended to ensure that it authorises health care for a notifiable disease of a young person who is not competent to consent to any "reasonable examination" etc and, therefore, presumably not competent to provide a refusal of health care, or whose parent refuses the health care of the young person. A young person who objected to health care for a sexually transmitted disease would be treated under s36 of the *Health Act 1937* (Qld) as amended.

TABLE 3: 16 OR 17 YEARS OF AGE AND COMPETENT FOR THE HEALTH CARE

Type of health care	Person protected under scheme	Competency of young person	Consent	Restrictions
Consent requirements				
3.1 Health care generally ⁷⁹³	Any HCP	Competent	Young person only (Young person can also refuse health care)	-
Exceptions to the need for consent				
3.2 Emergency health care	Any person	Competent	No consent requirement, but young person can refuse emergency health care ⁷⁹⁴	Health care must be urgently required to meet imminent risk to young person's life or health. Health care must be in young person's best interests.

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This includes the capacity to consent to health care for a sexually transmitted disease or to contraceptive health care. Those two types of health care are not, in the case of a competent 16 or 17 year old young person, subject to specific consent requirements. However, it excludes emergency health care, for which the Commission has made specific recommendations. See 3.2 of this Table.

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A HCP will not be protected if he or she knows, or ought to know, that the young person has refused the health care, was 16 or 17 and competent at the time he or she refused the health care, and that the young person has not subsequently retracted the refusal.

TABLE 4: 16 OR 17 YEARS OF AGE BUT NOT COMPETENT FOR THE HEALTH CARE

Type of health care	Person protected under scheme	Competency of young person	Consent by	Restrictions
Consent requirements				
4.1 Health care generally ⁷⁹⁵	Any HCP	Not competent	A parent	Health care must be in young person's best interests. A parent cannot, without court authorisation, provide a valid consent to a sterilisation that is not medically necessary.
4.2 Health care for a sexually transmitted disease ⁷⁹⁶	An authorised HCP	Not competent	A parent	Health care must be in young person's best interests.
4.3 Contraceptive health care ⁷⁹⁷	An authorised HCP	Not competent	A parent	Health care must be in young person's best interests. A parent's consent is not effective if the young person objects to the health care.
Exceptions to the need for consent				
4.4 Emergency health care	Any person	Not competent	No consent requirement	Health care must be urgently required to meet imminent risk to young person's life or health. Health care must be in young person's best interests. Health care can be given over the refusal of a parent.

⁷⁹⁵ This excludes health care for a sexually transmitted disease, contraceptive health care and emergency health care. The Commission has made specific recommendations for each of those types of health care. See 4.2, 4.3 and 4.4 of this Table.

⁷⁹⁶ See 4.7 of this Table for when health care for a sexually transmitted disease can be carried out without consent.

⁷⁹⁷ See 4.8 of this Table for when contraceptive health care can be carried out without consent.

4.5	Health care required without delay	An authorised HCP	Not competent	No consent requirement	Health care must be required without delay. The delay associated with taking reasonable steps to contact a parent for his or her consent would not be in the young person's best interests, or, if the authorised HCP has taken reasonable steps to contact a parent, no parental consent to, or refusal of, the health care is given. Health care must be in young person's best interests. Health care cannot be carried out under this provision if a parent has previously indicated in similar circumstances that the health care should not be carried out, and since then the parent has not indicated otherwise.
4.6	Minor health care	Any person	Not competent	No consent requirement	Health care must be in young person's best interests.
4.7	Health care for a sexually transmitted disease	An authorised HCP	Not competent	No consent requirement	Health care must be in young person's best interests. Health care cannot be carried out under this provision if the young person objects to it. ⁷⁹⁸
4.8	Contraceptive health care	An authorised HCP	Not competent	No consent requirement if the young person requests the health care.	Health care must be in young person's best interests.

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The Commission has recommended that s36 of the *Health Act 1937* (Qld) be amended to ensure that it authorises health care for a notifiable disease of a young person who is not competent to consent to any "reasonable examination" etc and, therefore, presumably not competent to provide a refusal of health care, or whose parent refuses the health care of the young person. A young person who objected to health care for a sexually transmitted disease would be treated under s36 of the *Health Act 1937* (Qld) as amended.

The recommendations contained in the previous four Tables are subject to the following:

- All recommendations are subject to an order made by either the Supreme Court of Queensland in its *parens patriae* jurisdiction or the Family Court of Australia in its welfare jurisdiction.⁷⁹⁹
- The proposed legislation will contain a schedule listing those forms of serious non-touching health care for which a valid consent will be required.
- The proposed legislation will contain a further schedule listing those forms of health care to which a young person's objection will override a parental consent if the young person has more than a minimal understanding of what is involved in the health care and why it is required.⁸⁰⁰
- In addition to being able to consent to health care, a young person who is 16 or 17 years of age and competent will also be able to refuse health care.
- The common law in relation to emergency health care is preserved, with the exception that a young person who is 16 or 17 years of age will be able to refuse emergency health care.
- A health care provider or other person who carries out health care in accordance with the proposed scheme will be protected from liability for assault. The scheme will not affect a person's potential liability in negligence.

⁷⁹⁹ See 94-97 of this Report.

⁸⁰⁰ See the Commission's recommendations in relation to health care to which a young person can provide a valid objection at 241-242, 264-265 and 283-284 of this Report.

CHAPTER 10

AUTHORISATION OF HEALTH CARE BY COMPETENCY AND AGE OF YOUNG PERSON: BIRTH TO 11 YEARS OF AGE

1. AUTHORISATION OF HEALTH CARE

At common law and under most legislative schemes reviewed by the Commission, there is no particular age below which a young person is unable to consent to his or her own health care. Of all the legislative schemes reviewed by the Commission, only Quebec has expressly legislated for a fixed age below which a young person will not be competent to consent to health care.⁸⁰¹

In Queensland, a young person of any age who is intelligent and mature enough to be capable of understanding the nature and consequences of particular health care (that is, who is *Gillick* competent) can provide a valid consent to that health care.⁸⁰² A health care provider who treats such a young person on the basis of his or her consent will not incur criminal or civil liability for assault or battery. Under current Queensland law, it would be possible for a 10 year old to provide a valid consent to quite serious medical procedures without the knowledge or consent of his or her parents, and possibly without the guidance and support of any adult, if he or she had sufficient degrees of intelligence, maturity and understanding.

The Commission is concerned that young children may be placed in a vulnerable position. Any legal challenge to a young person's competence to consent to health care is likely to take place after the health care has been carried out, which is obviously too late for the young person if it is ultimately held that the young person was not competent, that is, that the young person did not understand the nature and consequences of the health care.

In the Discussion Paper,⁸⁰³ the Commission proposed that, subject to certain exceptions, the consent of a parent should be required for the health care of a young person 12 years of age or under. The Commission believed that, by stipulating an age below which a young person would not be able to provide a valid consent to health care, the law would protect the young person from making detrimental decisions about his or her health care. It would also protect the young person from undergoing health

⁸⁰¹ The Quebec *Civil Code*, article 14 provides that parental or guardian consent is necessary for a person under 14 years of age in respect of treatment "required by the state of health" of the young person. A court may authorise such treatment where a parent or guardian has withheld consent.

⁸⁰² See Ch 3 of this Report.

⁸⁰³ Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995) at 12 and 205 (Recommendation 12).

care in circumstances where the support of a responsible person is necessary to ensure the effectiveness of the health care. For example, a young person may require supervision to ensure that medication is taken in accordance with a medical practitioner's instructions.

Presumably, the younger a child is, the less likely it is that he or she would be competent under the common law to provide a valid consent to serious health care. A 5 year old may understand the nature and consequences of dressing a small wound, but not be able to understand the nature and consequences of more significant health care, particularly if there are a number of different options for the health care.⁸⁰⁴

The younger a person is, the more likely it is that he or she will depend upon others to make significant decisions on his or her behalf. It is arguable that a very young child is more likely than an older child to be swayed by perceived authority figures such as medical practitioners.

Further, the younger a person is, the greater the likelihood that a health care provider will be mistaken as to the young person's ability to understand the nature and consequences of proposed health care, and that the health care provider will treat the young person in circumstances where the young person is not competent to consent to the health care.

A young person's parents generally have exclusive decision-making authority vis à vis their child's health care from birth until the young person has legal capacity to make his or her own decisions. In the main, it can be presumed that those decisions are made in the best interests of the young person's health and well-being. It is likely that parents will have a broader understanding of their child's circumstances than will the child - especially if the child is very young. Prior to adolescence, a young person is also less likely to be involved in serious risk-taking behaviour (which is not known to his or her parents) which might result in the need for serious health care, and it is therefore less likely that a requirement of parental involvement would deter the young person from seeking treatment.

The Commission believes that, in the vast majority of cases, the most appropriate advocates for a young person on health-related matters are his or her parents. This is particularly so the younger the child is. In any event, the benefits of involving young people in the decision-making process should always be acknowledged.⁸⁰⁵

⁸⁰⁴ Huddart J in the British Columbia Supreme Court decision of *Ney v Attorney General of Canada* (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.

⁸⁰⁵ See Ch 16 of this Report.

The submissions received in response to the Discussion Paper were generally in favour of a statutorily prescribed age below which young people would generally not be able to consent to their own health care.

For example, a parents and friends association noted:⁸⁰⁶

We welcome the recommendation that parental consent must be obtained to treatment of children 12 years of age and under save for exceptional circumstances such as those instanced in the Commission's Paper. The recommendation is an acceptance of the premise that the vast majority of parents can identify and will act in their child's best interests.

A number of submissions favoured an increase in the age limit from 12 to 13 years. A dentist noted:⁸⁰⁷

During the thirty eight years that I practised dentistry ... I have found that at 12 or 13 years of age, many young people could have difficulty in making valid independent health decisions and would benefit from adult guidance.

I would favour an increase from 12 years of age to 13 years [as the lower cut-off] ...

This would relate better to the Health Insurance Commission policy of issuing Medicare Cards to people at 14 years of age.⁸⁰⁸

Youth health nurses favoured a decrease in the age.⁸⁰⁹

A significant number of referrals in high schools arise in year 8. These year 8 students are aged 12-13. Under the arbitrary division of age at 12 it effectively causes an inequality within their own peers where half the class is 12 and the other 13. In situations where teachers refer students for screening/assessment because of concern regarding vision, hearing, health, and nutrition assessment, we have not required consent from the parents, or in some cases have only obtained a verbal consent from parents. By requiring consent within an age framework in year 8, this then creates barriers to equal access to services for some, eg those still 12 years old within this peer group.

Similarly, Queensland Health supported a requirement that below a certain age, the consent of a third party should be required, but suggested that the set age should be low rather than high.⁸¹⁰

⁸⁰⁶ Submission 39.

⁸⁰⁷ Submission 12.

⁸⁰⁸ See the discussion of the Health Insurance Commission's policy on issuing Medicare cards to young people at 357-359 of this Report.

⁸⁰⁹ Submission 35.

⁸¹⁰ Submission 62.

There were, however, a number of submissions which argued in favour of no lower cut-off age for young people to consent to their own health care. For example, a community organisation working with young people observed:⁸¹¹

There is a clear logic to considering consent as possible where a young person understands the nature and consequences of proposed actions, where as determining an age of consent is simply an arbitrary choice. Young people have the same human rights as any other member of the community. They should, in principle, be treated in the same way as adults wherever possible. In other words, ability to consent to treatment should be based on capacity to do so rather than age.

Similarly, a medical organisation specialising in terminating pregnancies noted:⁸¹²

Any legislation which stipulates a specific cut off age has the danger of creating enormous if not insurmountable barriers to young people below that cut off age obtaining treatment without informing the parents or resorting to the courts. This will greatly increase delays in obtaining treatment. The consequences on both the physical and mental health of very young adolescent women will be serious and carries life-threatening potential.

A legal academic criticised the scheme proposed in the Discussion Paper as too complicated and suggested:⁸¹³

Since there is general recognition that age is not the determining factor so far as capacity is concerned, why not simply say that those under the age of 16 can consent to treatment if the medical practitioner, on reasonable grounds believes that the minor has the maturity to understand the nature of the treatment and the consequences and gives their consent.

A religious organisation had reservations about the workability and appropriateness of a lower limit and was unaware of any medical or other sound reason for a lower limit:⁸¹⁴

All persons develop differently, and we question the wisdom of such a cut off point. Some twelve year olds will obviously be better able to make decisions than some 13 year olds. Who is going to be able to tell the age of these children. Practical difficulties for health care workers are therefore anticipated. We do recognise that 12 years is a very tender and young age. We pray that most children under 13 will be under parental supervision and not need treatment by themselves. However, this would be to ignore the reality that there are situations where such children need the attention of the medical profession, and we believe that this should not be denied to them, at least for treatment which is not "serious" ... We believe that even younger children should be able to provide good consent to treatments that they can understand. Thus a 7 year old should be able to give consent to bandaging and minor stitching, if such 7 year old understands the nature of the treatment, where it is impracticable to obtain timely parental consent. We therefore recommend that there be no lower age limit. There will, practically, be a *de facto* lower

⁸¹¹ Submission 8.

⁸¹² Submission 23.

⁸¹³ Submission 59.

⁸¹⁴ Submission 30.

age limit in any event below which doctors will deem children too young to understand. This recommendation is subject to our earlier recommendation recognising the importance of the existence of parental consent.

However, the Commission remains of the view that there should be a lower age limit below which young people should not be able to give a valid consent for their own health care. Obviously, the younger a child is, the less likely it is that he or she will seek health care on his or her own behalf. However, even if a child of, say 10 years of age, seeks health care by himself or herself, in most cases, it would be appropriate for parents to be involved.

In the view of the Commission, there is a wide community expectation that parents should generally be involved in all significant decisions affecting the health of their young children.

The Commission also believes that parents should generally be involved in health care decisions affecting their children under a certain age. In particular, in relation to the management of chronic illnesses (such as asthma or diabetes) the Commission considers the involvement and support of parents to be a vitally important part of the effective management of those illnesses.

Although in the Discussion Paper the Commission suggested 13 years of age as the age below which a young person would not be able to consent to health care,⁸¹⁵ the Commission is now of the view, for the reasons expressed in the submission by school health nurses,⁸¹⁶ that 12 years of age would provide a more appropriate cut off point. It is the age when Queensland children start high school. As such, it provides a degree of certainty, which would not be provided by other more variable cut-offs.

2. REFUSAL OF HEALTH CARE

The Commission has recommended that, under its legislative scheme, a young person under 12 years of age should be unable to provide a valid consent for his or her own health care.⁸¹⁷ It is consistent with that recommendation that a young person under 12 years of age should also, for the same reasons, be unable to refuse health care.

For a very young child, the justification for this goes without saying. However, even though a child approaching 12 years of age might be mature for his or her years, and might be able to understand the nature and consequences of proposed health care, the

⁸¹⁵ Discussion Paper at 12 and 205 (Recommendation 12).

⁸¹⁶ Submission 35. See 233 of this Report.

⁸¹⁷ See Ch 13 of this Report in relation to health care for which consent should not be a requirement.

Commission is not satisfied that most young people in this age group would be able to understand the nature and consequences of particular health care and the consequences of refusing it. A general recommendation permitting young people under 12 years of age to refuse health care could result in young people making decisions that could seriously damage their future health and well-being.

Further, given that a parent⁸¹⁸ is the only person who can ordinarily consent to the health care of a non-competent young person,⁸¹⁹ and that of all people, a parent is most likely to have a genuine concern for the young person's welfare, the Commission is of the view that the refusal by a young person under 12 years of age should not be effective to override a valid consent given by a parent of the young person. A parent is likely to be significantly more able than his or her child to make a sound decision as to whether health care should be carried out. For that reason, the consent of a parent should not lightly be overridden.

Accordingly, the Commission recommends that a young person under 12 years of age should not be able to refuse health care, and that the refusal of a young person in relation to particular health care should not render ineffective a valid consent given by a parent to that health care.

3. OBJECTION TO HEALTH CARE

While the Commission does not believe that a young person should generally be able to refuse health care, the Commission does see a need to protect young people from health care for which there may be doubtful medical justification, but which may, in the opinion of a health care provider and even a young person's parents, be thought to be in a young person's best interests.

The Commission is of the view that an objection by a young person to certain prescribed types of health care should render the consent of a parent ineffective. Those types of health care, if objected to by a young person, should only be able to be carried out with court authorisation. The authorisation by a court is necessary to protect the young person in circumstances where the young person's objection raises a serious question about the appropriateness of the health care.

The types of health care that the Commission has in mind include procedures performed for the purpose of a non-therapeutic termination of pregnancy and contraceptive health care. There is often confusion associated with the use of expressions such as "therapeutic" and "non-therapeutic" in describing health care.

⁸¹⁸ See the broad definition of "parent" recommended by the Commission in Ch 15 of this Report.

⁸¹⁹ There may be a court order authorising health care or appointing another person, such as the Director-General of the Department of Families, Youth and Community Care as the guardian of the young person.

Accordingly, the Commission is of the view that it would be simplest to define “termination of pregnancy” so as to exclude what would generally be regarded as “medically necessary” to treat organic malfunction or disease.

For example, if parents consented to a lawful termination of pregnancy for a young girl because of the serious effect of the pregnancy on their daughter’s mental state, but the daughter objected to having the termination, that objection should make the consent of her parents ineffective. For the young girl’s protection, court authorisation would be required.

The objection of a young person would not, however, be effective if the health care had court authorisation, or if the young person had minimal or no understanding of what the health care involved or why it was required, and the proposed health care was likely to cause the young person either no distress, or only temporary distress that would be outweighed by the benefit to the young person.

The prescribed list of health care to which a young person should be able to object should include termination of pregnancy and contraception.⁸²⁰

The High Court has held that a parent cannot, without court authorisation, consent to a non-therapeutic sterilisation procedure for his or her child.⁸²¹ That limitation on a parent’s authority to consent is expressly preserved by the proposed legislative scheme.⁸²² It is, therefore, not necessary to include sterilisation in the list of health care to which a young person’s objection should invalidate a parental consent. A young person is already protected by the fact that a parent can only consent to such a procedure with court authorisation.

There may be other types of health care that should also fall into this category.⁸²³ The Commission recommends that Queensland Health and the Department of Families, Youth and Community Care would be the appropriate bodies jointly to devise and update the list of other types of health care that should be regulated in this way.

⁸²⁰ See the Commission’s recommended definition of “contraceptive health care” at 243 of this Report.

⁸²¹ *Secretary, Department of Health and Community Services v JWB and SMB (Marion’s case)* (1992) 175 CLR 218.

⁸²² See 165 of this Report and clause 12(3) of the draft legislation in Ch 17.

⁸²³ It may be appropriate to consider whether some forms of what would ordinarily be regarded as contraceptive health care, but which are used for other purposes, such as menstrual management, should be regulated in this way.

4. OTHER POSSIBLE REQUIREMENTS FOR AUTHORISATION OF HEALTH CARE

In the Discussion Paper, the Commission made the preliminary recommendation that a young person 12 years of age or younger should not be treated without the consent of a legally competent parent.⁸²⁴

It was further recommended that, if a legally competent parent was not conveniently contactable or refused health care, a valid consent should be obtained from a substitute decision-maker,⁸²⁵ or the authorisation of either the Supreme Court of Queensland or the Family Court of Australia should be obtained. In all cases, it was recommended that health care should be in the best interests of the young person.⁸²⁶

The Commission has considered a number of requirements that might be relevant to the authorisation of health care of a young person under 12 years of age in addition to the consent of a parent. These are discussed in turn.

(a) Health care is in the best interests of the young person's health and well-being

In the Discussion Paper,⁸²⁷ the Commission made the preliminary recommendation that a registered health care provider⁸²⁸ could not treat a young person who was under 13 years of age unless the treatment was, in the health care provider's opinion, in the best interests of the young person. As stated above, the Commission is now of the view that 12 years of age is a more appropriate cut off point.⁸²⁹

At common law a valid consent cannot be given for health care that is not in the best interests of a young person. Accordingly, a health care provider who acts upon the

⁸²⁴ Discussion Paper at 12 and 205 (Recommendation 12).

⁸²⁵ Note that in Ch 9 of this Report the Commission did not adopt its preliminary recommendation in the Discussion Paper that the proposed Assisted and Substituted Decisions Tribunal (recommended for adults with a decision-making disability; see *Assisted and Substituted Decisions* (R49, June 1996)) be extended to include the function of substitute decision-maker for a young person without an available parent to consent to his or her health care. In view of the broader definition of "parent" recommended in Ch 15 of this Report, this was thought to be unnecessary.

⁸²⁶ Discussion Paper at 12 and 205 (Recommendation 12).

⁸²⁷ *Ibid.*

⁸²⁸ Note that the Commission has now recommended that the protective provisions of the scheme should not be confined to registered health care providers, but should apply to *all* health care providers: see the discussion of this issue at 210-213 of this Report and the Commission's recommendations at 220 of this Report.

⁸²⁹ See 235 of this Report.

consent of a parent will not be protected from liability if the health care was not, in fact, in the best interests of the young person's health and well-being. In South Australia, where there is a legislative scheme offering protection to health care providers who treat young people in certain circumstances, there is no such general restriction. The requirement that health care be in the best interests of a young person's health and well-being only applies if the health care provider is acting on the consent of the young person.⁸³⁰

The Commission believes that for young people under the age of 12 it is appropriate for their health care to be restricted to health care that is in the best interests of their health and well-being. Those young people are at a particularly vulnerable age and to enable the authorisation of health care that is not in their best interests could have serious detrimental effects.

The requirement that health care be in the best interests of the health and well-being of a young person under the age of 12 provides an important protection for young people. The Commission is therefore of the view that the proposed health care must be in the best interests of the health and well-being of the young person.⁸³¹

(b) Health care is in accordance with proper professional standards

In South Australia a medical practitioner or dentist will be protected from liability for assault and/or battery only if the health care is provided "in accordance with proper professional standards of medical practice",⁸³² even if the health care is carried out with the consent of a parent.

Some unorthodox or radical forms of health care may not be in accordance with such standards despite being, in the medical practitioner's or dentist's opinion, "in the best interest of the child's health and well-being". What were proper professional standards would need to be adduced from evidence presented at the relevant time.

The Commission considered whether its proposed legislative scheme should also provide that health care would only be authorised if the health care were given in accordance with proper professional standards. However, the Commission believes that it is more appropriate to leave to the law of negligence the question of the standard of the health care provided.

⁸³⁰ *Consent to Medical Treatment and Palliative Care Act 1995 (SA) s12.*

⁸³¹ The health care provider will also be protected if he or she has an honest and reasonable, but mistaken, belief that the health care is in the best interests of the young person's health and well-being. See 214-218 and 220 of this Report.

⁸³² *Ibid.*

The leading authority in this area is the High Court decision in *Rogers v Whitaker*.⁸³³ In that case the High Court rejected the notion, based on English case law,⁸³⁴ that the standard of care demanded of a health care provider should be determined according to what would be regarded as proper by a responsible body of professional medical opinion. The Court held that, particularly in relation to the provision of advice and information about the possible risks of proposed health care, evidence of acceptable medical practice provided a useful guide to the standard of care required, but would not be conclusive.⁸³⁵

Because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession.

The High Court recognised that a health care provider's duty of care to a patient includes a duty to warn of material risk inherent in proposed health care, unless there would be a particular danger that provision of all relevant information would harm an unusually nervous, disturbed or volatile patient. The Court defined a risk as material if:⁸³⁶

[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 Commission is of the view that the law of negligence provides greater protection to a patient than the South Australian provision, which merely limits protection to where health care is carried out in accordance with proper professional standards. Accordingly, the Commission does not recommend the inclusion of an equivalent provision in its scheme.

⁸³³ (1992) 175 CLR 479.

⁸³⁴ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

⁸³⁵ *Rogers v Whitaker* (1992) 175 CLR 479 at 489.

⁸³⁶ *Id* at 490.

5. THE COMMISSION'S RECOMMENDATIONS

The Commission makes the following recommendations with respect to the health care by a health care provider of a young person under 12 years of age:

- (a) A parent of a young person under 12 years of age should be able to consent to, and refuse, health care of the young person.
- (b) A young person under 12 years of age should not be able to consent to, or refuse, his or her own health care.⁸³⁷ Subject to the recommendation in paragraph (c) below, the refusal of health care by a young person should not make ineffective a valid consent to health care given by a parent.
- (c) Although the refusal of health care by a young person should not generally make ineffective consent to health care given by a parent, there should be a statutory list of health care that cannot be carried out over the objection of a young person under 12 years of age.

If the young person objects to the health care, the consent of a parent to such health care should be ineffective unless:

- (i) the health care is carried out pursuant to an appropriate court order; or
- (ii) the young person has minimal or no understanding of one or both of the following:⁸³⁸
 - what the health care involves; or
 - why the health care is required;

⁸³⁷ But see Ch 13 of this Report for a discussion of those forms of health care for which consent should not be a requirement.

⁸³⁸ See Queensland Law Reform Commission, *Assisted and Substituted Decisions* (R49, June 1996) Vol 2 *Assisted and Substituted Decision Making Bill* cl 163, for a similar provision in relation to the health care of adults with a decision-making disability.

and the proposed health care is likely to cause the young person:

- no distress; or
- temporary distress that is outweighed by the benefit to the young person.

The statutory list of health care that should not be carried out over the objection of a young person should be devised and updated jointly by Queensland Health and the Department of Families, Youth and Community Care.⁸³⁹ Initially, the list should include:

- termination of pregnancy; and
- contraceptive health care.⁸⁴⁰

(d) A health care provider may carry out health care of a young person under 12 years of age if:

- (i) a parent⁸⁴¹ of the young person consents to the health care; and
- (ii) the health care is in the best interests of the young person's health and well being.

These recommendations are reflected in clause 24 of the draft legislation in Chapter 17 of this Report.

⁸³⁹ See note 823 of this Report.

⁸⁴⁰ See the recommended definitions of "termination of pregnancy" and "contraceptive health care" at 243 of this Report.

⁸⁴¹ See the broad definition of "parent" recommended by the Commission in Ch 15 of this Report.

The Commission recommends the following definitions of “termination of pregnancy” and “contraceptive health care”:

- **“Termination of pregnancy” of a young person does not include a procedure primarily to treat organic malfunction or disease of the young person.⁸⁴²**
- **“Contraceptive health care” means health care of a young person that is primarily intended to prevent pregnancy, but does not include sterilisation or termination of pregnancy.**

This recommendation is reflected in clauses 8 and 11 of schedule 1 of the draft legislation in Chapter 17 of this Report.

⁸⁴² This definition is derived from the definition of “termination of pregnancy” in the Queensland Law Reform Commission’s Report, *Assisted and Substituted Decisions* (R49, June 1996) Vol 2, *Assisted and Substituted Decision Making Bill* cl 14, Sch 1.

CHAPTER 11

AUTHORISATION OF HEALTH CARE BY COMPETENCY AND AGE OF YOUNG PERSON: 12 TO 15 YEARS OF AGE

1. AUTHORISATION OF HEALTH CARE

In the Discussion Paper,⁸⁴³ the Commission made the preliminary recommendation that a young person of between 13 and 15 years of age should, in certain circumstances, be able to provide a valid consent to his or her health care.⁸⁴⁴ This recommendation was intended to recognise the increasing maturity of young people during these years, and was based on a combination of age and competence.⁸⁴⁵

In Chapter 10 of this Report, the Commission has recommended that a young person who is under 12 years of age should not be able to provide a valid consent to his or her own health care. The reasons outlined in that Chapter for justifying a cut-off at 12 years of age are the same reasons for the Commission's adoption in this Chapter of the age of 12 years as the lower age limit for the group of young people who will, subject to the recommendations made in this Chapter, be competent to consent to their own health care.

The Commission made a further preliminary recommendation in the Discussion Paper that a parent of a young person within this age group should also be able to consent to health care for his or her child, notwithstanding that the young person might also, under the Commission's proposed scheme, be competent to make his or her health care decisions.⁸⁴⁶ Under the current law it is not clear whether a parent can continue to make health care decisions for a child who is *Gillick* competent, so in this respect, the Commission was attempting to clarify and, indeed, enhance the role that parents play in health care of their adolescent children.

⁸⁴³ Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995) at 10-11 and 203-204 (Recommendations 5 and 7).

⁸⁴⁴ In relation to treatment by a registered health care provider, the health care provider had to be of the opinion that the young person understood the nature and consequences of the proposed treatment and the consequences of not being treated, and that the treatment was in the best interests of the young person. In relation to treatment by a non-registered health care provider, the young person actually had to understand the nature and consequences of the proposed treatment and the consequences of not being treated and the treatment actually had to be in the best interests of the young person, in order for the young person to be able to provide a valid consent.

⁸⁴⁵ The additional circumstances that might restrict when a competent young person of this age can consent to health care, such as that treatment must be the best interests of the young person, are discussed below. Those circumstances are intended to provide additional protection for the young person.

⁸⁴⁶ Discussion Paper at 204 (Recommendation 8).

The basis of the scheme proposed in the Discussion Paper was that a valid consent to health care for a young person of this age could be provided by a parent or, subject to certain restrictions, by the young person, if competent.

Only one respondent commented specifically on the Commission's preliminary recommendation that a parent should have the capacity, concurrent with his or her child, to consent to health care for his or her child between the ages of 13 and 15. That respondent agreed that parents should have that capacity.⁸⁴⁷

However, a number of respondents commented on the preliminary recommendations that a health care provider should, in certain circumstances, be able to treat a competent young person of this age on the basis of the consent of the competent young person. A number of respondents to the Discussion Paper welcomed the Commission's preliminary recommendations. For example, a dentist noted:⁸⁴⁸

From the health providers' point of view, I believe that they would be on safer legal ground with these proposed changes to the law and there would be clear guidelines ...

An administrator at a Base hospital reported on a hospital committee discussion of the Commission's preliminary recommendations:⁸⁴⁹

I believe the concepts of flexibility and some credibility given to the health professional's ability to assess the situation [were] acknowledged [by the committee] as extremely important.

Others welcomed the preliminary recommendations by contrasting them with the current law, which provides no clear guidelines for health care providers working with young people.⁸⁵⁰

Other respondents were not in favour of the Commission's proposal to provide that young people should, in certain circumstances, be able to consent to their own health care. It would appear, however, that some were under a misapprehension as to the effect of the current law in this regard.⁸⁵¹ For example, one respondent noted:⁸⁵²

I am against any medical procedure being practised on my children under the age of 16

⁸⁴⁷ Submission 30, although this respondent suggested that the refusal by a young person should override the consent of a parent.

⁸⁴⁸ Submission 12.

⁸⁴⁹ Submission 16.

⁸⁵⁰ Submission 9 (a director of nursing in a regional centre).

⁸⁵¹ See Ch 3 of this Report for a discussion of the current Queensland law.

⁸⁵² Submission 31.

years without my consent, unless there was an immediate emergency whereby I could not be contacted by every possible means.

However, the respondent did have a suggestion in relation to families unlike the respondent's family (which, it was suggested, was similar to the majority of families):

For majorly dysfunctional families ... there should be a separate medical authority other than an associate of the attending practitioner operating under very specific guidelines so as to avoid bias to assess whether or not the child is in actual danger from parents, or merely the fear of facing them. Parents, except in extreme cases, should be given the opportunity of supporting their children.

If young people are mature enough to enter into adult behaviour, then they must also accept that there are consequences of misuse of such behaviour. While parents are financially and morally responsible for their children, they should be contacted regarding such treatment.

Comments in identical words appeared in two other submissions.⁸⁵³

The Queensland Department of Tourism, Sport and Youth⁸⁵⁴ considered that it may be difficult for the general community to embrace the general right of consent for young people under the age of 16, particularly so in a range of diverse ethnic, religious and cultural groups.⁸⁵⁵

There is a focus in [Queensland] Government policy and practice in seeking to support families to stay together and to facilitate reconciliation between young people and their families. In this context, the proposed general right to consent for 13 to 15 year olds may not be acceptable to the community.

To deal with this issue, we suggest that the relevant recommendations ... are amended to focus only on 13 to 15 year olds who are living away from their parents, who are independent and for whom seeking parental consent may not be in their interest.

In the Discussion Paper, the Commission considered the appropriateness of enabling an "emancipated" young person to consent to treatment, irrespective of his or her maturity and understanding of the proposed treatment, or treating emancipation as one test of competence to consent under a particular age.⁸⁵⁶ However, as noted in the Discussion Paper:⁸⁵⁷

⁸⁵³ Submissions 32 and 46.

⁸⁵⁴ Submission 64. Note that the Youth Bureau that was previously within that Department is now located within the Department of Families, Youth and Community Care.

⁸⁵⁵ Submission 64.

⁸⁵⁶ Discussion Paper at 183-184.

⁸⁵⁷ Id at 184.

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.⁸⁵⁸

There may also be young people who qualify as being “emancipated”, but who are not intelligent or mature enough to understand the nature and consequences of proposed health care. For these reasons, the Commission does not favour emancipation as a criterion for competence to consent to health care.

The Commission acknowledges that the concerns raised by some respondents about allowing competent young people between 12 and 15 years of age to consent to health care are genuine. However, the current law already enables a young person of any age to be treated without parental knowledge or consent provided he or she is “*Gillick* competent”.⁸⁵⁹ There is presently no age below which a young person cannot seek health care without parental involvement.

The Commission’s proposed legislative scheme should not have any impact on those families in which young people are confident to talk to their parents about their health concerns. In such cases, consent *per se* is not an issue because parents in those types of families would presumably be in favour of any health care required to ensure their child’s good health and well-being. However, there will be cases - even in otherwise functional families - where young people need health care but are too embarrassed or fearful to inform their parents. In such cases, under the current law, a health care provider may be reluctant to treat a young person upon the young person’s own consent, even if the health care would be in the best interests of the young person, through fear of litigation resulting from a wrong assessment of the young person’s maturity. The consequence of reluctance by health care providers to treat and fear by young people that health care providers will inform parents may be that some young people fail to obtain the health care they need.

The Commission is, therefore, of the view that the health care of a young person who is between 12 and 15 years of age should be able to be carried out on the consent of the young person, if competent, or of a parent.

If the young person is not competent, that is, the young person does not understand the nature and consequences of the health care, the young person will not be able to provide a valid consent to health care. The consent of a parent will ordinarily be required.

⁸⁵⁸ It was also noted that Australia’s Health Insurance Commission’s policy of issuing separate Medicare cards to people under the age of 15 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. See 357-359 of this Report.

⁸⁵⁹ See Ch 3 of this Report for a discussion of *Gillick* competence.

2. EXCLUSION OF STERILISATION

Under the existing common law, it appears that a competent young person can consent to his or her own sterilisation, whether therapeutic or non-therapeutic. In *Marion's* case the majority of the High Court held:⁸⁶⁰

Sterilization comes within the category of medical treatment to which a legally competent person can consent.

Following *Marion's* case, parents are unable to consent to the non-therapeutic sterilisation of their children without court authorisation.⁸⁶¹

It is probably the case, however, that no person under the age of 16 could fully appreciate the implications of a decision to make himself or herself infertile. It would also be extremely difficult for a health care provider to feel confident that a young person understood the long term consequences of sterilisation.

The Commission believes that a young person who is between 12 and 15 years of age should not under the proposed scheme be competent to consent to a sterilisation that

⁸⁶⁰ *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 per Mason CJ, and Dawson, Toohey and Gaudron JJ at 234.

⁸⁶¹ See the discussion of *Marion's* case at 59-61 of this Report.

is not medically necessary (“a non-therapeutic sterilisation”). Such a sterilisation should only proceed with court authorisation.⁸⁶²

However, if the sterilisation is medically necessary, it should be regarded as being in the same category as other health care to which a young person or his or her parents can consent; court authorisation should not be required.

In Chapter 10 of this Report the Commission recommended a definition of “termination of pregnancy” that excludes a procedure that is medically necessary, that is, that is required to treat organic malfunction or disease.⁸⁶³ The Commission is of the view that “sterilisation” should similarly be defined to exclude health care that is required to treat organic malfunction or disease. On that basis, the Commission recommends that a young person between 12 and 15 years of age should be incapable of providing a valid consent for a sterilisation, as defined.

For example, if a young woman required a hysterectomy because of uterine cancer, that would be a medically necessary procedure. Accordingly, it would not fall within the

⁸⁶² This is the current law in relation to parents' ability to provide a valid consent to the sterilisation of their child (*Marion's case*). In New South Wales the regulations made under the *Children (Care and Protection) Act 1987* (NSW) would also restrict a young person's capacity to consent to a sterilisation. The *Children (Care and Protection-General) Regulation 1988* (NSW) 8A provides:

(1) The following treatments, procedures, operations and examinations are declared to be medical treatment for the purposes of section 20B of the Act (which makes it an offence to carry out special medical treatment on a child under the age of 16 years unless in the opinion of the medical practitioner it is necessary, as a matter of urgency, or necessary to save the child's life or to prevent serious damage to the child's health, or the Supreme Court consents to the treatment):

Administration of any drug of addiction within the meaning of the *Poisons Act 1966*

Administration of any long-acting injectable hormonal substance (such as medroxyprogesterone acetate in aqueous suspension) for the purpose of contraception or menstrual regulation.

Any treatment, procedure or operation in the nature of a vasectomy or tubal occlusion.

(2) The following medical treatment is declared to be special medical treatment for the purposes of section 20B of the Act:

Any medical treatment that involves the administration of a drug of addiction within the meaning of the *Poisons Act 1966* (otherwise than in association with the treatment of cancer) over a period or periods totalling more than 10 days in any period of 30 days.

Any medical treatment that involves an experimental procedure that does not conform to the document entitled “Statement on Human Experimentation and Supplementary Notes” issued by the National Health and Medical Research Council, as in force on 1 July 1989, a copy of which is deposited in the offices of the Director-General.

Any medical treatment that involves the administration of a long-acting injectable hormonal substance (such as medroxyprogesterone acetate in aqueous suspension) for the purpose of contraception or menstrual regulation.

Any medical treatment in the nature of a vasectomy or tubal occlusion.

⁸⁶³ At 243 of this Report.

Commission's proposed definition of "sterilisation"⁸⁶⁴ and the young woman, if competent, or her parents would be able to give a valid consent to that health care.

3. REFUSAL

The notion of a young person's capacity to consent to his or her own health care may tend to carry with it the notion of a capacity to refuse health care, at least where a choice of health care is available. Where there is no such choice, or where the choice is between health care that would be in the young person's best interests and health care that would not necessarily be in the young person's best interests, then the competence of a young person to refuse health care becomes a more complex issue.

In Chapter 4 of this Report, the Commission has set out what it considers to be the law relating to refusal of health care by young people in England and in Australia. The position in Australia is less certain than it is in England. In *Marion's case*,⁸⁶⁵ the majority of the High Court of Australia endorsed the English maturity approach in relation to consent, but appeared to be reluctant to adopt the English concept of concurrent powers of consent (which enables a health care provider to treat upon the consent of either a competent young person or one of his or her parents - even if a competent young person has refused the health care).

There appears to be no absolute right in young people under 16 years of age to refuse health care in any jurisdiction reviewed by the Commission.⁸⁶⁶ That does not mean, however, that a health care provider should ignore a young person's refusal, or feel bound to carry out health care on a young person merely because it is consented to by a parent.

Under the common law a health care provider is not protected from liability for assault or battery if he or she carries out health care that is not in the young person's best interests; as noted in Chapter 5 of this Report,⁸⁶⁷ one of the limitations on the capacity of a parent to provide a valid consent is that the health care be in the best interests of the young person. A health care provider cannot generally be required to carry out health care against the health care provider's clinical judgment on a young person. For that reason, a health care provider cannot be forced by a parent to carry out health care on a young person against the young person's will if the health care is not, in the health care provider's professional judgment, in the best interests of the young person.

⁸⁶⁴ See 263 of this Report.

⁸⁶⁵ (1992) 175 CLR 218.

⁸⁶⁶ See Ch 8 of this Report.

⁸⁶⁷ At 90-91 of this Report.

A number of arguments for and against giving a legally competent young person the capacity to refuse health care were set out in Chapter 4 of this Report.

The arguments in favour included:

- the right to refuse health care derives from the fact of having reached a sufficient level of decision-making capacity, in the same way as it does with a legally competent adult, who can choose whether or not to consent to health care;
- the right to refuse health care does not necessarily involve the refusal of all forms of health care - the concept of refusal is as fundamental to the right to choose between forms of health care, as it is to the right to refuse all forms of health care.

The arguments against included:

- a young person might exercise a right of refusal in a way that would not be beneficial to his or her health;
- the level of maturity needed to appreciate what is involved in refusing health care may be different from, and perhaps higher than, the level of maturity that is required for a decision to consent to health care.

The possibility that a health care provider might wrongly assess a young person's competence would, the Commission believes, increase the younger the person is. Part of that assessment of competence would be to determine if a young person understood the consequences of refusing the health care. The younger a person is, the less likely it is that he or she would be able to appreciate fully the long term consequences of refusal.

This was a point made to the Commission by a number of health care providers during the consultation meetings following the release of the Discussion Paper, and by respondents to the Discussion Paper. For example, one paediatrician noted at a consultation meeting that it was difficult for young people to be assessed as mature if they were unable to project into the future. They may understand what is asked of them, but may not be able to appreciate the long term consequences of their decisions.⁸⁶⁸ Another paediatrician, in a submission to the Discussion Paper, expressed a similar view.⁸⁶⁹

In my experience, children 13-16 years of age never believe they will grow old. They think anybody older than 25 years is over the hill and have absolutely no intention of reaching 30 or 40 years of age. Therefore to recommend treatment on the basis that refusal would

⁸⁶⁸ Consultation meeting 2.

⁸⁶⁹ Submission 5. For example, it is probable that a large proportion of young people who take up smoking between the ages of 12 and 15 years, have no view to their future health or, in particular, to the long term consequences of their actions.

cause long term problems to their health is difficult as the children are more likely to refuse in the short term. This particularly applies in diseases such as diabetes where the teenagers often have short term irritation with the restrictions of their treatment and trying to get them to see the long term implications of refusal of treatment is extremely difficult. I could also see problems arising in cancer therapy where the child may refuse treatment on the basis of the short term complications of the therapy without having the ability to see the long term implications of their refusal.

Of course, depending on the circumstances of the particular case, there would generally be a reluctance on the part of adults who are responsible for a young person's health and welfare to allow the young person to refuse health care that would be in the young person's best interests, particularly if the consequences of the decision to refuse health care could include the death or serious illness of the young person.

Where the proposed health care is in the best interests of a young person's health and well-being, the question arises whether the health care provider should be able to proceed with the health care upon the valid consent of a parent and against the refusal of the young person. Of course, this assumes that the health care provider in that type of situation is prepared to treat an unco-operative young person. Presumably the older and bigger an unco-operative young person is, the less likely it is that a health care provider would be prepared to treat the young person over his or her refusal. The position may be different for very serious conditions.

In the Discussion Paper the Commission sought comment on:⁸⁷⁰

- (i) Whether a health care provider should be able to treat a legally competent young person (under 16 years of age) upon the consent of the young person's parents but over the refusal of the young person;⁸⁷¹ and
- (ii) Whether a young person (under 16 years of age) should be entitled to refuse any treatment provided he or she understands the consequences of the refusal.⁸⁷²

Neither the submissions received by the Commission in response to the Discussion Paper nor the consultation meetings held after the release of the Discussion Paper highlighted any particular problems experienced by young people, parents or health care providers with respect to refusal of health care by young people. This may be as a result of a common sense and joint or multi-disciplinary approach adopted by all parties involved in very serious cases.

Most respondents who commented on this issue were in favour of a young person's refusal being overridden by the consent of his or her parents or the court, at least in situations where a lack of health care would seriously affect the health and well-being

⁸⁷⁰ Discussion Paper at 189.

⁸⁷¹ *Id* at 11 and 204 (Recommendation 8).

⁸⁷² *Id* at 12 and 205 (Recommendation 11).

of the young person. Some respondents, however, were in favour of an unconditional ability in competent young people to refuse any health care. For example, an organisation providing counselling and other services to young people said:⁸⁷³

The principle for being able to give consent can equally apply to refusing consent. If a young person does understand the nature of a procedure and the consequences of it not being performed they should be able to refuse. If not the procedure should be undertaken [after] consultation [with] other workers in the same field. Every effort should be made to assist the young person to gain such an understanding.

Similarly, the Department of Family and Community Services (now the Department of Families, Youth and Community Care) noted:⁸⁷⁴

The use of a competency test for young persons aged 13 to 15 - as an alternative to the use of a fixed age presumption test for capacity to refuse treatment would enable the wishes of those competent young persons to prevail.

A religious organisation was concerned about the adverse effects on a young person of not respecting his or her decision to refuse proposed health care.⁸⁷⁵

[We] recommend that whilst parents should have the concurrent ability to consent to treatment, that such consent should be of no effect if a competent child expressly refuses treatment, knowing and understanding the consequence of such refusal. We take this point of view having regard to the inherent inability to measure the psychological harm that might be done to someone by doing a procedure against their wishes.

Another respondent suggested:⁸⁷⁶

The right to refuse treatment must be unconditional. A person of any age, with any degree of "legal competence" and against the wishes of any other person, must be able to refuse any treatment.

Other respondents recognised benefits in respecting a competent young person's refusal of health care, but subject to limits - either by way of the seriousness of the young person's condition or the seriousness of failure to treat, or by way of an ability to have the young person's refusal overridden by a third party. For example, an Association interested in public policy was of the view:⁸⁷⁷

If the child refuses, and assuming a health care provider can be found who is willing to deliver treatment by force, it should be up to an independent tribunal or court to decide

⁸⁷³ Submission 8.

⁸⁷⁴ Submission 79.

⁸⁷⁵ Submission 30.

⁸⁷⁶ Submission 33.

⁸⁷⁷ Submission 3.

whether treatment is permitted. The criterion should not be “whether treatment would be in the best interests of the child” but “whether a reasonable person would consider treatment necessary to ensure survival or the avoidance of long term disability.”

A religious organisation noted:⁸⁷⁸

[A] parent or substitute decision maker should be able to obtain the authorisation of the Supreme Court or Family Court to have treatment provided over the refusal of a young person 15 or younger.

Queensland Health recommended caution against a concept that the capacity to refuse health care coexists with the capacity to consent.⁸⁷⁹ It suggested that young people aged 13 to 15 should only be able to refuse health care if they understand the consequences of refusal and “if a competent parent/guardian is not available and treatment is not urgent”.

Other respondents did not believe that young people under the age of 16 were capable of comprehending the consequences of refusal. A paediatrician observed:⁸⁸⁰

Although I think it is reasonable for children of this age to agree to treatment, as obviously the treatment recommended would be done in good faith for the welfare of the child, I do not feel children of this age have sufficient cognitive development to understand the implications of refusing treatment. This particularly applies where the refusal would cause long term problems with their health.

An organisation involved with people with disabilities observed:⁸⁸¹

Bearing in mind that we also believe an objective test should apply to the [health care] provider's opinion about whether the treatment is in their patient's best interests, we favour competent parents having the right to override their child's refusal. If the treatment actually is in the young person's best interests, it seems reasonable that the consent of a competent adult parent should override the refusal of a 13-15 year old.

A hospital ethicist considered the situation where a young person's experience with illness should perhaps have an impact on the effectiveness of the young person's refusal to undergo health care for the illness:⁸⁸²

[T]here are great risks involved in allowing eg a 13 year old to refuse necessary treatment. The risks may be too great. If a health care provider is dealing with a 13 year old with chronic disease, whose experience with the disease gives an increased competence, such

⁸⁷⁸ Submission 27.

⁸⁷⁹ Submission 62.

⁸⁸⁰ Submission 5.

⁸⁸¹ Submission 63.

⁸⁸² Submission 34.

a refusal may be considered as acceptable. There must be very serious deliberation by the health care provider when dealing with such refusals.

Although the Commission recognises the importance of a person's bodily integrity (regardless of age or maturity) and the growing autonomy of a young person as he or she develops and matures, the Commission is reluctant to recommend a legislated right for a young person under 16 years of age to refuse health care that is in his or her best interests, regardless of whether the young person is mature enough to understand the consequences of refusal.

The Commission's primary focus in this project has been that the law in Queensland should not be an impediment to young people's access to appropriate health care.⁸⁸³ Under this approach, a competent young person should, in appropriate circumstances, be able to provide a valid consent to health care, but not necessarily have a right to refuse health care.

4. OBJECTION TO HEALTH CARE

In Chapter 10 of this Report, the Commission recommended that a young person under 12 years of age should be able to object to certain prescribed types of health care, even though the young person should have no right to refuse health care in general. The effect of such an objection would be to make ineffective any consent given by a parent to one of the prescribed types of health care.

The Commission's concern was that in relation to certain types of health care, the very fact of an objection to the health care by the young person raises a serious doubt as to whether the health care is in the best interests of the health and well-being of the young person. For that reason, the Commission recommended that if a young person objected to that type of health care, only a court could authorise it.

For the same reasons the Commission is of the view that, although a young person between 12 and 15 years of age should not be regarded as competent to refuse health care generally, a young person of this age should nevertheless be able to object to a termination of pregnancy⁸⁸⁴ and contraceptive health care.⁸⁸⁵ The effect of an objection will be to make invalid any consent given by a parent to either of those types of health care.

⁸⁸³ See Preface at (i) above.

⁸⁸⁴ The Commission has defined "termination of pregnancy" to exclude a procedure primarily to treat organic malfunction or disease of the young person. Note the discussion at 236-237 of this Report of the significance of excluding the "medically necessary" termination from this definition.

⁸⁸⁵ The Commission has defined "contraceptive health care" to mean health care of a young person that is primarily intended to prevent pregnancy but does not include sterilisation or termination of pregnancy. See 243 of this Report.

As recommended in Chapter 10, any further types of health care to which a young person's objection should override parental consent should be identified by Queensland Health jointly with the Department of Families, Youth and Community Care.⁸⁸⁶

5. OTHER POSSIBLE REQUIREMENTS FOR AUTHORISATION OF HEALTH CARE

In addition to authorising health care to be carried out on a competent young person on his or her consent, or that of a parent, a number of requirements might be relevant to the authorisation of health care on young people in this age group. These requirements, some of which were the subject of preliminary recommendations in the Discussion Paper, are discussed below.

(a) Health care is in the best interests of the young person's health and well-being

In the Discussion Paper⁸⁸⁷ the Commission made the preliminary recommendation that where a registered health care provider treated a young person who was 15 years of age or younger, the treatment had to be, in the health care provider's opinion, in the best interests of the young person.

That recommendation was similar to the provision found in section 12 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA). Before a medical practitioner or dentist in South Australia can rely upon a young person's consent to treatment, the doctor or dentist must be of the opinion that the proposed treatment is in the "best interest of the child's health and well-being". Because the health care provider's opinion relates to the young person's "well-being" as well as "health", presumably the health care provider can take into account lifestyle and emotional factors to determine if the proposed treatment is in the young person's best interests. Medical practitioners and dentists would not be able to provide treatment which they did not believe to be in the best interests of both the health and well-being of the young person. Some health care may involve the well-being of a person but not his or her health - for example, some cosmetic surgery.

At common law, a valid consent cannot be given for health care that is not in the best interests of a young person.⁸⁸⁸ If it is subsequently determined by a court that the

⁸⁸⁶ See 236-237 of this Report and, in particular, note 823.

⁸⁸⁷ Discussion Paper at 10 and 203 (Recommendation 4).

⁸⁸⁸ See 90-91 of this Report.

health care was not, at the time it was carried out, in the best interests of the young person, then the health care provider could be liable for assault or battery of the young person on the basis that the young person's consent was not a valid one.

In the Commission's view, the requirement that health care be in the best interests of the health and well-being of a young person under the age of 16 provides an important protection for young people.

The Commission is, therefore, of the view that the proposed health care must be in the best interests of the health and well-being of the young person.⁸⁸⁹

This requirement should apply regardless of whether the health care is consented to by a competent young person or by a parent of the young person.

(b) A second opinion

Under the South Australian legislation, a medical practitioner or dentist may treat a young person if, in addition to the young person's consent, the medical practitioner or dentist is of the opinion that the "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 that opinion is supported by the written opinion of at least one other medical practitioner or dentist who personally examines the child before the treatment is commenced.⁸⁹⁰

Unless a second opinion supports the original opinion as to capacity, the medical practitioner or dentist may not treat a young person upon the young person's consent.

One submission to the Commission supported the concept of a second opinion, albeit only in circumstances where there was a doubt about the young person's maturity:⁸⁹¹

Clearly, there will be cases in which the young person's cognitive maturity and comprehension, and thus legal right to consent, will be in doubt. In such cases, it would be beyond the expertise of most practitioners to make a judgement about the legal competence of the young person.

In these cases, it is recommended that there should be an onus on the practitioner to seek a second opinion and that opinion should be from a professional who is trained to formally assess the cognitive maturity of young people using objective and standardised tests, viz a clinical and/or developmental psychologist. [original emphasis]

⁸⁸⁹ The health care provider will also be protected if he or she has an honest and reasonable, but mistaken, belief that the health care is in the young person's best interests. See 214-218 and 220 of this Report.

⁸⁹⁰ *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s12. This provision is set out in Appendix 6 to this Report.

⁸⁹¹ Submission 58.

This proposal, by an organisation of psychologists, would be highly impractical in Queensland. It would require appropriately qualified people to be available in population centres throughout the State to deal with health care decisions ranging from treatment for the common cold to treatment for more serious conditions.

The Commission is not convinced that a requirement of a second opinion is warranted. It should be unnecessary to require a second opinion in many circumstances, particularly in relation to relatively minor treatments. More importantly, it would be impracticable in circumstances where there is no other appropriate health care provider readily available.⁸⁹² The qualification that the health care provider's opinion must be supported by the opinion of a second health care provider who has personally examined the young person may be a significant limitation on the ability of health care providers to treat young people, particularly in rural or remote areas of the State. In rural and isolated areas of Queensland there is often only one medical practitioner or other health care provider covering a large geographical area. Young people must not be prevented from receiving health care because of the health care provider's inability to obtain a second opinion.

At common law, a *Gillick* competent young person can be treated simply on the basis of his or her consent. There is no requirement for a second opinion as to the young person's competence.

The Commission therefore rejects the proposal that a health care provider should be able to treat a young person only in circumstances where there is a second opinion as to the young person's competency.

(c) Health care is in accordance with proper professional standards

As discussed in Chapter 10,⁸⁹³ a medical practitioner or dentist in South Australia is protected from liability for carrying out health care on a patient only if, among other things, the health care is "in accordance with proper professional standards of medical practice".⁸⁹⁴

For the reasons outlined in Chapter 10, the Commission is of the view that it is more appropriate to leave the question of the standard of the health care provided to the law of negligence.

⁸⁹² Submission 12.

⁸⁹³ At 239-240 of this Report.

⁸⁹⁴ *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* s12.

(d) Mandatory provision of information to the young person

In the Discussion Paper, the Commission sought submissions on its preliminary recommendation that before a young person is able to give a valid consent to treatment, the young person must be provided with relevant information on the advantages and disadvantages of the proposed treatment.⁸⁹⁵ This recommendation was based on a provision in the South Australian legislation.

Under section 15 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) a medical practitioner or dentist 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.

It seems that a young person does not actually have to understand the information provided but, as section 12 of the Act provides, he or she must be *capable* of understanding the nature, consequences and risks of the treatment.⁸⁹⁶ Reading these two sections together, it seems that, if a young person is not adequately informed of the nature, consequences and risks of proposed treatment, he or she may not be able to give a valid consent to the treatment.

One submission to the Discussion Paper expressed concern as to how a health care provider is to determine a young person's level of understanding:⁸⁹⁷

How is an impartial description of the nature and consequences of the treatment to be obtained, given the tendency of any professional to present his/her service and expertise in a favourable light? It must be remembered that health professionals offer their services for sale and are not, therefore, impartial to whether or not the client consents to treatment. Many adults feel pressured to accept the advice of a medical 'expert' but adults have the advantage of having some experience in dealing with this facet of the professional relationship as well as some knowledge of how to seek redress when necessary. People under the age of 16 generally have much experience of being powerless in relation to adults and little experience of making independent decisions. There is a very real danger that the young person may accept the opinion of a well-educated, experienced, professional adult as true for reasons not based on the merits of the actual advice. There is every likelihood, too, that the young person will, at best, feel awkward about rejecting the advice of the professional and in all probability be unable to do so due to feelings of personal powerlessness and to inexperience. The perception that power in the

⁸⁹⁵ Discussion Paper at 10-11 and 203-204 (Recommendations 5(b) and 7(b)).

⁸⁹⁶ *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s12 is set out in Appendix 6 to this Report.

⁸⁹⁷ Submission 33.

professional relationship lies very much with the professional is undoubtedly very common among young people but may, perhaps, be more pronounced in the very group identified as needing assistance to access medical care, namely the young homeless and those in state care. These young people may have had feelings of personal power eroded through abusive relationships. Since personal empowerment is such an important component of general well-being in any individual it must be made a priority that young people not suffer the disempowering aspects of the medical relationship that often result, however well-intentioned the professional. A paternalistic approach is, then, inappropriate when dealing with young people who have a particular and identifiable need for positive, empowering experiences of self-determination.

For these reasons the explanation of treatment and the seeking of consent to treatment should be considered two separate issues, to take place independently. Once the nature and consequences of a treatment have been explained, consent or refusal should be established in private by a third party who is free of vested interest in the decision of the young person. This process would offer the young person at least some degree of protection from pressure to consent.

This proposal could very well delay needed health care. It may be very difficult to locate an independent third person who is free of any vested interest in the young person's decision. If it is obvious that a young person needs health care, most concerned "third parties" would probably try to convince the young person to consent to the health care. Further, in many cases it is likely that a young person would not want a third party involved in the decision-making process. If that were a requirement of the law, then it could very well deter some young people from seeking or proceeding with health care they require.

The Commission's primary concern has been to ensure that the law does not hinder a young person's access to the health care that he or she requires. A requirement that a third party be involved in a health care decision by an apparently competent young person, where the proposed health care is in the young person's best interests, would appear to be just such a hindrance.⁸⁹⁸

Generally, if a health care provider has any doubts about the ability of a young person to understand the nature and consequences of proposed health care, he or she cannot carry out the health care simply upon the consent of the young person, under either the existing law or the Commission's proposed scheme, without risking liability. The exceptions to this general rule are emergency health care (both under the current law and under the Commission's proposed scheme), minor health care (under the Commission's proposed scheme), and health care that is required without delay (under the Commission's proposed scheme).⁸⁹⁹

In order for a young person to be able to understand the nature and consequences of

⁸⁹⁸ This is a concern that the Commission has with the South Australian legislation, which provides for a medical practitioner's or dentist's opinion as to the competency of his or her young patient to be verified by the opinion of another medical practitioner or dentist. See *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* s12.

⁸⁹⁹ See Ch 13 of this Report for the recommendations in relation to health care for which consent should not be a requirement.

proposed health care, he or she would usually have to be provided with relevant information. The type and amount of relevant information will vary according to the circumstances. The provision of information or the absence of it may be particularly relevant to the question whether a health care provider has fulfilled the duty of care which he or she owes to a young person.⁹⁰⁰ The Commission recognises that it would be “best practice” for a health care provider to provide such information. However, a health care provider’s liability in negligence is beyond the Commission’s terms of reference.

The Commission is of the view that the proposed scheme should not specifically require a health care provider to provide specific information to a young person as a prerequisite to the validity of the young person’s consent.

(e) Completion of a written consent form

In the Discussion Paper, the Commission sought submissions on its preliminary recommendation that a young person must sign a “consent to treatment” form before a health care provider can treat the young person.⁹⁰¹

Respondents who commented on this issue were unanimous in their rejection of such a requirement.⁹⁰² Some argued that it would make health care less accessible because it assumes that a young person would have the capacity to read,⁹⁰³ and it could create suspicions as to the protection of the anonymity of a young person seeking health care.⁹⁰⁴ Medical practitioners responded that it would be quite impractical in a busy practice to obtain written consents from all young people, and queried why a written consent should be required for young people if it is not currently required for adults.⁹⁰⁵

⁹⁰⁰ See the discussion of *Rogers v Whitaker* (1992) 175 CLR 479 at 240 of this Report.

⁹⁰¹ Discussion Paper at 10-11 and 204 (Recommendations 5(c) and 7(c)).

⁹⁰² Submissions 1, 5, 7, 35 and 79.

⁹⁰³ Submission 79.

⁹⁰⁴ Submission 35.

⁹⁰⁵ Submissions 1 and 5.

At the consultation meetings held by the Commission written consent forms were also criticised. It was agreed that it would be impractical to obtain a written consent in a clinical setting,⁹⁰⁶ and it was suggested that it would be more appropriate for doctors to make notes at the time consent was sought than for a young person to sign a consent form.⁹⁰⁷

In light of these criticisms, the Commission is persuaded that, although written "consent to treatment" forms may help to ensure that health care providers obtain more than a perfunctory consent, they are not practical and may in fact make health care less accessible for young people.

⁹⁰⁶ Consultation meetings 2 and 22.

⁹⁰⁷ Consultation meeting 13.

6. THE COMMISSION'S RECOMMENDATIONS

The Commission makes the following recommendations with respect to the health care of a young person between 12 and 15 years of age:

- (a) Subject to the recommendation in paragraph (b) below, a valid consent to health care can be given by:
- (i) a parent of the young person;⁹⁰⁸ or
 - (ii) the young person, if the young person is competent, that is, if the young person understands the nature and consequences of the health care.⁹⁰⁹
- (b) A young person between 12 and 15 years of age should not be able to provide a valid consent to a sterilisation.⁹¹⁰ The sterilisation of the young person can only be carried out with court approval.

“Sterilisation”, for the purposes of the proposed legislative scheme, means health care performed on a young person (other than a procedure to treat organic malfunction or disease) that -

- (i) if the young person is not yet, or is reasonably likely to not yet be, fertile - is intended, or reasonably likely, to prevent the young person ever becoming, or ensure the young person does not ever become, fertile; or
- (ii) if the young person is, or is reasonably likely to be, fertile - is intended, or reasonably likely, to make the young person, or the ensure the young person is, permanently infertile.⁹¹¹

⁹⁰⁸ See the broad definition of “parent” recommended by the Commission in Ch 15 of this Report.

⁹⁰⁹ See the discussion of competency at 198-201 of this Report.

⁹¹⁰ Note also that the Commission has recommended at 165 of this Report that the common law limitations on a parent’s power to consent should be preserved. At common law, a parent is unable to provide a valid consent for the non-therapeutic sterilisation of his or her child. See the discussion at 59-61 and 92-93 of this Report.

⁹¹¹ This definition is derived from the definition of “sterilisation” in the Queensland Law Reform Commission’s Report, *Assisted and Substituted Decisions* (R49, June 1996) Vol 2, *Assisted and Substituted Decision Making Bill* cl 14, Sch 1.

(c) A parent may refuse health care of a young person between 12 and 15 years of age, but a refusal of health care by a parent should not make ineffective a valid consent to health care given by:

- (i) the young person; or**
- (ii) another parent.**

As long as a health care provider has one valid consent to the health care, he or she can lawfully carry out health care on a young person, regardless of a refusal by a parent.

(d) Subject to the recommendation in paragraph (e) below, a young person between 12 and 15 years of age should not be able to refuse health care.

(e) Although the refusal of health care by a young person should not generally make ineffective a consent to the health care given by a parent, there should be a statutory list of health care that cannot be carried out over the objection of a young person between 12 and 15 years of age.

If the young person objects to the health care, the consent of a parent will be ineffective unless:

- (i) the health care is carried out pursuant to an appropriate court order; or**
- (ii) the young person has minimal or no understanding of one or both of the following:**

- what the health care involves; or**
- why the health care is required;**

and the proposed health care is likely to cause the young person:

- no distress; or**
- temporary distress that is outweighed by the benefit to the young person.**

The statutory list of health care that should not be carried out over the objection of a young person should be devised and updated jointly by Queensland Health and the Department of Families, Youth and Community Care.⁹¹² Initially, the list should include:

⁹¹² See note 823 of this Report.

- termination of pregnancy;⁹¹³ and
- contraceptive health care.⁹¹⁴

(f) A health care provider may carry out health care of a young person between 12 and 15 years of age if:

(i) either

- A.
- the young person consents to the health care;
 - the young person understands the nature and consequences of the health care; and
 - the health care is of a kind to which the young person can provide a valid consent (that is, the health care is not in the nature of a sterilisation, as defined, of the young person);⁹¹⁵

or

- B.
- a parent of the young person consents to the health care; and
 - if the health care is of a kind to which the young person can object, the young person does not object to the health care;

and

(ii) the health care is in the best interests of the health and well-being of the young person.

These recommendations are reflected in clause 30 of the draft legislation in Chapter 17 of this Report.

⁹¹³ The Commission has defined "termination of pregnancy" as follows:
"Termination" of a pregnancy does not include a procedure performed primarily to treat organic malfunction or disease of the young person.

⁹¹⁴ The Commission has defined "contraceptive health care" as follows:
"Contraceptive health care" means health care of a young person that is primarily intended to prevent pregnancy, but does not include sterilisation or termination of pregnancy.

⁹¹⁵ Note that in recommendation (b) a young person will not be able to provide a valid consent to a sterilisation procedure.

CHAPTER 12

AUTHORISATION OF HEALTH CARE BY COMPETENCY AND AGE OF YOUNG PERSON: 16 AND 17 YEARS OF AGE

1. AUTHORISATION OF HEALTH CARE

Queensland legislation provides that at 18 years of age people attain full legal capacity.⁹¹⁶ People under 18 years of age attain particular adult-type rights and responsibilities at various ages (for example, the legal capacity to enter into full-time employment; to drive a motor vehicle; to leave full-time education; to engage in lawful sexual activity). There is, however, no fixed age in Queensland at which a young person attains any particular rights or responsibilities with respect to his or her own health care.

A number of jurisdictions have attempted to address the problems experienced by older adolescents in obtaining health care⁹¹⁷ by simply setting an age lower than 18 years at which a young person is to be treated as an adult for the purposes of making health care decisions - be it consenting to, or refusing, health care.⁹¹⁸ Most relevant statutory schemes reviewed by the Commission have set that age at 16, and have provided for young people under 16 years of age to consent to (but not refuse) health care in certain circumstances.

In the Discussion Paper⁹¹⁹ the Commission made the following preliminary recommendation:⁹²⁰

At 16 years of age a young person can consent to or refuse treatment as if an adult ...

From the submissions received by the Commission in response to both the Information Paper⁹²¹ and the Discussion Paper, and from discussions at the consultation meetings following release of the Discussion Paper, it would appear that many health care providers and others interested in the health care of young people have simply

⁹¹⁶ *Law Reform Act 1995* (Qld) s17.

⁹¹⁷ These problems are described in Ch 6 of this Report.

⁹¹⁸ See, for example, *Guardianship Act 1968* (NZ) s25, which is discussed at 184-187 of this Report.

⁹¹⁹ Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995).

⁹²⁰ *Id* at 10 and 203 (Recommendation 2).

⁹²¹ Queensland Law Reform Commission, Information Paper *Consent by Young People to Medical Treatment* (MP2, May 1993).

assumed that by about 16 years of age, young people are adults for the purposes of consenting to their own health care. This belief may be as a result of what a 16 year old young person can already lawfully do at that age. But, it may also be as a result of a general acknowledgment that maturity comes to most young people with late adolescence, and that these young people have the ability to do certain things that younger people are less competent to do.

An association interested in public policy commented:⁹²²

We accept that a 16 year old person should be able to consent to treatment recommended by a registered practitioner.

That association did, however, qualify its view:

In our view, the Commission's preliminary recommendation is rational only if the Commission believes the age of majority should be reduced to 16.

Detailed consideration of the possibility of reducing the age of majority generally is beyond the Commission's terms of reference. Nevertheless, the existing law does enable young people who are 16 years of age and people of other specified ages below the current age of majority to do certain things that younger people do not have legal capacity to do.

A dentist noted:⁹²³

Many young people are at work by age 16 years and have reached a stage of decision making that would allow them to consent to or refuse medical treatment.

A medical practitioner considered that:⁹²⁴

[T]he 16 year cut-off point is the youngest one should go when allowing young people an absolute power to consent to treatment, except where it is an emergency. Sixteen is younger than people, in Queensland at any rate, can legally drive a car, obtain or drink alcohol at a public place, vote or get cigarettes sold to them. Some of this is for practical rather than ideal reasons, but all are 'milestones' of adulthood.

Since other health decisions may be no less serious than whether to drink or smoke, I feel this is a reasonable lower limit. In practice, many young people already have some freedom in this area.

922 Submission 3.

923 Submission 12.

924 Submission 26.

The younger the person, the more likely it is that he or she will be dependent on his or her parents in matters of 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.

However, at 16, young people may be relatively independent in their decision-making processes (even if not economically independent) and may be in need of health care which, if not provided, could have a detrimental effect on their health and well-being.

This is not to say that at 16, all people have the ability to comprehend fully proposed health care. As an organisation of psychologists noted:⁹²⁵

Contrary to implications at various points in the body of the Discussion Paper, the age of 16 years is not in itself a guarantee of having reached the cognitive maturity of an average adult.

Then again, there may be just as many legally competent adults who are equally as uncertain about health care decisions. Although there is no one age at which all people become mature, intelligent, rational beings, there are nevertheless stages when most people have a greater understanding of matters that affect them. Late adolescence seems to be one of those stages.

There may, of course, be occasions when young people will need health care 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 reluctant or unwilling to treat such young people in the absence of parental consent, then it is imperative that the law be reformed.

The Commission remains of the view that, subject to the matters discussed below, a cut off point of 16 years is appropriate in relation to giving young people exclusive legal capacity to make decisions about their own health care, including the right to refuse health care.

(a) The appropriate competency test

The Commission has considered the most appropriate competency test to apply to 16 and 17 year old young people.

In the Discussion Paper⁹²⁶ the Commission proposed that a young person at that age be dealt with as if he or she were an adult. An adult is competent to consent to health care if he or she has a broad understanding of the proposed health care.

⁹²⁵ Submission 58.

⁹²⁶ Discussion Paper at 10 and 203 (Recommendation 2).

The adult competency test is a significantly simpler test to satisfy than the *Gillick* test, which is the current law in Queensland for determining the competency of a young person. A young person is *Gillick* competent, that is, competent to consent to his or her own health care, only if he or she is intelligent and mature enough to be able to understand the nature and consequences of the proposed health care.

The adult competency test is also simpler than the Commission's proposed young person competency test, which is whether the young person understands the nature and consequences of the health care.⁹²⁷

The result of the proposal in the Discussion Paper would have been that there were two different competency tests for young people under 18 years of age. The adult competency test would have applied to young people who were 16 or 17, while the Commission's proposed young person competency test would have applied to young people who were under 16 years of age.

The Commission has been concerned that having two different tests of competency for people under the age of 18 may be confusing for health care providers. It may in fact have the opposite effect to that desired by the Commission - which is to remove unnecessary legal impediments to young people's access to appropriate health care. If a health care provider is unsure which test applies, or is not confident about the differences between the two tests, it is possible that he or she would be hesitant to treat at all through fear of liability.

The Commission also believes that the simpler its proposed legislative scheme is, the more likely it is to be complied with. A significant simplification of the scheme proposed in the Discussion Paper would be the adoption of a single competency test for all young people.

Obviously, it would not be appropriate to lower the age for the application of the adult competency test to 12 years. The alternative approach would be to apply to all young people the proposed young person competency test - that is, that the young person understands the nature and consequences of the health care.⁹²⁸

This approach has a number of advantages. Once a young person has that level of competency in relation to particular health care, then he or she should be able to provide a valid consent for the health care.⁹²⁹ Understanding the consequences of health care is a significant aspect of health care decision-making, perhaps even more so for a young person who may not have had the life experience necessary to

⁹²⁷ See 201 of this Report.

⁹²⁸ This competency test is not significantly different from the *Gillick* test, which currently applies to all young people under 18 years of age.

⁹²⁹ The young person must, however, be at least 12 years of age. See Ch 11 of this Report.

comprehend the long term or serious consequences of choosing one form of health care over another. For adults it could perhaps be assumed that they would have a greater understanding of the consequences of proposed health care, or at least the initiative to make relevant enquiries.

The Commission also believes that its competency test for young people would provide extra protection to 16 and 17 year old young people in relation to refusal of health care. Under the scheme as proposed in the Discussion Paper, a 16 year old young person with adult competency would be entitled to refuse health care if he or she had a broad understanding of the nature of the health care being rejected. The young person would not be required to understand the consequences of the refusal. Under the young person competency test now proposed by the Commission, a 16 or 17 year old young person would have to understand the consequences of refusal before being competent to provide an effective refusal.⁹³⁰

The Commission is therefore of the view that its proposed young person competency test should apply to all young people under the age of 18 years.

(b) Competent 16 or 17 year old young person

Although the Commission has now recommended that a 16 or 17 year old young person should have to satisfy the more stringent young person competency test, if competent, the young person's decision-making powers will still include the significant indicia of adulthood in relation to health care decision-making.⁹³¹

- (i) only the young person will be able to provide a valid consent to his or her own health care;⁹³²
- (ii) the young person will be able to provide a valid consent to health care which is not necessarily in the best interests of his or her health and well-being.⁹³³

⁹³⁰ See 274-276 and 282 of this Report for a discussion of the Commission's proposals in relation to refusal of health care by 16 and 17 year olds.

⁹³¹ For further discussion on these matters see 268, 274-276 and 281 of this Report.

⁹³² Compare this with the Commission's recommendation for young people under 12 years of age, where only a parent will be able to provide a valid consent, and with the Commission's recommendation for young people between 12 and 15 years of age, where either a parent or the young person is able to provide a valid consent.

⁹³³ Compare this with the Commission's recommendations for young people under 12 years of age, and for young people between 12 and 15 years of age, where a health care provider will not be able to treat a young person unless the health care is in the best interests of the young person's health and well-being.

(iii) the young person will be able to refuse health care.⁹³⁴

(c) Non-competent 16 or 17 year old young person

The Commission has considered the situation of a young person of 16 or 17 years of age who is not competent according to the young person competency test. This may be due to an intellectual or mental disability, or it may be because of an inability to comprehend the nature and consequences of the proposed health care.

In the Discussion Paper, the Commission proposed that the Assisted and Substituted Decisions legislation (which it was considering in a reference on adults with decision-making disabilities)⁹³⁵ and the jurisdiction of the tribunal to be established thereunder be extended to cover 16 and 17 year old young people who were not legally competent to provide a valid consent to their own health care.⁹³⁶

Under the Commission's proposed scheme for assisted and substituted decision-making for adults, a number of people would be statutorily authorised decision-makers for the person with the decision-making disability, namely, the spouse, parents, adult son or daughter or close friend.⁹³⁷ Those people would be able to provide a valid consent for health care of the person, other than special consent health care which would require the consent of the proposed tribunal (for example, tissue donation, sterilisation and termination of pregnancy). The tribunal would also have the power to appoint someone to make health care decisions for the person with the decision-making disability. Any health care decision made under that scheme would have to comply with the "health care principle".⁹³⁸

934 Compare this with the Commission's recommendations for young people under 12 years of age, where only parents are able to refuse health care for their child, and for young people between 12 and 15 years of age where a young person's refusal can be overridden by a valid consent by a parent.

935 See Queensland Law Reform Commission, Report *Assisted and Substituted Decisions* (R49, June 1996).

936 Discussion Paper at 10 and 203 (Recommendation 3).

937 Queensland Law Reform Commission, Report *Assisted and Substituted Decisions* (R49, June 1996) at 332-341 and cl 155 of the draft legislation in Vol 2 of the Report.

938 Clause 144 of the draft legislation Vol 2 of the Report provided:

Health care principle

- 144.(1) A health care or special consent health care decision for an adult should be made only if the decision is appropriate to promote and maintain the adult's health and well-being. This principle is the "health care principle".
- (2) In deciding whether a decision is appropriate, the tribunal or relevant person must, to the greatest extent practicable -
- (a) seek the adult's views and wishes and take them into account; and
 - (b) take the information given by the adult's health care provider to the person or tribunal into account.
- (3) Views and wishes may be expressed orally, in writing or in another way, including, for example, by conduct.

Under the Commission's proposal in the Discussion Paper, in the ordinary course of events the parents of a young person with a decision-making disability would, upon the young person turning 16, continue to be able to make the health care decisions that they had previously made for their child, albeit as statutorily authorised decision-makers.

The respondents who commented on the Commission's preliminary recommendation that health care decisions for 16 and 17 year old young people be regulated by the proposed Assisted and Substituted Decisions scheme agreed with the Commission's proposal.⁹³⁹

One of those respondents,⁹⁴⁰ however, went further than the Commission's preliminary recommendation and suggested that the age jurisdiction of the proposed tribunal should be lowered to 16 years generally, and not just for health care decisions. This respondent argued that the proposal created a discrepancy between different substitute decision-making mechanisms depending on the nature of the decision:⁹⁴¹

For medical consents a new legislated mechanism would apply; for other decisions the common law or *Family Law Act* and *parens patriae* jurisdiction of the Supreme Court would continue to apply. While for many young people the difference would have little practical impact, it is not difficult to imagine a situation where this discrepancy could cause confusion, and prejudice a young person's interests.

For example, medical advice is that a young man with severe multiple disability aged 16 years requires orthopaedic surgery to his legs. Delays in public hospital waiting lists, scarcity of specialists who can perform the surgery, and the need for comprehensive post-operative therapy all point to the need for private hospital admission.

However, the young person's parents are in disagreement about the benefits of the surgery, and one applies to the proposed Tribunal for resolution of the dispute. The Tribunal favours the mother. The father, who opposes the surgery because he fears the risk of an anaesthetic, is the sole signatory of a bank account in his son's name which was set-up with money given to his son by his recently deceased grandmother, the father's mother. The father refuses to pay the costs of the operation. The mother has no private medical insurance and is unable to afford the surgery. The Tribunal has no jurisdiction over financial management until the young man turns 18, and thus cannot appoint a financial manager to override the father's control.

It was to avoid this type of situation that the respondent suggested that the proposed tribunal's jurisdiction should be reduced to 16 generally, rather than just for health care decisions. The respondent also suggested another possible way to avoid this situation, although one it regarded as less satisfactory:

⁹³⁹ Submissions 2 (an organisation representing people with disabilities and their families), 3 (an organisation with an interest in public policy), 58 (an organisation representing psychologists), 60 (a community mental health centre), 62 (Queensland Health) and 63 (an advocacy organisation representing people with disabilities).

⁹⁴⁰ Submission 63.

⁹⁴¹ *Ibid.*

The Tribunal could be given a limited jurisdiction to intervene in decision-making areas other than medical consents for people between 16 and 18 years, but only where it was necessary to give practical effect to the Tribunal's powers relating to medical consents.

The Commission acknowledges the validity of the respondent's concerns. In the view of the Commission, however, it is beyond the terms of this reference to make recommendations with respect to decision-making by and for young people in areas other than health care.

Despite the general support for the Commission's recommendations in the Discussion Paper relating to 16 and 17 year old young people who are not legally competent to make their own health care decisions, the Commission now considers that it would be inappropriate for the proposed Assisted and Substituted Decisions legislation to apply to young people of that age group.

The Commission believes that most parents of a young person who is unable to understand the nature and consequences of proposed health care, whether as a result of a decision-making disability or otherwise, are the best advocates and decision-makers for their child.

Furthermore, the Commission perceives a legitimate community expectation that parents should be able to make all significant decisions, including medical, lifestyle and financial decisions, on behalf of children who are unable through intellectual or mental disability or who are otherwise not competent to make such decisions, until those children attain adulthood. The only current limits on the capacity of a parent to consent to health care for such children are limits which apply generally to parents of all children: that is, they are unable to consent to serious, non-therapeutic procedures, such as sterilisation, without court authorisation. Further, a valid consent cannot be provided for health care that is not in the best interests of the young person's health and well-being.⁹⁴²

If the only significant effect of bringing 16 and 17 year old young people who are unable to provide a valid consent to their own health care within the adult based Assisted and Substituted Decisions scheme is that parents will be statutorily authorised decision-makers for their children, then there is no practical reason for altering the existing law in that regard; parents are already able to provide a valid consent for the health care of those of their children who are not competent to consent to health care on their own behalf.

The Commission is of the view that if a young person of 16 or 17 years of age does not understand the nature and consequences of proposed health care, the young person's parents should continue to be able to provide a valid consent to the proposed health care.

⁹⁴² See 90-91 of this Report. Note, the Commission has recommended at 165 of this Report that the common law limitations on a parent's power to consent be preserved in the proposed legislative scheme.

2. REFUSAL OF HEALTH CARE BY A COMPETENT 16 OR 17 YEAR OLD YOUNG PERSON

In South Australia, a young person who is 16 or 17 years of age is able to consent to, or refuse, health care as if he or she were an adult.⁹⁴³ This is in contrast to the position in England and Wales where a young person at 16 years of age is able to consent to health care as if he or she were an adult,⁹⁴⁴ but only acquires a right to refuse health care on reaching 18.⁹⁴⁵

Most of the respondents to the Discussion Paper who commented on refusal of health care by young people were in favour of a young person at 16 years of age having the ability to provide an effective refusal of proposed health care, in the same way that an adult is able to refuse health care.⁹⁴⁶

Only one of the respondents who supported the right of 16 and 17 year old young people to refuse health care qualified that support by suggesting that it was not appropriate for such young people to be able to refuse life saving treatment.⁹⁴⁷

The Commission recognises that the issue of refusal of health care highlights important, but sometimes conflicting, considerations in relation to the health care of young people, and that it is an issue on which people's opinions may differ. On the one hand, there is the developing capacity for decision-making in the young person with respect to his or her own health care decisions; on the other hand, there is the desire to ensure that the young person receives health care which is in his or her best interests.

⁹⁴³ The *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s6 provides:

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.

See 169 of this Report for a discussion of this provision.

⁹⁴⁴ The *Family Law Reform Act 1969* (UK) s8 provides, in part:

(1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his [or her] person, shall be as effective as it would be if he [or she] were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his [or her] parent or guardian.

⁹⁴⁵ See 68-71 of this Report.

⁹⁴⁶ Submissions 16 (a regional hospital), 27 (a religious organisation), 33, 34 (a group of 4 public and private hospitals), 39 (a Parents and Friends Association), 60 (a medical officer from a community mental health centre), 62 (Queensland Health), 79 (Queensland Department of Family and Community Services - now called Department of Families, Youth and Community Care).

⁹⁴⁷ Submission 3.

This tension was observed by an organisation representing young people's legal interests.⁹⁴⁸

The difficulties that arise in relation to medical consent requirements for children and young people are the difficulties in striking a balance between the rights of the individual child or young person to bodily integrity and self-determination and the responsibility of parents and doctors to promote the child's health and welfare.

If a child has sufficient understanding and intelligence to make an informed decision the child should have the legal power to make that decision and the decision to refuse treatment should not be capable of being overridden by his/her parents.

The Commission agrees generally with the sentiments expressed in this submission.⁹⁴⁹ However, the Commission takes the view, with respect to the issue of refusal, that self-determination of the young person is a factor that carries considerably more weight the older the young person is.

It is for this reason that the Commission has considered the question of refusal separately for young people who are 16 and 17 years of age and for those under 16 years of age.

The Commission considers that, if a competent 16 or 17 year old young person is the only person who should be able to provide a valid consent to his or her own health care, the young person should also be able to provide an effective refusal of health care.⁹⁵⁰ This would recognise that a young person of that age has assumed many other legal responsibilities⁹⁵¹ and that, in any event, the young person is close to attaining the age of majority and assuming adult decision-making rights in all areas.

The conferral of the legal capacity on competent 16 and 17 year old young people to refuse health care, as well as to provide a valid consent in relation to health care, also provides a high degree of certainty for a health care provider who treats a young person in this age group. This certainty is presently lacking.

As noted above,⁹⁵² the Commission's recommendation of a higher test of competency for young people could protect them by requiring that they understand the

⁹⁴⁸ Submission 56.

⁹⁴⁹ The respondents did not confine their comments regarding refusal to young people who are 16 or 17 years of age, but suggested a general corollary between the capacity to consent to health care and the right to refuse health care.

⁹⁵⁰ The view is supported by a number of respondents to the Discussion Paper, for example, Submissions 34 (a hospital), 39 (a Parents and Friends Association), 62 (Queensland Health), and 79 (the Department of Family and Community Services, now the Department of Families, Youth and Community Care).

⁹⁵¹ See 266 of this Report.

⁹⁵² See 269-270 of this Report.

consequences of refusing health care. An adult is competent to refuse health care as long as he or she merely has a broad understanding of the health care proposed.

Obviously there will be very difficult cases where a young person's life may be in jeopardy if he or she refuses certain health care. This may occur, for example, when a young person has undergone one difficult course of treatment for cancer and refuses to undergo further treatment. Presumably in most cases a young person in such a situation will have the benefit of the support of family and friends, and will make his or her decision in the light of that support and in the light of medical advice. However, the Commission considers that, in the end, the wishes of a competent young person who is 16 or 17 years of age must be respected, in the same way that the wishes of a young person would have to be respected if he or she had already turned 18 years of age.⁹⁵³

Other situations may arise, however, where the conferral of a right to refuse health care might be regarded as being for the young person's benefit, for example, where parents want their 16 year old daughter to undergo a termination of pregnancy in the face of her desire to proceed with the pregnancy. Even if a medical practitioner could be found who would perform the procedure against the wishes of the young woman, the Commission considers that it would be totally inappropriate for this to happen.⁹⁵⁴

3. BLOOD TRANSFUSIONS

The Commission has considered the interaction between section 20 of the *Transplantation and Anatomy Act 1979 (Qld)*⁹⁵⁵ and any legislation conferring the capacity to refuse health care on a competent 16 or 17 year old young person.

Section 20 provides that a medical practitioner [or other prescribed person] 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 certain conditions are satisfied. As observed in Chapter 2 of this Report, the operation of the section is unclear in circumstances where it is a competent young person, rather than a parent, who refuses the transfusion.⁹⁵⁶ It is probably fair

⁹⁵³ The Commission also recognises that there would be considerable practical and physical difficulties in carrying out health care on a 16 or 17 year old young person who was resisting treatment.

⁹⁵⁴ See 171 of this Report where the possibility of this occurring legally under the present law is noted. It should also be noted that the apparent consent of a young person under pressure from a parent to undergo a termination of pregnancy may not amount to a real consent, that is, one that is given freely and willingly.

⁹⁵⁵ This section and a discussion of its effect is set out at 30-32 of this Report.

⁹⁵⁶ At 32 of this Report. While under English law the consent of a parent (over the refusal of a child) would be sufficient to authorise the treatment, it is not yet clear how that type of conflict will ultimately be resolved by the Australian courts. See the discussion of this issue at 72-74 of this Report.

to say, however, that when the provision was first introduced into the *Health Act 1937* (Qld) in 1959, it was not even contemplated that a young person might have a right to refuse health care, and that the provision has been understood by the medical profession to constitute an absolute right to administer a transfusion with impunity if the conditions set out in the provision are satisfied.

Most jurisdictions in Australia have a similar specific provision authorising the administration of a transfusion to a young person under the age of 18 years, despite the refusal by a parent.⁹⁵⁷

The exceptions are South Australia and New South Wales, which are the two jurisdictions that have enacted general legislation relating to consent to health care of young people.⁹⁵⁸ Those States have repealed their more specific provisions with respect to transfusions⁹⁵⁹ and have enacted legislation that deals generally with emergency treatment.⁹⁶⁰ In that way, the administration of transfusions is regulated as part of each jurisdiction's general scheme relating to consent to and refusal of health care.

In South Australia, where a young person who is 16 years of age or over can provide an effective refusal of health care, a medical practitioner cannot administer medical treatment to a patient 16 years of age or over, if he or she is aware that the patient has refused to consent to the treatment.⁹⁶¹ Accordingly, if a medical practitioner was aware that a 16 year old young person had previously refused a transfusion, the transfusion could not be lawfully administered under the legislation.

⁹⁵⁷ *Emergency Medical Operations Act 1973* (NT) s3; *Transplantation and Anatomy Act 1978* (ACT) s23; *Human Tissue Act 1982* (Vic) s24; *Human Tissue and Transplant Act 1982* (WA) s21; *Human Tissue Act 1985* (Tas) s21.

⁹⁵⁸ *Minors (Property and Contracts) Act 1970* (NSW); *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

⁹⁵⁹ In South Australia, s2 of the *Emergency Medical Treatment of Children Act 1960* defined "operation" to include "an operation of transfusion of human blood". S3 of that Act permitted the performance of an "operation" upon a child where his or her parents refused to consent to the operation if, among other specified conditions, two medical practitioners agreed that the operation was essential in order to save the child's life. The *Emergency Medical Treatment of Children Act 1960* (SA) was repealed by s3 of the *Consent to Medical and Dental Procedures Act 1985* (SA). In New South Wales, blood transfusions for young people were specifically dealt with in s39B of the *Public Health Act 1902* (between 1960 and 1984) and s49B of the *Medical Practitioners Act 1938* (between 1984 and 1989).

⁹⁶⁰ *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s13 applies where a person is incapable of consenting, 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 (which opinion is supported by a second opinion), and, if the patient is 16 or over, the patient has not refused consent to the treatment. This section is not limited by reference to the age of the patient. See 169-170 of this Report for a discussion of this section.

Children (Care and Protection) Act 1987 (NSW) s20A permits a registered medical practitioner or dentist to carry out medical or dental treatment on a child without the consent of the child or a parent or guardian if the medical practitioner or dentist is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child in order to save the child's life or to prevent serious damage to the child's health. This section applies to any child, that is, any person under the age of 18.

⁹⁶¹ *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s13(1)(c).

In New South Wales (where a young person under 18 years of age does not have a legislated capacity to provide an effective refusal of health care) health care, and hence a blood transfusion, can be administered to a young person under 18, despite the refusal of the young person or his or her parents, if it is necessary to save the young person's life or to prevent serious damage to his or her health.⁹⁶²

Both jurisdictions have, therefore, dealt with the question of refusal of a transfusion in a manner that is consistent with the age limits, if any, that they have set in relation to the refusal of health care generally.

The Commission is of the view that a competent 16 and 17 year old young person should be able to provide a valid consent to, or an effective refusal of, a blood transfusion, in the same way that, under the scheme, such a young person will be able to provide a valid consent to, or an effective refusal of, any other form of health care. Section 20 of the *Transplantation and Anatomy Act 1979* (Qld) will need to be amended to permit a competent 16 or 17 year old young person to refuse a blood transfusion.

However, for blood transfusions given with consent, the general provisions of the proposed legislative scheme will apply, depending on the competency and age of the young person.

4. OBJECTION TO HEALTH CARE BY A NON-COMPETENT 16 OR 17 YEAR OLD YOUNG PERSON

The recommendation above in relation to refusal applies only to a competent 16 or 17 year old young person. If the young person is not competent, the Commission is of the view that the young person should not generally be able to refuse health care.

However, the Commission is of the view, which is consistent with its recommendations with respect to young people under 12 years of age⁹⁶³ and young people between the ages of 12 and 15,⁹⁶⁴ that there are some circumstances in which a 16 or 17 year old young person who is not competent should be able to object to certain health care being carried out. In those circumstances, the objection of the young person should render the consent of a parent ineffective.

The Commission is of the view that a non-competent 16 or 17 year old young person should be able to object in the same circumstances recommended in relation to young people under 16, and that the same limitations on the effectiveness of the young

⁹⁶² *Children (Care and Protection) Act 1987* (NSW) s20A.

⁹⁶³ See 236-237 and 241-242 of this Report.

⁹⁶⁴ See 255-256 and 264-265 of this Report.

person's objection should apply.⁹⁶⁵ The Commission considers this to be a vital aspect of the scheme, as it is intended to protect vulnerable young people from serious, non-therapeutic health care that may have serious detrimental effects.⁹⁶⁶

5. PARENS PATRIAE JURISDICTION

One issue that arises out of the Commission's recommendation that a competent 16 or 17 year old young person should be the only person able to provide a valid consent to, or refusal of, his or her own health care, is whether the *parens patriae* jurisdiction of the Supreme Court of Queensland⁹⁶⁷ should be retained in relation to a competent 16 or 17 year old young person.

The *parens patriae* jurisdiction of the Supreme Court, which has been likened to a parental role, enables the Court to supervise young people under 18 years of age. As noted in Chapter 5 of this Report, it is possible for the *parens patriae* jurisdiction to be displaced by legislation,⁹⁶⁸ although it will only be displaced if the legislation in question does so expressly or by necessary or inescapable implication.⁹⁶⁹

Under the *parens patriae* jurisdiction, the Supreme Court can also make orders to protect the welfare and property of those persons whose mental or intellectual disabilities make it impossible for them to look after themselves. The Court does not, however, have the same jurisdiction over adults of sound mind. They have an absolute right to consent to or refuse health care.⁹⁷⁰

There is an apparent inconsistency between purporting to provide competent 16 and 17 year old young people with autonomy in relation to their health care decisions, while at the same time preserving the applicability of a jurisdiction under which their

⁹⁶⁵ These are discussed in some detail at 237 of this Report.

⁹⁶⁶ This recommendation is discussed at 236-237 of this Report in relation to young people under 12 years of age and at 255-256 of this Report in relation to young people between 12 and 15 years of age.

⁹⁶⁷ See the discussion of this jurisdiction at 94-95 of this Report.

⁹⁶⁸ The relevant legislation in New South Wales and South Australia does not expressly exclude the application of the *parens patriae* jurisdiction in relation to those young people who are given certain rights to make their own health care decisions. It is arguable that s6 of the *Consent to Medical Treatment and Palliative Care Act 1995* (SA), which provides that "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" would better support an argument that the *parens patriae* jurisdiction was excluded by implication than would s49(2) of the *Minors (Property and Contracts) Act 1970* (NSW), which merely provides that the consent of a minor aged 14 or over has the same effect in relation to a claim for assault or battery as if the minor were aged 21 or over.

⁹⁶⁹ *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.

⁹⁷⁰ *In re T (Adult: Refusal of Treatment)* [1993] Fam 95 at 102.

decisions could be overruled in circumstances where the same decision, if made by an adult, could not be overruled.

On the other hand, the *parens patriae* jurisdiction could be regarded as a safety net which could, if necessary, be invoked for the protection of a young person. This could be especially important for a young person who is the subject of a care and protection order made pursuant to the *Children's Services Act 1965* (Qld) and, therefore, not subject to the Family Court's welfare jurisdiction.⁹⁷¹

Even if the *parens patriae* jurisdiction were abolished for 16 and 17 year old young people, they would still not have complete autonomy with respect to their health care decisions. The Family Court in its welfare jurisdiction can make orders affecting a young person until he or she turns 18 years.⁹⁷² A young person under or apparently under the age of 17 years is also a "child" for the purposes of the *Children's Services Act 1965* (Qld) and could therefore be the subject of a care and protection application made under that Act.⁹⁷³

Because of the existence of those provisions, the abolition of the *parens patriae* jurisdiction with respect to competent 16 and 17 year old young people could not, of itself, have the effect of providing them with complete autonomy; it would simply remove one of a number of safeguards that exists for the protection of young people. In the view of the Commission, this renders the argument, that retention of the *parens patriae* jurisdiction for 16 and 17 year old young people is inconsistent with the Commission's recommendation that they should have the right to make their own health care decisions, of somewhat less force.

Further, while there is a possibility (although perhaps remote) that parents who object to their children obtaining health care without parental consent could abuse this jurisdiction by bringing applications to have the court override their children's consent, there is no reason to suppose that there would be any abuse of the jurisdiction in respect of any orders ultimately made by the court. The number of applications brought would also be affected by the costs involved in making Supreme Court applications.

⁹⁷¹ The *Commonwealth Powers (Family Law - Children) Act 1990* (Qld) referred a number of matters relating to the maintenance, custody and guardianship of, and access to, children to the Commonwealth. The matters excluded from the referral of power by s3(2) of the Act included:

... the making of provision for or in relation to authorising the taking, of action that would prevent or interfere with -

- (a) a Minister, an officer of the State or any other person having or acquiring the custody, guardianship, care or control of children under a provision of an Act specified in schedule 1 [which includes the *Children's Services Act 1965*].

⁹⁷² *Family Law Act 1975* (Cth) s67ZC. Although s67ZC is expressed to apply to all children, it is arguable that its scope may be limited by reference to other sections in Part VII of the Act, for example, s65H(1) (which provides that a parenting order must not be made in relation to a child who is or has been married or is in a de facto relationship) and s66V(1) (which provides that a child maintenance order does not apply to a child who marries or enters into a de facto relationship). See also the discussion of the Family Court's welfare jurisdiction at 96-97 of this Report.

⁹⁷³ *Children's Services Act 1965* (Qld) ss8, 46-59.

In all cases, the court would have to regard the welfare of the young person as the paramount consideration.

6. OTHER POSSIBLE REQUIREMENTS FOR AUTHORISATION OF HEALTH CARE

In addition to a valid consent (from the young person, if competent, or from a parent if the young person is not competent) the Commission has considered a number of circumstances that might be relevant to whether a health care provider may carry out health care on a 16 or 17 year old young person. These are discussed in turn.

(a) Health care is in the best interests of the young person's health and well-being

It would be inconsistent with the Commission's view that a competent young person be given the autonomy to make his or her own health care decisions, to restrict the young person's capacity to consent to health care in the young person's best interests.

However, in relation to health care for a 16 and 17 year old young person who is not competent, the Commission is of the view that the young person should be dealt with in the same way under the scheme as other young people who are not competent. Accordingly, a health care provider should only carry out health care on such a young person on the consent of a parent if the health care is in the best interests of the young person's health and well-being.

(b) Health care is in accordance with proper professional standards

As discussed in Chapter 10 of this Report, the Commission does not consider this to be a necessary safeguard for the provision of health care under this scheme.⁹⁷⁴

⁹⁷⁴ At 239-240 of this Report.

7. THE COMMISSION'S RECOMMENDATIONS

The Commission makes the following recommendations in relation to health care of a competent 16 or 17 year old young person:

- (a) A competent 16 or 17 year old person should be able to consent to, and refuse, his or her own health care.**
- (b) No other person should be able to consent to, or refuse, health care of a competent 16 or 17 year old person.**
- (c) A health care provider may carry out health care of a young person who is 16 or 17 years of age if:**
 - (i) the young person consents to the health care; and**
 - (ii) the young person understands the nature and consequences of the health care.**

These recommendations are reflected in clause 36 of the draft legislation in Chapter 17 of this Report.

The Commission makes the following recommendations in relation to health care of a 16 or 17 year old young person who is not competent:

- (a) A parent of a young person who is 16 or 17 years of age and not competent to consent to his or her own particular health care should be able to consent to, or refuse, that health care for his or her child.**
- (b) A young person who is 16 or 17 years of age and not competent should not be able to consent to, or (subject to paragraph (c) below) refuse, his or her own health care.⁹⁷⁵**
- (c) There should be a statutory list of health care that cannot be carried out over the objection of a young person who is 16 or 17 years of age and not competent.**

If the young person objects to the health care, the consent of a parent to such health care will be ineffective unless:

- (i) the health care is carried out pursuant to an appropriate court order; or**
- (ii) the young person has minimal or no understanding of one or both of the following:⁹⁷⁶**
 - what the health care involves; or**
 - why the health care is required;**

and the proposed health care is likely to cause the young person:

- no distress; or**
- temporary distress that is outweighed by the benefit to the young person.**

⁹⁷⁵ But see Ch 13 of this Report for a discussion of those forms of health care for which consent should not be a requirement.

⁹⁷⁶ See Queensland Law Reform Commission, Report *Assisted and Substituted Decisions* (R49, June 1996) Vol 2 *Assisted and Substituted Decision Making Bill* cl 163, for a similar provision in relation to the health care of adults with a decision-making disability.

The statutory list of health care that should not be carried out over the objection of a young person should be devised and updated jointly by Queensland Health and the Department of Families, Youth and Community Care.⁹⁷⁷ Initially, the list should include:

- termination of pregnancy;⁹⁷⁸ and
 - contraceptive health care.⁹⁷⁹
- (d) A health care provider may carry out health care of a young person who is 16 or 17 years of age if:
- (i) a parent of the young person consents to the health care;
 - (ii) the young person does not understand the nature and consequences of the health care;
 - (iii) the health care is in the best interests of the health and well-being of the young person.

These recommendations are reflected in clause 37 of the draft legislation in Chapter 17 of this Report.

The Commission recommends that the *parens patriae* jurisdiction of the Supreme Court of Queensland be retained with respect to all young people under 18 years of age.

This recommendation is reflected in clause 12(5) of the draft legislation in Chapter 17 of this Report.

⁹⁷⁷ See note 823 of this Report.

⁹⁷⁸ The Commission has defined "termination of pregnancy" in the following way:
 "Termination" of a pregnancy does not include a procedure performed primarily to treat organic malfunction or disease of the young person.

⁹⁷⁹ The Commission has defined "contraceptive health care" to mean health care of a young person that is primarily intended to prevent pregnancy but does not include sterilisation or termination of pregnancy. See 243 of this Report.

CHAPTER 13

HEALTH CARE FOR WHICH CONSENT SHOULD NOT BE A REQUIREMENT

1. INTRODUCTION

In an emergency situation, consent is not required before carrying out health care on a person.⁹⁸⁰ An emergency situation usually connotes an imminent risk to a person's life or health. However, there will sometimes be situations short of an emergency when a young person who is not competent to give a valid consent requires health care without delay, for example, to relieve significant pain or distress. There may be no available parent who can consent to the health care, or it may be the case that the young person will not seek health care if his or her parents are likely to be informed. Under the current law, a health care provider who treats a young person in those circumstances risks criminal and civil liability for assault and/or battery if there has not been a valid consent to the health care.

For procedures involving minimum intervention - such as first aid - it is also possible, though unlikely, that a health care provider could be held criminally or civilly liable for assault and/or battery for carrying out the health care, unless there is a valid consent. For health care requiring greater intervention, the health care provider may be more wary of carrying out the health care without a valid consent.

Despite the potential liability under the current law, it is likely, in practice, that many health care providers faced with a young person of any age in pain or distress would assist the young person in the most appropriate way, whether or not the situation could be classified legally as an emergency.⁹⁸¹ Obviously, for young children it would be preferable to have a parent present to assist in the decision-making required before the health care is carried out. However, if a parent is not reasonably contactable, if the young person would refuse the needed health care if anyone else were involved, or if a young person has been presented by someone other than a parent for urgent treatment, then there is a strong case that the health care should proceed if it would be in the best interests of the health and well-being of the young person.

During the Commission's consultation meetings following the release of the Discussion Paper⁹⁸² the Commission heard from a number of health care providers who had not hesitated to treat a young person who had presented himself or herself to a treatment facility, or who had been brought in for health care by a person with an obvious interest

⁹⁸⁰ See 44-48 of this Report.

⁹⁸¹ See the discussion on the law of emergency in Ch 2 of this Report.

⁹⁸² Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995).

in the young person. The fact that the young person had the initiative to seek health care was regarded by some health care providers as an indication that the young person was competent to consent to the proposed health care. Of course, not all such cases will involve a young person who is intelligent and mature enough to understand the nature and consequences of the proposed health care (which is the current test of a young person's competency to consent - the *Gillick* test).⁹⁸³ It could, however, be argued in any particular case that the young person should nevertheless be treated on humanitarian grounds, and that the health care provider should not fear liability for assault or battery for treating the young person.

For health care not involving a touching (such as, advice and counselling) that is provided to a young person without a valid consent, the current law imposes little if any legal liability on a health care provider.⁹⁸⁴ The Commission considers that this should generally remain the case, except in relation to serious non-touching health care which may pose a significant risk to a young person (for example, some forms of psychotherapy). In those cases, there should be a valid consent provided before the health care provider can proceed with the health care.⁹⁸⁵

2. EMERGENCY HEALTH CARE⁹⁸⁶

The general requirement of consent does not apply to emergency situations where immediate health care is necessary in order to save a person's life or to prevent serious injury to the person's health.⁹⁸⁷ A person who provides emergency health care without a valid consent will not incur criminal or civil liability for assault or battery. Additional

⁹⁸³ See Ch 3 of this Report for a discussion of the *Gillick* test of competency.

⁹⁸⁴ See 20 and 206-208 of this Report for a discussion of the liability attaching to a health care provider who carries out non-touching health care on a young person without having first obtained a valid consent.

⁹⁸⁵ See the Commission's recommendation in relation to serious non-touching health care at 208 of this Report.

⁹⁸⁶ See the discussion of emergency health care at 44-51 of this Report.

⁹⁸⁷ Note that in certain circumstances a health care provider may in fact be under a duty to provide such treatment. The New South Wales Court of Appeal has held in *Lowns v Woods* (1996) Aust Torts Reports ¶181-376 that if, in a medical emergency, a doctor is urgently requested to attend a person who is not and has never been a patient, the doctor has a duty to attend the person. All three members of the Court agreed with the legal principles espoused by the trial judge, that in general the common law does not impose a duty to assist a person in peril even where it is foreseeable that the consequence of a failure to assist will be the injury or death of the person in peril. Similarly, a doctor has no duty to attend upon a person who is sick, even in an emergency, if that person is not, and has never been, a patient of the doctor. However, the majority of the court agreed with the trial judge who held that a duty of care arose in the circumstances because of the relationship of proximity that existed between the doctor and the patient. The doctor had been specifically requested by the patient's sister to attend and treat the patient, and he had refused. The risk of injury to the patient if he did not attend was foreseeable, and there was an obvious physical proximity between the doctor and the patient because the patient's sister had come to the surgery on foot.

statutory protection for some health care providers has been referred to earlier.⁹⁸⁸

In the Discussion Paper the Commission did not consider there to be any apparent need to reform significantly the common law relating to emergencies.⁹⁸⁹ The Commission is, generally, still of that view. However, the Commission considers that there are several matters that should be addressed in relation to emergency health care of young people.

(a) Desirability of contacting the young person's parents

The Commission believes that wherever practicable, the parents of a young person who is under 16 years of age or 16 or 17 years of age but not competent to consent to his or her own health care should be contacted before emergency health care is carried out on the young person. Obviously, this will depend on the circumstances of the case. If any delay in the health care would adversely affect the health or well-being of the young person, the health care should proceed without the parents first having been contacted.

There will, however, be cases where parents are easily contactable and where their input may have a significantly beneficial effect on the outcome for the young person. For example, it may be that the parents know of an allergy that the young person has, which would determine the most appropriate form of health care.

The Commission considered making compulsory notification of parents, where practicable, a requirement for protection of health care providers under the scheme. However, the Commission is of the view that if it was otherwise appropriate to carry out emergency health care, a health care provider should not be liable for assault merely because of a failure to contact the young person's parents.

The purpose of contacting the young person's parents is not to obtain their consent,⁹⁹⁰ it is merely to inform them of their child's condition and receive any input they may be able to give in relation to their child's condition. Nevertheless, the Commission recognises the desirability of involving parents in the emergency health care of their children.

⁹⁸⁸ See 48-50 of this Report.

⁹⁸⁹ Discussion Paper at 202.

⁹⁹⁰ Indeed, the Commission has recommended at 288 and 291 of this Report that a person who carries out emergency health care in accordance with the scheme should be protected from liability for assault notwithstanding that a parent has refused the health care.

The Commission recommends, in relation to emergency health care for young people under 16 years of age or 16 or 17 years of age but not competent, that health care providers be encouraged but not compelled to take reasonable steps to contact a parent of the young person about the health care, unless the delay in doing so would not be in the best interests of the young person's health and well-being.

(b) Refusal by a parent

In Chapters 10, 11 and 12 of this Report the Commission has recommended that a parent be able to refuse health care for a young person under 16 years of age⁹⁹¹ or for a young person who is 16 or 17 years of age, but not competent.

However, the Commission does not consider that it would be appropriate for a parent's refusal of health care to expose a person who carries out emergency health care to liability for assault. If a parent's refusal of emergency health care were to have that effect, serious damage could be done to a young person's health before a health care provider or other person had an opportunity to seek a court order authorising the health care.

Accordingly, although parents should be able to refuse health care for their children, a person who overrides a parent's refusal of emergency health care should be protected from liability for assault.⁹⁹²

However, this recommendation is to be subject to the operation of the more specific requirements contained in section 20 of the *Transplantation and Anatomy Act 1979* (Qld) (as amended by the proposed legislative scheme).⁹⁹³ If a parent refuses a blood transfusion for a child who is under 16 years of age, or 16 or 17 years of age but not legally competent to consent to his or her own health care, the general requirements of section 20 of that Act will have to be satisfied before the health care provider will be protected from liability for assault for administering a blood transfusion over the refusal of a parent.⁹⁹⁴

⁹⁹¹ If, however, the young person is between 12 and 15 years of age and legally competent, the young person can consent to his or her own health care and the parental refusal will not be effective.

⁹⁹² It is possible, however, that a person could be liable in negligence if the person providing the emergency health care ignored and overrode relevant instructions about the young person's health. For example, if a health care provider ignored a parent's advice that the young person was allergic to a particular drug and administered the drug over the refusal of a parent.

⁹⁹³ See 289 of this Report.

⁹⁹⁴ See the discussion of s20 of the *Transplantation and Anatomy Act 1979* (Qld) at 30-32 of this Report.

(c) Refusal by a competent 16 or 17 year old young person

In Chapter 12 the Commission recommended that a young person who is 16 or 17 years of age and understands the nature and consequences of health care should be able to consent to, or refuse, health care. The Commission also recommended that the young person should be the only person who should be able to consent to, or refuse, his or her health care.

The Commission is of the view that, if a young person is 16 or 17 years of age and competent, the young person should also be able to refuse emergency health care, including a blood transfusion.

Section 20 of the *Transplantation and Anatomy Act 1979* (Qld) should, therefore, be amended to make it clear that a competent 16 or 17 year old young person can refuse a blood transfusion.

(d) Protection for health care providers and other persons

In all cases, a health care provider or other person carrying out emergency health care on a young person will be protected from liability for assault only if the health care provider or other person honestly and reasonably believes that:

- the health care should be urgently carried out to meet imminent risk to the young person's life or health; and
- the health care is in the best interests of the young person's health and well-being.

The Commission has considered whether any other circumstances should affect the liability of a person who carries out emergency health care on a young person.

In considering these circumstances, the Commission has recognised that people who are not health care providers are not as likely to be as familiar, if at all, with the legislative scheme as people who are health care providers. For that reason, the Commission has been conscious not to impose too many restrictions for the protection of people who are not health care providers, but who nevertheless carry out emergency health care.

(i) Effect of refusal by a young person of emergency health care by a health care provider

The Commission has recommended in Chapter 12 that a competent young person who is 16 or 17 years of age should be able to refuse health care.⁹⁹⁵ In this Chapter the Commission has recommended that such a young person should also be able to refuse emergency health care.⁹⁹⁶

If a health care provider knows, or ought to know, that a competent young person who is 16 or 17 years of age has refused particular emergency health care, but the health care provider nevertheless ignores that refusal and carries out the emergency health care, the health care provider should not, in the Commission's view, be protected.

For example, if a competent young person who is 16 or 17 years of age gives instructions upon being admitted to hospital that he or she refuses any blood transfusion, but a health care provider who knows, or ought to know of those instructions, proceeds to administer a blood transfusion, that health care provider will not be protected under the scheme from liability for assault.

(ii) Effect of refusal by a young person of emergency health care by a person who is not a health care provider

The Commission does not believe that the liability of a person who is not a health care provider should be affected by any refusal of the health care by a competent young person. A person, other than a health care provider, who carries out emergency health care on a young person under 18 years of age should be protected from liability for assault, as long as the person honestly and reasonably believes that:

- the health care should be urgently carried out to meet imminent risk to the young person's life or health; and
- the health care is in the best interests of the young person's health and well-being.

⁹⁹⁵ At 274-276 and 282 of this Report.

⁹⁹⁶ At 289 of this Report.

(e) The Commission's recommendations

The Commission makes the following recommendations with respect to the provision of health care to a young person in an emergency situation:

- (a) Subject to the recommendations made below, the common law with respect to emergency health care should be preserved.**
- (b) Before carrying out emergency health care of a young person who is under 16 years of age, or who is 16 or 17 years of age but not competent, a health care provider is encouraged to take reasonable steps to contact a parent of the young person, unless the health care provider honestly and reasonably believes that the delay associated with taking such steps would not be in the best interests of the young person's health and well-being.**
- (c) A young person who is 16 or 17 years of age and competent (that is, who understands the nature and consequences of the health care), should be able to refuse emergency health care, including a blood transfusion.**
- (d) Regardless of whether a parent refuses, or a young person objects to, emergency health care, a person (including a health care provider) who carries out emergency health care on a young person should be protected from liability for assault⁹⁹⁷ if the person honestly and reasonably believes that:
 - (i) the health care should be urgently carried out to meet imminent risk to the young person's life or health; and**
 - (ii) the health care is in the best interests of the young person's health and well-being.****
- (e) However, a health care provider should not be protected under the previous recommendation if he or she carries out emergency health care on a young person who:
 - (i) has refused the health care; and**
 - (ii) was 16 or 17 years of age and competent at the time of the refusal;****

⁹⁹⁷ See 220 of this Report for the definition of "liability for assault".

if the health care provider knows, or ought to know, that the young person:

- (iii) had refused the health care;
- (iv) was 16 or 17 years of age and competent at the time of the refusal; and
- (v) had not subsequently retracted that refusal.

These recommendations are reflected in clauses 25, 31, 38 and 52 of the draft legislation in Chapter 17 of this Report.

The Commission acknowledges that these recommendations overlap to some extent with section 16 of the *Law Reform Act 1995* (Qld), which deals with the provision of health care in emergency situations, and section 52 of the *Medical Act 1939* (Qld), which deals with surgical procedures for people who are incapable of consenting to them.⁹⁹⁸ The Commission's recommendations in relation to emergency health care are necessarily limited by the terms of this reference to emergency health care for young people; a review of emergency health care for adults is outside the terms of reference.

The Commission considers it desirable for a general review to be undertaken either by Queensland Health or by this Commission of all Queensland law regulating consent requirements for emergency health care and the liability of people who carry out emergency health care. This would include a review of section 20 of the *Transplantation and Anatomy Act 1979* (Qld).⁹⁹⁹

3. HEALTH CARE REQUIRED WITHOUT DELAY

In light of the submissions received by the Commission and the discussions held at the consultation meetings, it is apparent that the current law may hinder some young people from obtaining the health care they require, if they are not competent to provide

⁹⁹⁸ These provisions are discussed at 26-27 and 49 of this Report. Neither provision is restricted in its application to health care of a person of any particular age.

⁹⁹⁹ This section protects certain people who carry out emergency blood transfusions on young people without a consent or over the refusal of a parent.

a valid consent or if their competency to provide a valid consent to the health care is uncertain. This is particularly the case with conditions requiring health care without delay, if parents are not available to consent to the health care.

For example, one Brisbane Hospital commented:¹⁰⁰⁰

Children in this age group [under 12 years of age] often present with significant pain or other conditions requiring immediate management, but where a parent is absent or not contactable. The institution and the health care provider need the protection of law when providing treatment to such a young person when a delay in treating would be medically inadvisable.

Such a situation may not necessarily qualify as an emergency (in which case consent would not be required before health care could proceed). As noted in Chapter 2 of this Report,¹⁰⁰¹ the types of circumstances that would qualify as an emergency under the current law are uncertain. It is unclear, for example, whether the fact that a person was experiencing extreme pain would, of itself, qualify as an emergency, so as to enable health care to proceed without the need for consent. It may seem to many that it would be more humane to treat a person without delay in such a situation, rather than defer health care in order to obtain a valid consent. However, under the current law, a health care provider could face criminal and civil liability for assault or battery for providing health care in those circumstances without a valid consent.

The Commission considers it important that at least certain health care providers should be able to carry out health care on a young person in the absence of consent, in circumstances where it is desirable in the interests of the young person's health and well-being that health care proceed without delay, even though the circumstances might not constitute an emergency.

(a) Limitation on who can treat

In an attempt to reduce the risk of such a provision being abused by health care providers, the Commission believes that there should be a restriction on the type of health care provider who can treat without a valid consent in these circumstances.

For this reason, the Commission is of the view that only a registered medical practitioner, registered dentist, registered nurse or such other health care provider as may be prescribed by regulation (hereafter referred to as "an authorised health care provider") should be able to treat a young person without consent in these circumstances.

Although other health care providers may perceive a need to treat a young person

¹⁰⁰⁰ Submission 34.

¹⁰⁰¹ At 46 of this Report.

without delay, and possibly in the absence of a valid consent, the Commission considers that this proposed limitation offers some protection to a young person who does not, at the time of requiring the health care, have the support of an available parent. Only members of the highly regulated health care professions listed (all of which subject their members to strict disciplinary proceedings should they engage in unethical or unreasonable health care practices) would be able to treat young people in non-emergency situations in the absence of a valid consent. Those health care providers are also subject to professional Codes of Ethics which are likely to guide them in their dealings with young patients.¹⁰⁰²

Other health care providers would not be able to treat a young person who is not competent without a valid consent from a parent.¹⁰⁰³

Subject to the limitations described below, the Commission recommends that an authorised health care provider may treat a young person without consent if the young person is not competent under the scheme to consent to his or her own health care, and the health care is required without delay. If the young person is competent, health care cannot be carried out on the young person under this recommendation; a valid consent must be obtained.

(b) Scope of health care

The health care that can be carried out pursuant to this proposed provision should not include:

- any type of health care to which, under the Commission's legislative scheme, a young person can object (whether or not the young person objects to it),¹⁰⁰⁴ or
- health care for a sexually transmitted disease.

The Commission considers that if a type of health care is sufficiently serious that a young person's objection to the health care should override a parental consent to the health care, it would not be appropriate for the health care to be carried out in the absence of a valid consent. The Commission regards the requirement of a valid consent to be an important safeguard for the young person's protection from inappropriate health care. Such protection should not depend on whether the young person objects to the health care, or would even be capable of objecting to it.

¹⁰⁰² See Appendix 5 for a sample of relevant Codes of Ethics.

¹⁰⁰³ See the broad definition of "parent" recommended by the Commission in Ch 15 of this Report.

¹⁰⁰⁴ See the discussion of these types of health care at 236-237, 255-256 and 278-279 of this Report. This provision could not be used to authorise a termination of pregnancy or contraceptive health care. Nor could a sterilisation procedure be performed under this provision, as court authorisation would always be required: see *Marion's case* (1992) 175 CLR 218. See also clause 12(2) of the draft legislation in Ch 17 of this Report.

In relation to health care for a sexually transmitted disease and contraceptive health care, the Commission has made specific recommendations;¹⁰⁰⁵ such health care must be carried out in accordance with those specific recommendations.

Accordingly, if a young person who is not competent to consent to health care for a sexually transmitted disease nevertheless seeks such health care, the Commission's recommendation relating to health care required without delay would not authorise the health care. Rather, the Commission's specific recommendation relating to health care for a sexually transmitted disease would apply. It follows that the obligation to take reasonable steps to contact the young person's parents for their consent (see below) would also not apply.

(c) Parents to be contacted

In an attempt to ensure that, generally, health care proceeds only upon the basis of a valid consent, the Commission believes that if a young person is not legally competent to consent to his or her own health care, reasonable steps should be taken to contact the young person's parents in order to seek their consent to the health care before health care required without delay will be authorised by the proposed scheme.

(d) Refusal by a parent

If a parent, when contacted, refuses the health care for his or her child, the health care cannot proceed. Nor can the health care proceed if the authorised health care provider knows that a parent of a young person has previously indicated that the particular type of health care is not to be carried out on the young person and, since then, the parent has not indicated otherwise.

The purpose of the proposed provision is to facilitate health care required without delay in circumstances where a parent is not reasonably available to consent to the health care. Its purpose is not to enable an authorised health care provider to take advantage of a parent's absence to give health care that is known to be objected to by a parent.

The Commission has recommended that a person should be able to provide emergency health care to a young person over the refusal of a parent.¹⁰⁰⁶ However, short of an emergency, the Commission does not believe that a parent's refusal of health care for a non-competent young person should be overridden, unless by a court order.

¹⁰⁰⁵ See the discussion of health for sexually transmitted diseases at 303-308 of this Report and the discussion of contraceptive health care at 308-313 of this Report.

¹⁰⁰⁶ At 288 and 291 of this Report.

(e) Objection by a young person

As recommended above, the proposed provision does not authorise any type of health care to which a young person can, under the legislative scheme, object - regardless of whether the young person actually objects to the health care or would be capable of objecting to it. The Commission takes the view that those types of health care are sufficiently serious to require a valid consent in all cases.

The Commission also considered whether a young person should be able to object to any health care that might otherwise be able to be performed under this provision. This would be particularly relevant in relation to the older "non-competent" child who strenuously objected to proposed health care which, in the opinion of the health care provider, should be performed without delay.

The decision whether or not to treat a young person who is objecting to health care will arise only once it has been determined that the young person's parents cannot be reasonably contacted to obtain their consent. Also, the authorised health care provider would have to be aware of his or her potential liability for negligence (that is, for breach of the duty of care owed by the health care provider to the young person), which could be exacerbated if he or she failed to take into account the young person's objections. For example, if a young person objected to an injection of penicillin claiming to be allergic to it, that information would obviously have to be taken into account by the health care provider in deciding whether and, if so, how to treat the young person.

The Commission is of the view that the decision whether or not to treat the young person over his or her objection should be left to the professional judgment of the authorised health care provider. The authorised health care provider's liability will be subject, of course, to the other restrictions imposed by the Commission's proposed scheme.¹⁰⁰⁷

(f) Certification by authorised health care provider

The Commission considered whether it should be a requirement that an authorised health care provider certify as to the various matters that authorise the health care required without delay. However, the Commission considers that if it would otherwise be appropriate for an authorised health care provider to carry out health care required without delay, the health care provider should be able to treat regardless of a failure to certify as to the matters authorising the health care.

Nevertheless, the Commission believes that it would be best practice for an authorised health care provider to certify in his or her clinical records relating to the health care of the young person as to the relevant matters that will have to be satisfied to authorise

¹⁰⁰⁷ Such as the requirement that the health care be in the best interests of the young person's health and well-being.

health care required without delay, namely, that: the young person was not competent to consent to the proposed health care; the health care was in the best interests of the young person's health and well-being; the health care should be performed without delay; reasonable steps were taken to contact the young person's parents in order to seek a consent for the health care; and the health care was within the scope of this recommendation.¹⁰⁰⁸

(g) Practical effect of the proposed provision

The Commission considers that the provision relating to health care required without delay should fill a gap that currently exists in relation to health care for young people who are not competent to consent to their own health care. It should facilitate the health care of those young people who may currently be left untreated in circumstances where health care should proceed without delay, merely because there is no available parent who can consent to health care for the young person.

Although the proposal extends only to the provision of health care by a registered medical practitioner, registered dentist or registered nurse (or other prescribed health care provider), the Commission is of the view that it would be rare for a young person who was not competent to consent to his or her own health care, unaccompanied by a parent, to require health care without delay from a health care provider other than one of those authorised health care providers or, in any event, to be able to pay for medical services from someone other than a health care provider entitled, and willing, to bulk-bill Medicare for the cost of services provided.

¹⁰⁰⁸ See 236-237, 255-256 and 278-279 of this Report for a discussion of health care to which a young person can object.

(h) The Commission's recommendations

The Commission recommends the following:

- (a) An authorised health care provider (that is, a registered medical practitioner, registered dentist, registered nurse or other health care provider who may be prescribed by regulation) may carry out health care of a young person without a valid consent if:**
- (i) the health care should be carried out without delay;**
 - (ii) the young person is not competent to consent to the health care (that is, that the young person is under 12 years of age, or is 12 years of age or older but does not understand the nature and consequences of the health care);**
 - (iii) the health care does not involve:**
 - health care to which a young person can object (whether or not the young person objects or could object to the health care, for example, a termination of pregnancy or contraceptive health care); or**
 - health care for a sexually transmitted disease.**
 - (iv) the health care is in the best interests of the young person's health and well-being; and**
 - (v) either:**
 - the delay associated with taking reasonable steps to contact a parent for parental consent to the health care would not be in the best interests of the young person's health and well-being; or**
 - reasonable steps have been taken to contact a parent for parental consent to the health care, but no parental consent to, or parental refusal of, the health care has been given.**

- (b) Health care will not be authorised under the previous recommendation if:**
- (i) a parent, if contacted, refuses the health care; or**
 - (ii) the authorised health care provider knows that a parent of a young person has previously indicated that the particular type of health care is not to be carried out on the young person, and, since then, the parent has not indicated otherwise.**

These recommendations are reflected in clauses 26, 32 and 39 of the draft legislation in Chapter 17 of this Report.

4. MINOR HEALTH CARE

(a) Authorisation of minor health care

Although it is unlikely that criminal or civil liability for assault would attach to a person who performed minor health care on a young person without a valid consent, it is nevertheless possible. That possibility may deter some people from treating a young person in circumstances where it is desirable that minor health care be provided.

The Commission understands the term “minor health care” to include first aid, non-intrusive examinations for diagnostic purposes and the administration of non-prescription drugs. Depending on the circumstances of a particular case, first aid might involve more serious health care such as the stitching of a wound or resuscitation. However, the Commission does not believe that it is useful to define “first aid”, as it is a widely used term of art which may alter in meaning if an attempt were made to define it. Nevertheless, the term at least connotes a need to treat an injury promptly.

Minor health care, especially first aid, is often performed by people other than health care providers. The Commission believes that the law should not deter anyone from providing necessary health care to a young person, particularly in circumstances where the risks to the young person are minimal.

The Commission does not believe it would be useful to insist on a consent requirement before a person can lawfully carry out minor health care on a non-competent young person, as long as the minor health care is in the best interests of the young person’s health and well-being.

The Commission has considered the situation of a young person who objects to minor health care. For a very young or immature child it is most likely that any objection

would be overlooked if the health care was considered to be in the young person's best interests - particularly if the young person would suffer or continue to suffer without the health care. For an older child, it is more likely that his or her objection would be respected, particularly if failure to treat would not be likely to result in significant long term adverse consequences for the young person.

The Commission believes that to regulate all these situations would unduly complicate the Commission's proposed legislative scheme. The Commission would prefer to leave the decision whether or not to respect a young person's objection to minor health care to the judgment of the health care provider or other person proposing to carry out the minor health care. However, all health care must be in the best interests of the young person's health and well-being. Further, the person would always be liable in negligence if he or she failed to fulfil a duty of care owed to the young person and the young person suffered damage as a result.

The Commission recommends that minor health care should be able to be carried out without consent on a young person who is not competent under the scheme to consent to health care. If a young person is competent to consent to particular health care (that is, if the young person is 12 years of age or older, and understands the nature and consequences of the health care), a valid consent (either from the young person or a parent) will be required before minor health care can be lawfully carried out on the young person.

(b) The Commission's recommendations

The Commission recommends that a person may carry out minor health care of a young person without consent if:

- (a) the young person is not competent to consent to the health care (that is, the young person is under 12 years of age, or is 12 years of age or older but does not understand the nature and consequences of the health care); and
- (b) the health care is in the best interests of the young person's health and well-being.

The Commission recommends the following definition of "minor health care":

- (a) first aid;
- (b) a non-intrusive examination for diagnostic purposes; or
- (c) the administration of a pharmaceutical drug if-
 - (i) a prescription is not needed to obtain the drug; and
 - (ii) the administration is for a recommended purpose and at a recommended dosage level;

but does not include:

- (d) health care in respect of which a young person's objection makes a parental consent ineffective;
- (e) emergency health care; or
- (f) a blood transfusion; or
- (g) health care required without delay; or
- (h) health care for a sexually transmitted disease;¹⁰⁰⁹ or
- (i) contraceptive health care.¹⁰¹⁰

These recommendations are reflected in clauses 27, 33 and 40 of the draft legislation in Chapter 17 of this Report.

¹⁰⁰⁹ This is the subject of specific recommendations in this Chapter.

¹⁰¹⁰ *ibid.*

5. APPLICATION OF THE COMMISSION'S RECOMMENDATIONS

The effect of the Commission's recommendations can be illustrated by the following hypothetical examples:

Example 1 - Emergency health care

A 10 year old boy is involved in a car accident. He has serious internal injuries and requires immediate surgery to save his life.

As the situation is an emergency, the child can lawfully be treated.

Example 2 - Health care required without delay

An 11 year old girl with a promising tennis career is injured at school during a sports lesson. It is suspected that she may have damaged the ligaments in her knee. She is not in immediate danger, but prompt investigation and treatment of her injuries is desirable. The sports teacher takes the girl to the medical practitioner next door to the school. The medical practitioner is an "authorised health care provider" for the purposes of the Commission's scheme.

Before treating the girl, the medical practitioner is required under the Commission's recommendations to take reasonable steps to contact one of the girl's parents for parental consent to the health care.

The medical practitioner telephones the girl's parents, who inform the medical practitioner that their daughter is already under the care of an orthopaedic surgeon in relation to previous sports injuries sustained by her, and that they will collect their daughter and make arrangements to take her to her own surgeon.

If neither parent could reasonably have been contacted, or if the delay associated with taking reasonable steps to contact the girl's parents would not have been in the best interests of her health and well-being, the medical practitioner to whom the girl was taken could lawfully have carried out such health care as was required without delay, including the administration of pain relief.

Example 3 - Minor health care

A 6 year old child falls off a swing in the school playground and grazes his knee. As the child is not competent under the Commission's scheme to consent to his own health care, no consent is required before providing minor health care. The teacher is able to clean the wound and apply an antiseptic without the need for a consent to that health care.

6. PARTICULAR CONDITIONS

In the Discussion Paper, the Commission discussed a number of particular types of health care that had been referred to it by submissions to the Information Paper. Those types of health care were considered to be ones about which young people may be particularly reluctant to talk to their parents - but which nevertheless should be addressed by a health care provider without delay. They may also relate to conditions that will harm young people if health care is delayed or not undertaken at all.

The types of health care discussed in the Discussion Paper were health care for sexually transmitted diseases, contraceptive health care, and psychiatric and psychological advice, treatment and counselling (including suicide prevention). The Commission invited comment on what, if any, restrictions should apply to a young person's ability to seek those types of health care, and on whether a different test of competency should apply to those types of health care.¹⁰¹¹

After considering the submissions received in response to the Discussion Paper,¹⁰¹² the Commission is of the view that it is necessary to clarify the circumstances in which a young person can consent to these types of health care, although it does not now believe it will be necessary to make recommendations in relation to all of the specific treatments or conditions referred to above.

(a) Sexually transmitted diseases

There is an important public interest in having sexually transmitted diseases treated. The significance of that public interest is reflected in section 36 of the *Health Act 1937* (Qld), which permits a person's refusal to be treated for a notifiable disease to be

¹⁰¹¹ Discussion Paper at 111 (sexually transmitted diseases), 118 (contraceptive advice and treatment) and 128 (psychiatric and psychological advice and treatment).

¹⁰¹² These submissions are referred to in Ch 6 of this Report.

overridden.¹⁰¹³ Subsection 36(1) provides:

If a person suspected by a medical practitioner to be suffering from or to have been exposed to a notifiable disease-

- (a) fails or refuses to enter or remain in a hospital or temporary isolation place; or
- (b) refuses to submit to any reasonable examination, test or treatment in respect of that notifiable disease;

a justice may upon the application of the chief health officer and the production of a certificate of the medical practitioner certifying as to the medical practitioner's suspicion, order that the person be removed to a public hospital or temporary isolation place specified in the order.

Subsection 36(5) then provides that such force as may be reasonably necessary may be used in the hospital or "temporary isolation place" for such things as:

- (a) detaining the person in the public hospital or place; or
- (b) isolating and treating the person in respect of a notifiable disease; or
- (c) performing any examination or test to determine whether or not the person is suffering from a notifiable disease.

It is not clear, however, that section 36 of the *Health Act 1937* (Qld) would be capable of authorising the treatment of a young person who is not legally competent to consent to particular treatment. It is certainly arguable that a young person who is not legally competent to consent to treatment could not be said to "refuse" to submit to an examination, test, or treatment, so as to enable a justice to make an order under section 36 of the *Health Act 1937* (Qld).

If that is the case, then the mechanism provided by section 36 to ensure the treatment of persons with notifiable diseases might not be able to be employed to authorise the examination, testing or treatment of a person who is not competent to consent to treatment and who cannot, therefore, be said to have refused to submit to "any reasonable examination, test or treatment". This would mean that treatment for a sexually transmitted disease could not lawfully be carried out on a non-competent young person unless it was consented to by a parent.

In the Commission's view, a recommendation that meant that parental consent would be required before a sexually transmitted disease could lawfully be treated would most probably mean that many sexually transmitted diseases would go untreated.

Any scheme that regulates the circumstances in which a young person should be able

¹⁰¹³ Notifiable diseases for the purpose of s32 of the *Health Act 1937* (Qld) are listed in schedule 2, part 1 of the *Health Regulation 1996* (Qld): see s202 of the Regulation. The diseases included in schedule 2, part 1 include a number of sexually transmitted diseases, as well as other diseases. See the discussion at 117-120 of this Report of the sexually transmitted diseases that are included in that schedule.

to consent to the treatment of a sexually transmitted disease should also ensure that a young person who is not competent to consent to health care will nevertheless be able to obtain treatment for a sexually transmitted disease. In so doing, it should take account of the serious consequences to a young person if a sexually transmitted disease is left untreated,¹⁰¹⁴ and the likelihood that treatment will not be sought if parental consent is a necessary requirement for the treatment of a sexually transmitted disease.

It is important for young people (whether or not they are competent) to be able to receive treatment for a sexually transmitted disease. The fact that the occurrence of a sexually transmitted disease in a young person might also raise serious concerns about the young person's welfare generally does not detract from the need for treatment, or from the need for a mechanism to ensure that the treatment can be provided without unnecessary barriers.

It is, therefore, essential for the Commission's proposed scheme to accord young people the capacity, in appropriate circumstances, to consent to the treatment of a sexually transmitted disease, and to provide an appropriate mechanism to facilitate the treatment of a young person who is not competent to consent to the treatment of a sexually transmitted disease.

(i) Competency test - no minimum age

The imposition of an age requirement for competency to consent to treatment of a sexually transmitted disease would obviously prevent a young person who was below that age, but who otherwise understood the nature and consequences of the health care required, from consenting to his or her own health care. Even if subsection 36(1) of the *Health Act 1937* (Qld) does, on a proper construction, extend to authorise the examination and treatment of a person who is not competent to consent to the treatment, the Commission is of the view that that is not a reason for adopting an unduly restrictive test of competency for consent by a young person to treatment of a sexually transmitted disease.

Section 36 should only have to be used as a last resort to ensure that treatment takes place. The procedures set out in the section must inevitably result in a delay in treatment, pending the necessary order being made by a justice. The section should not be the primary means of facilitating the treatment of a young person who is willing to be treated and who has an understanding of the treatment, but who, because of the imposition of a particular age requirement or other higher test for competency, is not competent to consent to his or her own health care.

For that reason, the Commission is of the view that in determining the standard

¹⁰¹⁴ See 119 of this Report.

of competency for consent by a young person to treatment for a sexually transmitted disease, it should be sufficient if the young person understands the nature and consequences of the health care involved. No further limitation, such as a minimum age requirement, should be imposed.

(ii) Health care for a young person who is not competent

In relation to a young person who does not understand the nature and consequences of the proposed health care for a sexually transmitted disease, it is nevertheless important that the young person be treated. For that reason the Commission recommends that a valid consent should not be required to treat a non-competent young person for a sexually transmitted disease, as long as the health care is in the best interests of the young person's health and well-being. The only limitation the Commission would place on this recommendation is that it should not authorise the health care of a young person who is objecting to the health care.

The purpose of the recommendation in relation to a young person who is not competent to consent to health care for a sexually transmitted disease is to facilitate the treatment of a young person who is willing to be treated, but who lacks the competency to provide a valid consent. The recommendation it is not intended to usurp the function of section 36 of the *Health Act 1937* (Qld).

If a young person objects to treatment for a sexually transmitted disease, any health care should only be provided once the requirements of section 36 of the *Health Act 1937* (Qld) have been satisfied. In that regard, the Commission also recommends that section 36 should be amended to ensure that there is no doubt that it will authorise treatment of a person who lacks the competence to refuse health care, even if the treatment is refused by a parent.

A medical practitioner who treats a young person in accordance with either this or the previous recommendation should, however, bear in mind the obligation imposed by section 76K of the *Health Act 1937* (Qld) to notify a person authorised under the *Health Regulation 1996* (Qld) if he or she suspects on reasonable grounds the maltreatment or neglect of the young person.

(iii) The Commission's recommendations

The Commission makes the following recommendations in relation to the health care of a young person for a sexually transmitted disease:

- (a) A young person is competent to consent to health care for a sexually transmitted disease if the young person understands the nature and consequences of the health care.**
- (b) A valid consent to health care of a young person for a sexually transmitted disease can be given by:**
- (i) if the young person is under 16 years of age and is competent to consent to the health care-**
 - a parent; or
 - the young person;
 - (ii) if the young person is 16 or 17 years of age and is competent to consent to the health care - the young person.**
 - (iii) if the young person is under 18 year of age, but is not competent - a parent.**
- (c) An authorised health care provider¹⁰¹⁵ may carry out health care of a young person for a sexually transmitted disease if:**
- (i) there is a valid consent to the health care from the young person or from a parent of the young person; and**
 - (ii) the health care is in the best interests of the young person's health and well-being.¹⁰¹⁶**

¹⁰¹⁵ See 298 of this Report. The recommendations apply to a registered medical practitioner, a registered dentist, a registered nurse and such other health care providers as may be prescribed by regulation.

¹⁰¹⁶ This requirement does not apply to the health care if it is a competent 16 or 17 year old who consents to the health care. See 281-282 of this Report.

- (d) An authorised health care provider may carry out health care of a young person for a sexually transmitted disease, without a valid consent, if:
- (i) the young person is not competent to consent to the health care;
 - (ii) the health care is in the best interests of the young person's health and well-being; and
 - (iii) the young person does not object¹⁰¹⁷ to the health care.
- (e) Section 36 of the *Health Act 1937* (Qld) should be amended to ensure that it authorises the treatment for a sexually transmitted disease of a young person who is not competent to consent to the particular health care, and that it authorises such treatment even if a parent of a young person refuses the treatment.

These recommendations are reflected in clauses 28, 34, 36 and 41 of the draft legislation in Chapter 17 of this Report.

(b) Contraceptive health care¹⁰¹⁸

The Commission's legislative scheme would not impose a general consent requirement on non-touching contraceptive health care.¹⁰¹⁹ Consent would not, therefore, be required for the provision of contraceptive health care that did not involve a touching, such as the prescription of the contraceptive pill, or mere advice.

Consistent with its view in relation to health care for a sexually transmitted disease, the Commission is of the view that an unduly restrictive competency test should not be adopted for contraceptive health care requested by the young person that involves a

¹⁰¹⁷ The Commission has recommended at 241-242, 264 and 283 of this Report that a young person's objection will be effective unless:

- (i) the health care is carried out pursuant to an appropriate court order; or
- (ii) the young person has minimal or no understanding of one or both of the following:
 - what the health care involves; or
 - why the health care is required;
 and the proposed health care is likely to cause the young person:
 - no distress; or
 - temporary distress that is outweighed by the benefit to the young person.

Note, however, that if a young person objected to health care for a sexually transmitted disease, it is probable that an order would be made under s36 of the *Health Act 1937* (Qld) that the young person be detained at a public hospital and treated.

¹⁰¹⁸ Note, that at 243 of this Report the Commission has defined "contraceptive health care" to mean "health care of a young person that is primarily intended to prevent pregnancy, but does not include sterilisation or termination of pregnancy".

¹⁰¹⁹ See 208 of this Report. Only certain prescribed non-touching health care will have a consent requirement.

touching, such as the insertion of an internal contraceptive device. It is highly likely that a young person who seeks contraceptive health care is, if not already sexually active, likely to be so in the near future.

(i) Competency test - no minimum age

The Commission is of the view that the consequences of not providing contraceptive health care to a young person who seeks it are serious, and that in all likelihood contraceptive health care will not be sought if parental consent is a necessary requirement for the provision of the health care.

For this reason, the Commission is of the view that a young person who understands the nature and consequences of contraceptive health care should be competent to give a valid consent to the health care. No minimum age requirement should be imposed with respect to competency.

The Commission does not condone unlawful sexual activity involving young people. However, if contraception is denied to young people, it does not necessarily follow that they will not engage in sexual activity. The provision of contraception to young people will obviously not guarantee the avoidance of sexual abuse, sexually transmitted diseases or unwanted pregnancies. However, in conjunction with appropriate information, education and counselling, it may assist in the preservation or improvement of their health and well-being.

(ii) Health care for a young person who is not, or may not be, competent

The Commission also considers it important for the legislative scheme to provide a mechanism to facilitate contraceptive health care, in appropriate circumstances, for a young person who may not be competent, or about whose competency an authorised health care provider may have some doubts. The Commission has in mind here a young person who might understand the nature of the health care, but because of the complexity of the health care, might not understand its consequences.

The Commission considered the possibility of relaxing the competency test for contraceptive health care to something akin to the adult common law competency test - that is, that the person simply understands the broad nature of the health care involved. However, rather than complicate the scheme by introducing a second competency test in relation to young people under the age of 18, the Commission is of the view that it is preferable to have a competency test for contraceptive health care that is consistent with its competency test for young people generally (apart from having, in this case, no lower age cut-off), and provide an alternative mechanism for those young people who do not satisfy that test, but who may nevertheless seek contraceptive health care.

In considering an appropriate mechanism, the Commission was concerned that the mechanism adopted should not permit contraceptive health care to be given in inappropriate circumstances. For example, it should not permit a carer in a residential facility to subject young people to contraception routinely as a management tool. For that reason, the Commission rejected the possibility of simply deeming young people to be competent to consent to contraceptive health care.

In the Commission's view, the most important restriction on the provision of any health care should be that it is in the best interests of a young person's health and well-being. Accordingly, the Commission recommends that a valid consent should not be required for the provision by an authorised health care provider¹⁰²⁰ of contraceptive health care to a young person who is not competent to consent to the health care if:

- the young person requests the contraceptive health care; and
- the health care would be in the best interests of the young person's health and well-being.

The Commission hopes that a health care provider who is faced with a young person seeking contraceptive health care will act responsibly and consider the reasons for the request. If a medical practitioner has reasonable grounds to suspect that a young person is the victim of sexual abuse, maltreatment or neglect, the medical practitioner has a duty to notify a person authorised by the *Health Regulation 1996 (Qld)*,¹⁰²¹ who will refer the matter to a S.C.A.N. team.¹⁰²²

(iii) Objection by a young person

A parent would still be able to give a valid consent to contraceptive health care for a child who was under 16 years of age, or who was 16 or 17 years of age, but not competent to make his or her own decision in relation to the health care.

¹⁰²⁰ See 298 of this Report. The Commission has recommended that an authorised health care provider is a registered medical practitioner, a registered dentist, a registered nurse, and such other health care provider as may be prescribed by regulation.

¹⁰²¹ *Health Act 1937 (Qld)* s76K. Authorised persons are listed in schedule 1 of the *Health Regulation 1996 (Qld)*: s63 of the Regulation. Note also the Commission's recommendation at 348-349 of this Report about extending the application of s76K to health care providers other than medical practitioners. If the young person is at, or has been presented to, a hospital, the medical practitioner can detain the young person for up to 96 hours even if the young person's parents object: s76L. See this Commission's Research Paper *Medical Examinations in Cases of Suspected Child Abuse* (MP17, June 1996) for a detailed discussion of s76L.

¹⁰²² Suspected Child Abuse and Neglect Teams are hospital based teams set up by the Co-ordinating Committee on Child Abuse run by the Departments of Families, Youth and Community Care; Health; Education; Justice; and Queensland Police Service. They consider reported cases of suspected child abuse and neglect and make recommendations about how the Departments will respond in a co-ordinated manner. A young person may be placed in the care and protection of the Director-General of the Department of Families, Youth and Community Care: see the *Children's Services Act 1965 (Qld)* ss46-59. See the Commission's Research Paper *Medical Examinations in Cases of Suspected Child Abuse* (MP 17, June 1996).

In this Report,¹⁰²³ the Commission has recommended that there be certain types of health care to which a young person should be able to object effectively unless he or she had minimal or no understanding of what the health care involved or why it was required, and the health care was likely either to cause the young person no distress or temporary distress that was outweighed by the benefit of the proposed health care to the young person. Contraceptive health care was included as one of those treatments. Accordingly, even if a parent of a young person consented to contraceptive health care for the young person, the young person could, if he or she had more than a minimal understanding of what was involved and why it was required, object to the health care and override the consent of his or her parent.

¹⁰²³ See 241-242, 264-265 and 283-284 of this Report.

(iv) The Commission's recommendations

The Commission makes the following recommendations in relation to contraceptive health care for a young person:

- (a) A young person is competent to consent to contraceptive health care if the young person understands the nature and consequences of the health care.**
- (b) A valid consent to contraceptive health care of a young person can be given by:**
- (i) if the young person is under 16 years of age and is competent to consent to the health care -**
 - a parent; or
 - the young person;
 - (ii) if the young person is 16 or 17 years of age and is competent to consent to the health care - the young person.**
 - (iii) if the young person is under 18 year of age, but is not competent - a parent.**
- (c) If a young person of any age objects to contraceptive health care, the consent of a parent will be ineffective unless:**
- (i) the health care is carried out pursuant to an appropriate court order; or**
 - (ii) the young person has minimal or no understanding of one or both of the following:**
 - what the health care involves; or
 - why the health care is required;**and the proposed health care is likely to cause the young person:**
 - no distress; or
 - temporary distress that is outweighed by the benefit to the young person.¹⁰²⁴

¹⁰²⁴ See the discussion of this recommendation in relation to contraceptive and other types of health care at 236-237, 255-256 and 278-279 of this Report.

- (d) An authorised health care provider¹⁰²⁵ may carry out contraceptive health care of a young person if:**
- (i) • there is a valid consent to the health care from the young person; or**
 - there is a valid consent to the health care from a parent of the young person and the young person does not object to the health care;**
- and**
- (ii) the health care is in the best interests of the young person's health and well-being.¹⁰²⁶**
- (e) An authorised health care provider may carry out contraceptive health care of a young person, without consent, if:**
- (i) the young person is not competent to consent to the health care;**
 - (ii) the young person requests the health care; and**
 - (iii) the health care is in the best interests of the young person's health and well-being.**

These recommendations are reflected in clauses 29, 35, 36 and 42 of the draft legislation in Chapter 17 of this Report.

¹⁰²⁵ See 298 of this Report. The recommendations apply to a registered medical practitioner, a registered dentist, a registered nurse and such other health care providers as may be prescribed by regulation.

¹⁰²⁶ This requirement does not apply if it is a competent 16 or 17 year old who consents to the health care. See 281-282 of this Report.

(c) Psychiatric and psychological health care

In relation to psychiatric and psychological health care, which, by its nature is unlikely to involve a touching of the young person, the Commission's legislative scheme would not impose a consent requirement on anything but the most serious types of health care.¹⁰²⁷ Those forms of non-touching health care that were considered to be so serious as to require a consent would, therefore, be unavailable to a young person unless the young person was competent to consent (according to the general test recommended by the Commission for consent to health care by a young person¹⁰²⁸) and was 12 years of age or older, or unless a parent consented to the health care.

(d) Other health care

The Commission did not make any particular recommendation in the Discussion Paper about terminations of pregnancy. There is currently no restriction in Queensland on the capacity of a competent young person to consent to a lawful termination.

A number of respondents to the Discussion Paper expressed the view that a young person should not be able to consent to a termination of pregnancy without the consent of, or at least the knowledge of, the young person's parents.¹⁰²⁹ An anti-abortion organisation stated:¹⁰³⁰

We do not believe that a minor could be fully competent in making a decision regarding their medical treatment be it for cosmetic surgery or an abortion. We would be abandoning our youth if we were to subject them to the [Commission's preliminary] proposals We believe parents/guardians should be involved in the decision making process because of the obvious lack of experience the minor would have in this area and because in the main the parents/guardians would have the minor's best interest at heart. Therefore the support and care of a family environment where matters can be discussed is necessary to make the required decision.

¹⁰²⁷ See 206-208 of this Report for a discussion of the Commission's recommendation in relation to a consent requirement for certain serious forms of non-touching health care.

¹⁰²⁸ That is, the young person understands the nature and consequences of the health care. See 201 of this Report.

¹⁰²⁹ Submissions 10, 11, 13, 17, 22, 26, 31, 32, 37, 38 and 46.

¹⁰³⁰ Submission 20.

A termination of pregnancy can be lawfully performed in Queensland only if necessary to protect the woman from danger to her physical or mental health.¹⁰³¹ Further, a health care provider who performs a termination must do so upon a valid consent in order to avoid civil liability for assault and/or battery.

There will be situations where a competent young person consents to a lawful termination without the knowledge or support of her parents. A requirement that the young person's parents be involved in the decision making may in fact result in the young person being deprived of health care that would protect her from danger to her physical or mental health.

The primary philosophy underlying the Commission's legislative scheme is that the law should not hinder a young person's access to needed health care. To deprive a competent young person of the ability to consent to a lawful termination of pregnancy without the involvement of her parents could have the effect of depriving her of health care which, in her particular situation, is in the best interests of her health and well-being.

The Commission believes that in many situations a competent young woman would wish to discuss the possibility of a termination of pregnancy with a parent before proceeding with a termination. However, in those situations where a young woman decides not to involve her parents in the decision making process, the Commission sees no need to alter the current law, which would enable the young woman to provide a valid consent to health care which is lawful only if it protects her from a danger to her physical or mental health.

¹⁰³¹ The lawfulness of terminations in Queensland hinges on the interpretation of the phrase "for the preservation of the mother's life" in s282 of the *Criminal Code* (Qld). That section provides a complete defence to someone who performs a surgical operation "upon anyone for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance is reasonable having regard to the patient's state at the time and to all the circumstances of the case". In 1986 McGuire DCJ in the Queensland District Court case of *R v Bayliss and Cullen* (1986) 9 Queensland Lawyer Reps 8 gave a comprehensive statement on the law in Queensland. His Honour followed and applied in Queensland the two leading cases in the non-criminal code States: *R v Davidson* [1969] VR 667 and *R v Wald* (1971) 3 NSWDCR 25.

In *R v Davidson* [1969] VR 667 Menhennit J held (at 672) that for the use of an instrument with intent to procure a miscarriage to be lawful on therapeutic grounds:

- the accused must have honestly believed on reasonable grounds that the act done by him was:
- (a) necessary to preserve the woman from a serious danger to her life or her physical or mental health (not being merely the normal dangers of pregnancy and childbirth) which the continuance of the pregnancy would entail; and
 - (b) in the circumstances not out of proportion to the danger to be averted.

In *R v Wald* (1971) 3 NSWDCR 25 Levine J at 29 stated:

In my view it would be for the jury to decide whether there existed in the case of each woman any economic, social or medical grounds or reason which in their view could constitute reasonable grounds upon which an accused could honestly and reasonably believe there would result a serious danger to her physical and mental health.

See also the unreported decision of McPherson J in *Re Bayliss* (OS 326/1985, 24 May 1985); *K v T* [1983] 1 Qd R 396 affirmed by the Full Court of the Supreme Court of Queensland on appeal in *Attorney-General for the State of Queensland (Ex rel Kerr) v T* (1983) 57 ALJR 285; *Veivers v Connolly* [1995] 2 Qd R 326 and *CES v Superclinics (Australia) Pty Ltd* (1995) 38 NSWLR 47.

There is also the possibility that young women will resort to “backyard” terminations, which could be extremely detrimental to their health if they are denied the ability to consent to lawful terminations in circumstances that will ensure the confidential nature of the health care sought.

For these reasons, the Commission makes no specific recommendation as to the capacity of a competent young person to consent to a lawful termination of pregnancy.¹⁰³²

¹⁰³² Note, however, that the Commission has recommended that if a young person objects to a termination of pregnancy, that objection will make ineffective, and will override, the consent of a parent to the termination: see 241-242, 264-265 and 283-284 of this Report.

Clause 12(7) of the draft legislation in Ch 17 also provides that s282 of the *Criminal Code* (Qld) will not excuse a person who carries out health care that is regulated under the legislation from liability for assault, unless the health care is also authorised under the legislation.

CHAPTER 14

YOUNG PEOPLE AS PARENTS

1. INTRODUCTION

In 1994, 2988 teenage females (including 339 who were 16 years of age or younger) became parents in Queensland. This represented 6.5% of all confinements in the State for that year.¹⁰³³

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 young parents have, or should have, the same power to consent to health care for their children, notwithstanding that they may not be legally competent to consent to their own health care.

The courts have not drawn any distinction between those parents who are adults and those who are not yet adults in defining the general duties and responsibilities of parents, including the ability to consent to health care for their children. 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 the dilemma of whether to assume a young parent has the legal competence (which most adult parents have) to consent to health care for his or her child, or whether to assess the legal competence of a young parent and treat the young parent's child only if the young parent is competent to consent to the particular health care.

The *Family Law Act 1975* (Cth), which recognises that parental responsibility vests in each parent of a child, does not distinguish between parents of different ages or legal competency either in its specific provisions or in adopting the common law position in its general grant of responsibilities.¹⁰³⁴ 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 under the age of 16 with the necessaries of life, which is imposed by the *Criminal Code* (Qld).¹⁰³⁵

¹⁰³³ Australian Bureau of Statistics, *1994 Demography Queensland* (Cat no 3311.3) at 17, 20.

¹⁰³⁴ The *Family Law Act 1975* (Cth) s61C provides that each of the parents of a child who is not 18 has parental responsibility for the child. "Parental responsibility" is defined in s61B as meaning all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.

Although s61C(1) is expressed to apply to all children, it is arguable that its scope may be limited by reference to other sections in Part VII of the Act, for example, s65H(1) (which provides that a parenting order must not be made in relation to a child who is or has been married or is in a de facto relationship) and s66V(1) (which provides that a child maintenance order does not apply to a child who marries or enters into a de facto relationship).

¹⁰³⁵ *Criminal Code* (Qld) s286. See 87 of this Report.

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 distinction is drawn between those parents who are 18 years of age or more and those parents who are under 18 years, and no distinction is drawn between those parents who are legally competent and those who are not.¹⁰³⁶

However, if a young parent does not understand the nature and consequences of a particular form of health care (that is, is not legally competent), it is unlikely that he or she will be able to assess the health care and its alternatives properly. It is also likely that he or she will have difficulty in deciding whether the health care is 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 health care in question. It may also be unclear what is in the child's best interests, given the lack of reliable direction from the parent.

Whether a particular form of health care 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 the health care should be carried out. In the case of the child of young parents, a health care provider may be less able to rely on the guidance, if any, given by the parents.

As legal competency is determined by reference to particular health care, a young parent would not generally be precluded from making a health care decision for a child. No general limitation on the competence of a young parent to consent to health care for his or her child has been identified in any case law to date. However, it would be highly unusual if a young parent could give a valid consent to health care for his or her child in circumstances where that parent did not understand the nature and consequences of that health care and would not, therefore, be competent to consent to the health care being carried out on himself or herself. Adults are not required to understand the nature and consequences of health care in order to provide a valid consent; they are only required to have a broad understanding of the nature of the treatment.¹⁰³⁷ It would be wholly inconsistent if a young parent who was not considered competent to consent to certain health care for himself or herself could nevertheless consent to that health care being carried out on his or her child.

¹⁰³⁶ The reason why competency is relevant is that many young parents may not be legally competent in the sense that they cannot make decisions concerning health care (that is, they may not be *Gillick* competent). See Ch 5 of this Report for a discussion of the statutory duties and responsibilities of parents.

¹⁰³⁷ See Ch 1 of this Report.

2. MECHANISMS AVAILABLE TO FACILITATE HEALTH CARE FOR A CHILD OF A YOUNG PARENT

If a health care provider is not prepared to treat a child on the basis of the consent of a young parent, there are a number of mechanisms in place to facilitate the child's treatment:

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

Under Part 6 of the Act, an application may be made to the Director-General of the Department of Families, Youth and Community Care to admit a child into his or her care and protection. The application may be made by the child's parent, guardian, or relative or by a person of good repute.¹⁰³⁸ If the Director-General is satisfied that a child is in need of care and protection, and that such care and protection cannot be secured by the giving of assistance under part 5 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.¹⁰³⁹ Similarly, a child may be admitted to the Director-General's care and protection by an order of the Childrens Court upon the application of either the Director-General (made at any time whilst a declaration that the child be admitted to the Director-General's care and protection remains in force),¹⁰⁴⁰ an officer of the Department of Families, Youth and Community Care authorised by the Director-General, or a police officer.¹⁰⁴¹

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 exists, including:¹⁰⁴²

- (a) not having a parent or guardian who exercises proper care of and guardianship over him or her, the child 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;

¹⁰³⁸ *Children's Services Act 1965 (Qld)* s47(1). A doctor or other health care provider caring for a child would be regarded as "a person of good repute" and would thus be able to make such an application.

¹⁰³⁹ *Children's Services Act 1965 (Qld)* ss47(2), 55(1).

¹⁰⁴⁰ Note that a declaration of the Director-General cannot continue indefinitely and that where it is made upon the application of a child's parent or guardian, it will automatically expire one month after the application is made: *Children's Services Act 1965 (Qld)* s48(b).

¹⁰⁴¹ *Children's Services Act 1965 (Qld)* ss49(1), 50(1).

¹⁰⁴² *Id* s46(1).

- (b) the child is in the custody of a person who is unfit by reason of the child's conduct and habits to have custody of the child;
- ...
- (o) the child is for any other reason in need of care and such care cannot be adequately provided by the giving of assistance under part 5.

A child with young parents could be considered in need of care and protection on one of the above grounds if his or her young parents were unable to make a valid decision regarding the child's health care.

In his or her capacity as guardian of a child, the Director-General would have the power to consent to health care for the child. In doing so, the Director-General would be required to exercise that power to further the best interests of the child. When a declaration is made in favour of the Director-General, a child will usually be placed in the custody of another person who will also have the power to consent to health care on behalf of the child.¹⁰⁴³

(b) Application to the Supreme Court of Queensland under its *parens patriae* jurisdiction

The Supreme Court of Queensland is vested with a jurisdiction (known as its *parens patriae* jurisdiction) to supervise parents and other guardians and to protect the welfare of children.¹⁰⁴⁴ As part of that jurisdiction, the Supreme Court may make protective orders, either by imposing wardship,¹⁰⁴⁵ or by making *ad hoc* orders otherwise leaving the guardianship and custody of the child intact.¹⁰⁴⁶

It follows that an application may be made to the Supreme Court by any interested party to determine the appropriateness of particular health care or the best way to determine the appropriateness of health care for a young person on an ongoing basis. In exercising this jurisdiction, the welfare of the child is paramount.¹⁰⁴⁷

¹⁰⁴³ The effectiveness of a similar procedure in New South Wales was discussed in *Faulkner v McPherson* (1995) 120 FLR 64.

¹⁰⁴⁴ *Johnson v The Director-General of Social Welfare (Victoria)* (1976) 135 CLR 92. See also 94-95 of this Report.

¹⁰⁴⁵ *Fountain v Alexander* (1982) 150 CLR 615 per Gibbs CJ at 626.

¹⁰⁴⁶ *In re N (Infants)* [1967] Ch 512 at 531.

¹⁰⁴⁷ See also 94-95 of this Report.

(c) Application to the Family Court of Australia

As noted in Chapter 5 of this Report,¹⁰⁴⁸ the Family Court of Australia has jurisdiction to deal with issues relating to the welfare of children. Section 67ZC¹⁰⁴⁹ of the *Family Law Act 1975* (Cth) provides:¹⁰⁵⁰

- (1) In addition to the jurisdiction that a court has under this Part in relation to children, the court also has jurisdiction to make orders relating to the welfare of children.
- (2) In deciding whether to make an order under subsection (1) in relation to a child, a court must regard the best interests of the child as the paramount consideration.

An application can be made to the Family Court under section 69C of the *Family Law Act 1975* (Cth) to authorise health care that may exceed the scope of a parent's power of consent.¹⁰⁵¹ This welfare jurisdiction could also be used to authorise health care where a particular parent, by reason of legal incapacity, is unable to provide a valid consent to health care for his or her child.

3. PROBLEMS WITH THE MECHANISMS AVAILABLE TO FACILITATE HEALTH CARE FOR A CHILD OF A YOUNG PARENT

The mechanisms currently available to ensure that the children of young parents receive appropriate health care are onerous and cumbersome. Accordingly, health care providers resort to them only in obvious and extreme cases of need. Part of the problem would appear to be that the mechanisms are aimed at assisting children in

¹⁰⁴⁸ See 96-97 of this Report.

¹⁰⁴⁹ The majority of the High Court in *Marion's case* (1992) 175 CLR 218 at 257 noted in relation to the then s64(1) (the nearest current provision being s67ZC) of the *Family Law Act 1975* (Cth):
The sub-section does not in terms confer jurisdiction on the Court but it confers power to make orders and presupposes jurisdiction.

¹⁰⁵⁰ This section applies to all children in Queensland except those who are the subject of prescribed child welfare laws. Subsection 3(2)(a) of the *Commonwealth Powers (Family Law - Children) Act 1990* (Qld) excluded from the matters referred to the Commonwealth Parliament:
the matter of the taking, or the making of provision for or in relation to authorising the taking, of action that would prevent or interfere with -
(a) a Minister, an officer of the State or any other person having or acquiring the custody, guardianship, care or control of children under a provision of an Act specified in schedule 1...
Although s67ZC is expressed to apply to all children, it is arguable that its scope may be limited by reference to other sections in Part VII of the Act, for example, s65H(1) (which provides that a parenting order must not be made in relation to a child who is or has been married or is in a de facto relationship) and s66V(1) (which provides that a child maintenance order does not apply to a child who marries or enters into a de facto relationship).

¹⁰⁵¹ *Marion's case* (1992) 175 CLR 218 at 253, although the majority acknowledged that it was costly for parents to fund court proceedings, that delay was likely to cause painful inconvenience and that the strictly adversarial process of the court was very often unsuitable for arriving at this kind of decision. See 203-205 of this Report for a discussion of the ways in which the Family Court and others have attempted to address these concerns in Queensland. See 204-205 of this Report for a discussion of O23 of the *Family Law Rules*.

clear cases of need, where the most fundamental necessities of life (such as food and accommodation) might otherwise be lacking. In this context, it would usually be necessary for alternative custody or guardianship arrangements to be made to cater for a wide range of unmet needs of the children. In cases where all that is required is a valid consent for a particular health care procedure, such formal intervention may be unwarranted and potentially destructive of family life.

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.¹⁰⁵² With appropriate support, some young parents who would otherwise be considered not legally competent to consent to particular health care for their children, may in fact attain such competence.

As a group, teenager mothers frequently come from a deprived social and economic background¹⁰⁵³ and from families with a history of teenage pregnancy. They frequently come from families with single parents, and have often experienced a lack of affection throughout their lives.¹⁰⁵⁴ An academic who has been conducting research into teenage mothers in Queensland has observed that most young mothers with whom she has had contact could name only one person able to give them support and, even then, only a small degree of support was identified.¹⁰⁵⁵

It has also been observed that, even where support is available to the young mother from her own mother (the baby's grandmother), the grandmother of the child may not necessarily be the most appropriate person to assist her daughter in making decisions regarding the child. This may be due, for example, to a 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.¹⁰⁵⁶

The experience of people consulted by the Commission who work with teenage parents is that a young parent is usually the best person to make decisions concerning his or her child. This was put on the basis that generally no one cares more for a child than the child's parents. However, it cannot be ignored that a young parent may sometimes be unable to make a valid decision concerning his or her child's health care because the young parent does not have sufficient maturity.

¹⁰⁵² Consultations with people working in programs with young mothers (29 November 1994, 8 December 1994).

¹⁰⁵³ See Winter I, Report to the National Youth Affairs Research Scheme *Young people living on the urban fringe* 1995 at 37-44.

¹⁰⁵⁴ Consultation (29 November 1994).

¹⁰⁵⁵ *Ibid.*

¹⁰⁵⁶ *Ibid.*

In the case of a young parent who is not legally competent, it may be appropriate to enable other competent significant carers of the child to provide a valid consent for health care - thus avoiding unnecessary cost and disruption to the family life of the child.¹⁰⁵⁷

4. ARGUMENTS FOR AND AGAINST A PRESUMPTION THAT YOUNG PARENTS BE AUTOMATICALLY ABLE TO CONSENT TO HEALTH CARE FOR THEIR CHILDREN

Whilst it would seem appropriate to give a legally competent young parent the same power to consent to health care as a legally competent adult parent currently has, it may not be appropriate for a young parent to possess that power if he or she is not competent to provide a valid consent for his or her own health care.

More importantly, if a young parent who may not be legally competent is, in all cases, presumed to have the same powers as an adult parent, there is a real risk that decisions would be made concerning health care of the young parent's child without a proper appreciation of the nature of the health care and the immediate and future consequences of that health care. As a result, the health and well-being of the child could be placed at risk.

(a) Arguments for a presumption of competence

The arguments in favour of presuming the legal competence of a young parent to consent to health care for his or her child include:

(i) Corollary to the young parent's duties and responsibilities

Since a young parent has certain legal responsibilities and duties to his or her child, the young parent, as a necessary corollary to these responsibilities and duties, should have the legal capacity to make decisions about his or her child's health care.

¹⁰⁵⁷ See Ch 15 of this Report.

(ii) Maturity through child-rearing

By reason of raising a child, a young parent has certain legal duties and responsibilities imposed upon him or her that most people of his or her age could not even contemplate. In some cases, as a result of those duties and responsibilities, the young parent may develop a level of maturity that may not otherwise have developed until a later time.

If the legal competence of a young parent were presumed, the various problems with finding an alternative mechanism for health care decision-making would be overcome, except in the rarest cases where the young parent was simply unable to consent (for example, because of unconsciousness or another disability).

(b) Arguments against a presumption of competence

The arguments against a presumption of legal competence include:

(i) A young parent's rights and responsibilities are not based on a duty to provide health care

The fact that a person is under a legal duty to provide health care for a young person in that person's care¹⁰⁵⁸ does not, of itself, ensure that that person is the most appropriate person to consent to the health care for the young person.

(ii) Parenthood does not always connote maturity

The fact that a young person has become a parent does not indicate that the young person has undergone the complete process of maturation. Indeed, it has been observed that:¹⁰⁵⁹

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:¹⁰⁶⁰

¹⁰⁵⁸ See *Children's Services Act 1965* (Qld) s69(3); *Criminal Code* (Qld) s286.

¹⁰⁵⁹ Fleming S, "Adolescent pregnancy in Australia: perspectives and problems" *Modern Medicine of Australia* (May 1990) 64 at 66.

¹⁰⁶⁰ *Id* at 65.

- (i) developing intellectual skills;
- (ii) developing a sense of one's own identity;
- (iii) developing a conscience and moral values;
- (iv) achieving independence from parents;
- (v) adjusting to sexual maturity and to changing gender-related roles;
- (vi) establishing new working relationships with age mates of both genders;
and
- (vii) making educational and vocational choices which will lead to economic independence.

It would appear that certain of these steps are hastened or omitted altogether as a result of teenage parenthood, because, unlike other teenagers, the young mother must assume responsibility, must think of the needs of another, must plan ahead, and is likely to experience maternal instincts and a desire to nurture that are usually not experienced by women until later in life. Important decisions must often 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 other teenagers in certain respects.

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 many young parents still see issues in black and white, and may be unable to appreciate the consequences of certain decisions. In many cases, they may sacrifice their autonomy because of a need to find love and affection, and often prefer the interests of their partner to their child.¹⁰⁶¹ 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:¹⁰⁶²

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.

It therefore cannot be assumed that a young parent necessarily has the requisite maturity to make a valid decision regarding health care for his or her child. In fact, the two aspects of maturation that 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

¹⁰⁶¹ Consultation with an academic in the nursing field who is involved in research in relation to young Queensland mothers (29 November 1994).

¹⁰⁶² Thompson C and Liddy U, "Adolescent Sexuality: Issues, Choices and Reproductive Rights" (Oct 92-Feb 93) *Transitions - the YANQ Journal* 34 at 38.

of types of health care. Development of intellectual capacity leading to the ability to understand and foresee the consequences of events is more critical to the ability of a young person to provide a valid 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 is not a sufficient reason to justify granting that parent the power to consent to health care for his or her child.

5. PRELIMINARY PROPOSAL IN DISCUSSION PAPER

Taking into account the considerations outlined above, the Commission, in the Discussion Paper, made the following preliminary proposal:¹⁰⁶³

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 ...

The respondents to the Discussion Paper were generally in favour of the Commission's recommendation. For example, an organisation interested in assessing public policy stated:¹⁰⁶⁴

Young people who are parents should be able to consent to treatment for their own child to the same extent to which they are able to consent to treatment for themselves. If neither of a child's parents is 18 or over, this will mean that cases will arise in which the parents lack the capacity to consent to certain treatments for their child. In such a case, the matter should be brought before the court, which in its discretion would issue (a) an order that one or both of the parents be regarded as having the same capacity to consent to their child's treatment as if they were 18, or (b) some other more restrictive order.

Similarly, an organisation providing counselling and other services to young people, expressed the view that:¹⁰⁶⁵

If a young parent is able to understand the nature and consequences of treatment, they should have the same rights as any other parent.

Some young people who responded to the Commission's questionnaire¹⁰⁶⁶ expressed the view that a teenage parent should be able to consent to the health care of his or her

¹⁰⁶³ Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995) at 13 and 206 (Recommendation 16).

¹⁰⁶⁴ Submission 3.

¹⁰⁶⁵ Submission 8.

¹⁰⁶⁶ A copy of the Commission's questionnaire is set out in Appendix 2 to this Report.

child, with most of those respondents adding the qualification that the young parent should first understand what is being proposed.¹⁰⁶⁷

Initial consultations held by the Commission prior to the release of the Discussion Paper¹⁰⁶⁸ and submissions to the Information Paper¹⁰⁶⁹ indicated that in dealing with this issue in practice, health care providers tend to treat young parents as adults and accord their opinion and consent the same status as those of adult parents. Furthermore, it was indicated that in practice, an assessment of the legal competency of a young parent was considered irrelevant, and that it would be rare for a health care provider to consider a young parent incapable of making decisions for his or her child, or for a health care provider to decline to accept the young parent's consent. The Commission was informed that this was more likely to occur when a young parent was experiencing other, perhaps more important, problems in caring for his or her child (such as an inability to pay for food and accommodation, or an inability to care for the child alone).

Consultations held by the Commission following release of the Discussion Paper generally supported these earlier observations. However, the Commission was informed about a number of cases involving health care providers who, when faced with the situation of a young parent with a child in need of health care, were unsure how to deal with the situation. A youth worker in a rural community reported to the Commission that she was aware of separate cases where the child of a 12 year old mother who was regarded by her as legally competent was refused treatment by a medical practitioner, while the child of a 14 year old mother who was probably not legally competent was treated by the same medical practitioner on the basis of the young mother's consent. It is possible that the confused state of the current law has contributed to this apparently inconsistent approach (although there may very well have been other factors taken into account by the medical practitioner when making the decision whether or not to treat each of the children).¹⁰⁷⁰

Another anecdote was provided to the Commission during its consultations in Northern Queensland of a 12 year old young mother with alcohol and other personal problems whose baby was being cared for on a temporary basis by different members of her community. A number of people were concerned about the issue of who would have authority to consent to health care for the child.¹⁰⁷¹

¹⁰⁶⁷ Submissions 68, 69, 70, 71, 73, 74, 75, 77 and 78.

¹⁰⁶⁸ Queensland Law Reform Commission, *Discussion Paper Consent to Medical Treatment of Young People* (WP44, May 1995).

¹⁰⁶⁹ Queensland Law Reform Commission, *Information Paper Consent by Young People to Medical Treatment* (MP2, May 1993).

¹⁰⁷⁰ Consultation meeting 23.

¹⁰⁷¹ Consultation meeting 4.

6. THE COMMISSION'S RECOMMENDATION

In light of the submissions received in response to the Discussion Paper and the discussions held during the consultation meetings, the Commission continues to support the recommendation proposed in the Discussion Paper in relation to young people as parents.

The Commission recommends that a parent who is under 18 years of age should be able to consent to, or refuse, health care of his or her child if the parent:

- (a) understands the nature and consequences of the health care; and**
- (b) communicates his or her decision about the health care in some way.**

This recommendation is reflected in subclauses 21(1) and (6) of the draft legislation in Chapter 17 of this Report.

CHAPTER 15

CONSENT BY A SIGNIFICANT CARER

1. INTRODUCTION

In the Discussion Paper¹⁰⁷² the Commission queried whether:¹⁰⁷³

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 the registered health care provider and the carer should be immune from liability.

To a large extent, the Commission's recommendations in Chapter 13 of this Report (health care for which consent should not be a requirement) should obviate the need for a carer to be able to consent to the health care of a young person in his or her care, at least in cases where the health care is required in an emergency situation, or is required without delay.

However, there will be situations where the young person is in the care of a person other than his or her parents, or in a residential facility, and health care that does not amount to an emergency and is not regarded as being required without delay is nevertheless in the young person's best interests. In such situations, if the young person is not competent to consent to the health care and his or her parents are not reasonably contactable, then it is desirable to enable the young person's carer to provide a valid consent to the health care. This would avoid the need to obtain a court order authorising the health care, and would enable a person with a genuine interest in the young person's welfare to make decisions that a parent would normally make.

For example, if a young person had been raised by an aunt, without formal adoption arrangements having been entered into, it would be reasonable to expect the aunt to be able to consent to the health care as if she were a parent of the young person. This would be particularly relevant if the young person's parents did not play a significant role in his or her day to day care, or if they were not reasonably contactable. Similarly, if a young person was living in a residential facility, but was not the subject of a care and protection order,¹⁰⁷⁴ and the young person's parents were not reasonably contactable, it would be desirable for the head of the institution to be able to consent to health care that was in the young person's best interests.

¹⁰⁷² Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995).

¹⁰⁷³ *Id* at 14 and 207 (Recommendation 21).

¹⁰⁷⁴ See the discussion of these orders at 205 and 319-320 of this Report.

The Commission understands that at common law parents are unable to delegate their capacity to consent to, or refuse, health care for their child.¹⁰⁷⁵ Thus, for example, any authority given by the parents of a school boarder, that purports to authorise the head of the boarding school to arrange for and consent to any health care on behalf of their child, is likely to be of no legal effect.

Although the head of the boarding school would be under a legal duty to ensure that the young person received appropriate health care,¹⁰⁷⁶ he or she would not have the legal capacity to consent to the health care. If the young person was not competent to consent to his or her own health care, then, subject to any court order to the contrary, only the young person's parents could provide a valid consent. That consent could be given in advance, perhaps in writing, but would nevertheless have to be directed to the health care provider and relate to the particular form of health care that the health care provider proposed to carry out.

In an emergency, no consent is required. However, in all other situations, no one other than a parent,¹⁰⁷⁷ unless authorised by the court, can provide a valid consent to the young person's health care. This would preclude a baby sitter or another adult who has the significant care of a young person - such as a grandparent or aunt who is raising the young person without a formal adoption arrangement - from providing a valid consent to health care for the young person.

The Commission considers the current law to be unsatisfactory in this respect, particularly in situations where a young person is being cared for by a competent person or by a residential facility, and the young person's parents are not reasonably contactable. If it is not an emergency situation, but the proposed health care is nevertheless in the best interests of the health and well-being of the young person, the law should enable the carer or responsible person within the facility to provide a valid consent to the health care.

All the submissions to the Discussion Paper that addressed this issue were in favour of providing a significant carer (including an institutional carer) of a young person with the capacity to consent to health care for the young person.¹⁰⁷⁸

The Department of Family and Community Services (now the Department of Families, Youth and Community Care) suggested in its submission that a wider definition of "parent" was needed, especially for Aboriginal communities, where it was common for

¹⁰⁷⁵ See 93 of this Report.

¹⁰⁷⁶ *Criminal Code* (Qld) s285. See 86-87 of this Report.

¹⁰⁷⁷ See note 9 of this Report.

¹⁰⁷⁸ For example, Submissions 7, 49, 60, 63 and 79.

a child to be in the care of his or her extended family.¹⁰⁷⁹

One respondent, a community advocacy organisation, suggested that the authority of a carer should not extend beyond that of a parent.¹⁰⁸⁰

One suggestion has been made that those people standing *in loco parentis* to a young person should have the capacity to consent to health care for the young person.

2. THE COMMON LAW MEANING OF THE TERM *IN LOCO PARENTIS*

In 1875, the question whether a person stood *in loco parentis* (that is, in the place of a parent) to a young person - which is a question of fact - was described as "probably one of the most difficult of legal problems to solve".¹⁰⁸¹ Much of that difficulty has arisen because of the numerous different legal contexts in which the term *in loco parentis* has been used.¹⁰⁸²

The Commission is not aware of any case that has considered the ambit of the term *in loco parentis* in the context of a discussion of a person's capacity to consent to health care for a young person.

However, a number of cases have considered the meaning of the term *in loco parentis* in the context of deciding an application brought on behalf of a young person for compensation for the death of a person said to have stood *in loco parentis* to the young person. Those cases offer the best available guidance to the common law meaning of the term *in loco parentis* when it is used in the context of a discussion of a person's capacity to consent to health care for a young person.

In *Nash v Commissioner for Railways*¹⁰⁸³ the Full Court of the Supreme Court of New South Wales had to consider the meaning of the term *in loco parentis* where it appeared in the *Compensation to Relatives Act 1897* (NSW). That Act entitled close relatives, including children of a deceased person, to bring an action for damages

¹⁰⁷⁹ Submission 79.

¹⁰⁸⁰ Submission 63.

¹⁰⁸¹ See *Fowkes v Pascoe* (1875) 10 Ch App 343 per James LJ at 350.

¹⁰⁸² Note, for example, that in *Fowkes v Pascoe* (1875) 10 Ch App 343, the legal issue to be decided was whether the presumption of advancement or the presumption of a resulting trust applied; that in *Powys v Mansfield* (1837) 3 My & Cr 359; 40 ER 964, the legal issue to be decided was whether the presumption of law against double portions applied; and that in *Stone v Carr* (1799) 3 Esp 1; 170 ER 517, the legal issue to be decided was whether a stepfather was liable in contract to a schoolmaster for fees for his stepchildren's education.

¹⁰⁸³ [1963] SR (NSW) 357.

against the person who had wrongfully caused the death of the deceased. The Act defined the word "child" to include a son and daughter, grandson and granddaughter, stepson and stepdaughter and any person to whom another stands *in loco parentis*.

The Court in *Nash v Commissioner for Railways* made the following comments about the term *in loco parentis*:¹⁰⁸⁴

What the [Compensation to Relatives] Act appears thus to embrace is a state of notional parenthood, of *de facto* incorporation into a family, irrespective of ties of blood, marriage or adoption, and regardless of legitimacy. It would accordingly not appear to be sufficient, to found a claim under the *in loco parentis* relationship, merely to show that the deceased ... in the role of "father" ... provided, or might reasonably have been expected to provide, benefits or services measurable in money to another member of the family. It is necessary to show that the "father" stood in the shoes of an actual father, and the "child" in the shoes of an actual child, looking to the "father" for care, protection, maintenance and upbringing ... We are, in other words, not concerned, as was the Court in *Powys v Mansfield* merely to seek a person taking upon himself the duty of making financial provision for a child, and a child so provided for; **what must be shown is a relationship of foster parent and foster child with all its incidents.** [emphasis added]

This passage was adopted with approval by the Supreme Court of Queensland in *Hunt v National & General Insurance Co Ltd*.¹⁰⁸⁵ In that case, the application for compensation had been brought on behalf of the illegitimate child of an unmarried, deceased mother pursuant to section 12 of the *Common Law Practice Act 1867* (Qld).

The decision in *Re Schneider and Secretary to the Department of Social Security*¹⁰⁸⁶ is a useful example of a case where a court found that a person stood *in loco parentis* to a young person.

In that case, the applicant had moved to Australia in 1981 with her new Australian husband and left her three children (who had all been born in the Philippines) in the care of her sister in Manila. She first sought family allowance from the Department of Social Security for her children in 1984. It was not granted until the children arrived in Australia a year later. The Administrative Appeals Tribunal ("the AAT") held that the applicant was entitled to receive family allowance whilst her children were still living in Manila because she had retained a sufficient degree of custody, care and control over her children.

The evidence was that the applicant's sister always accepted the applicant's advice, suggestions, opinions and decisions concerning the manner in which the applicant's children were to be brought up. The AAT found that the applicant's sister "who was,

¹⁰⁸⁴ *Id* at 362.

¹⁰⁸⁵ [1974] Qd R 157 at 158.

¹⁰⁸⁶ (1986) ASSC 92-085.

in a sense, only minding them"¹⁰⁸⁷ stood *in loco parentis* to the three children in all respects but that she sought the applicant's approval in relation to any important issue concerning the children's lives (including the administration of any serious treatment).

The AAT made the following comments about the relationships between the applicant, her sister and the three children:¹⁰⁸⁸

[T]he applicant had that ultimate responsibility [for the care, custody and control of her children] even although she arranged with her sister to carry it out from day to day.... [T]he applicant achieved a firm and successful arrangement with a close and trusted relative which enabled her to exercise as much care and control as was reasonably possible and necessary in order to discharge through her agent full responsibility for the day to day maintenance, training and advancement of her children.

Based on the cases discussed above, it would seem that there are two main situations at common law where a person can be said to stand *in loco parentis* to a young person:

- (i) Where a person (other than a legal guardian) stands in the shoes of a parent, in the sense that he or she becomes, in effect, a foster parent and takes on all of the responsibilities and obligations of a parent.

An example of this category of person *in loco parentis* would be a grandparent who informally takes over the care of his or her young orphaned grandchild.

- (ii) Where a person (other than a legal guardian) is responsible for the day to day care of a young person on a long term basis, but is subject to the direction of the young person's parents or legal guardian who retain ultimate responsibility for the care of the young person.

An example of this category of person *in loco parentis* would be a person in charge of a boarding school, or a person in charge of a residential facility that takes on the responsibility of caring for young people who have run away from home.

3. CAPACITY TO CONSENT FOR PERSONS WITH DUTY TO SEEK HEALTH CARE

A person who has responsibility for the care of a young person, including a person standing *in loco parentis* to a young person, has certain obligations under the common law and under Queensland legislation to ensure that the young person receives adequate health care.

¹⁰⁸⁷ *Id* at 90,161.

¹⁰⁸⁸ *Id* at 90,162.

For example, subsections 69(1) and (3) of the *Children's Services Act 1965* (Qld) provide that:

- (1) A person having a child in his or her charge shall not ill-treat, neglect, abandon or expose the child in a manner likely to cause the child unnecessary suffering or to injure the child's physical or mental health nor suffer the child to be so ill-treated, neglected, abandoned or exposed.
- (3) A person having the charge of a child shall be deemed to have neglected the child in a manner likely to cause the child unnecessary suffering or to injure the child's physical or mental health, as the circumstances may indicate, if-
 - (a) being able to so provide from the person's own resources, the person fails to provide adequate food, clothing, medical treatment, lodging or care for such child; or
 - (b) being unable to so provide from the person's own resources, the person fails to take all lawful steps within the person's knowledge to procure the provision of adequate food, clothing, medical treatment, lodging and care for such child.

Other examples of statutory obligations to ensure that a young person receives adequate health care include section 40 of the *Children's Services Act 1965* (Qld) and sections 285 and 286 of the *Criminal Code* (Qld).¹⁰⁸⁹

Although a person with the responsibility for the care of a young person is under a legal duty to seek appropriate health care for the young person, there is no Australian case authority that would support the notion that such a person is legally authorised to consent to health care for the young person.

This would appear to be the case even where a parent or legal guardian of a young person has attempted to delegate his or her authority to make all decisions concerning the young person's health care to a person or institution having the care of the young person.

A number of jurisdictions have remedied this gap in the common law by legislating to enable a person (other than a parent or legal guardian) with responsibility for the care of a young person to do some or all of the things that parents are able to do for or on behalf of their children.

For example, subsections 2(9) and 3(5) of the *Children Act 1989* (UK) provide that:

- 2(9) A person who has parental responsibility for a child may not surrender or transfer any part of that responsibility to another but may arrange for some or all of it to be met by one or more persons acting on his [or her] behalf.
- 3(5) A person who -

¹⁰⁸⁹ Note that these three provisions have already been discussed in some detail at 84-89 of this Report.

- (a) does not have parental responsibility for a particular child; but
- (b) has care of the child,

may (subject to the provisions of this Act) do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare. [emphasis added]

In New Zealand there is a provision enabling a person "who has been acting in the place of a parent" or (if no such person can be found) the Director-General of the relevant Government Department or a District Court Judge to give consent to medical treatment.¹⁰⁹⁰

Another example is found in the *Consent to Medical Treatment and Palliative Care Act 1995* (SA). Subsection 4(1) of that Act defines the word "parent" to include a person *in loco parentis* to the child. This means that, in South Australia, a person who stands *in loco parentis* to a young person has the same legal authority to consent to health care for the young person as a parent or legal guardian of the young person.

The Commission is concerned that by simply defining "parent" to include a person *in loco parentis* to a child, there will be cases where it is unclear whether a person actually stands in the place of the parent of a child. Without such certainty, a health care provider may justifiably be reluctant to treat the child upon the consent of such a person.

It would generally not be appropriate for a casual baby sitter or some other person with the temporary care of a young person to have the capacity to consent to health care that was neither emergency health care nor health care required without delay.¹⁰⁹¹ For example, a decision concerning whether a young person should be immunised against a particular disease would not be an emergency situation and should not be made by a person who only has the temporary care of the young person. It is a matter that can generally wait until one of the young person's parents is available to consent.

Similarly, there would be no need for the head of a boarding school to be able to consent to health care for a young person who is not competent to consent to his or her own health care if it is the subject of a specific consent from the young person's parents, or is emergency health care or health care required without delay. Although the young person is in the school's full-time care, that care is subject to the direction of the young person's parents. If the young person's parents are reasonably contactable, then their consent should be sought before any health care (which is not the subject of a specific consent) is carried out on the young person.

¹⁰⁹⁰ *Guardianship Act 1968* (NZ) s25(3)(b) and (c).

¹⁰⁹¹ See Ch 13 of this Report for a discussion of those treatments for which consent will not be a requirement under the Commission's scheme.

However, in the case of a young person in the significant care of a residential facility or an individual where the young person's parents exert little or no direction over their child because, for example, they are not competent to care for their child or are not reasonably contactable, the Commission believes it would be reasonable to permit the head of the facility or the individual caring for the young person to provide a valid consent to whatever health care the young person may require.

This would permit, for example, the principal of a boarding school who has the significant care of a young person to consent to health care for the young person if a parent cannot reasonably be contacted.

In the view of the Commission, the law should not impede young people's access to health care by unduly limiting the class of persons who can consent to health care for a young person. A broader definition of "parent" should be adopted to reflect the fact that many young people have primary carers who are not their natural parents.

The Commission is of the view that it would increase certainty for parents, carers and young people for the scheme to specify those people who should be able to consent to health care for a young person as if a parent, and the circumstances in which they should be able to do so.

The major limitation that should apply is that a significant carer should be able to provide a valid consent only if the young person's parents are not reasonably contactable, or are not themselves competent to consent to health care for the young person. The principal of a boarding school, for example, should not be able to contract out of the obligation to take reasonable steps to contact the young person's parents; it should be a statutory requirement that a significant carer will have the capacity to consent only if the parents are not reasonably contactable.

(a) The Commission's recommendations

The Commission recommends that each of the following persons be regarded as a "parent" for the purposes of being able to provide a valid consent to health care of a young person:

- (a) a natural¹⁰⁹² or adoptive parent, as well as a guardian of a young person appointed by operation of law, a guardian appointed by deed or by will to care for the testator's children upon the testator's death,¹⁰⁹³ or a guardian appointed by order of the Family Court of Australia, or by the Supreme Court of Queensland or pursuant to care and protection proceedings;**
- (b) a step-parent or foster parent who has full-time care of the young person; and**
- (c) a competent person of or over 16 years of age (including the head of a residential facility) who has the full-time or significant care of a young person, but only if the young person's parents:**
 - (i) are not reasonably contactable; or**
 - (ii) are not themselves competent to consent to health care of the young person.**

This recommendation is reflected in clause 21 of the draft legislation in Chapter 17 of this Report.

Thus, under the Commission's proposed legislative scheme, a temporary carer such as a baby sitter or a family day carer would not be able to provide a valid consent to health care for a young person in his or her care. Such a person would not generally fall within the broad definition of "parent" recommended by the Commission.

This should not hinder the provision of needed health care for young people. If the health care is required without delay, the young person's parents are not reasonably contactable, and the health care is in the best interests of the young person's health

¹⁰⁹² But see s28(1) of the *Adoption of Children Act 1964* (Qld) which provides that upon the making of an adoption order the adopted child ceases to be the natural child of a person who was a parent of the child before the making of the adoption order.

¹⁰⁹³ See *Children's Services Act 1965* (Qld) s90.

and well-being, it can proceed without consent.¹⁰⁹⁴ If the health care is required in an emergency situation, no consent is required.¹⁰⁹⁵ If the health care falls within the proposed definition of “minor health care”, no consent is required for a young person who is not competent.¹⁰⁹⁶ It is unlikely, therefore, that a consent would be required for any health care that could not wait until a parent could be contacted.

The Commission has considered the possibility of enabling parents to provide a specific or general authority to temporary carers, so as to enable them to provide a valid consent to the health care of the young people in their care. The law in Queensland does not currently provide for such a delegation of authority. However, the Commission believes that the provisions referred to above, which would enable health care to be carried out without a consent in certain circumstances, adequately cover the types of situations in which a young person who was not competent to consent to his or her own health care might require health care while his or her parents were not reasonably contactable.

(b) Relationship between the Commission’s recommendations and the *Family Law Act 1975 (Cth)*

It is possible for a parenting order made under Division 6 of Part VII of the *Family Law Act 1975 (Cth)* to take away or diminish the parental responsibility of a parent, including the power to consent to health care.¹⁰⁹⁷ Where, in a particular case, the Family Court made an order taking away a parent’s capacity to consent to health care for his or her child, that would create an inconsistency with the various provisions in the proposed legislative scheme that provide that a parent is able to consent to health care for his or her child.

In *P v P*¹⁰⁹⁸ the High Court of Australia held that where, in a particular case, a provision in State legislation conflicted with an order made by the Family Court in its welfare jurisdiction, the order of the Family Court would, by virtue of the operation of section 109 of the Constitution, override the particular legislative provision. The proposed legislative scheme will, therefore, be subject to any specific orders made by the Family Court in a particular case.

¹⁰⁹⁴ The health care can only be carried out in these circumstances by an authorised health care provider and only on a young person who is not competent: see 292-299 of this Report.

¹⁰⁹⁵ See 286-292 of this Report.

¹⁰⁹⁶ See 299-301 of this Report.

¹⁰⁹⁷ *Family Law Act 1975 (Cth)* s61D(2).

¹⁰⁹⁸ (1994) 181 CLR 583. See the discussion of this case at 97-99 of this Report.

For example, if the Family Court took away a parent's power to consent to health care for his or her child, that parent would then be unable to provide a valid consent, despite being a "parent" within the meaning of the proposed legislative scheme, and despite the fact that the parent was purporting to consent to health care for which, under the scheme, a parent would ordinarily be able to provide a valid consent.

The fact that the proposed legislative scheme will be subject to the power of the Family Court to make specific orders in a particular case affords some further protection of the interests of young people.

The Commission is, however, concerned about the potential liability of a health care provider who carries out health care on a young person on the basis of the purported consent of a parent who no longer has any authority to provide a valid consent. In the absence of a valid consent, the health care provider would potentially be liable for assault.

Of course, if a health care provider knew that a parent no longer had authority to consent to the health care, there would be no reason to wish to protect the health care provider. However, where a health care provider acts in ignorance of the fact that, because of a Family Court order, a parent no longer has authority to consent to health care for his or her child, it is desirable to protect the health care provider from liability for assault, notwithstanding the absence of a valid consent.

The Commission recommends that if a person carries out health care of a young person contrary to a court order, the person's liability for assault should be decided as if there were no court order unless the person knew, or ought reasonably to have known, of the court order.

This recommendation is reflected in clause 46 of the draft legislation in Chapter 17 of this Report.

CHAPTER 16

MISCELLANEOUS

1. PENALTIES AND ENFORCEMENT

(a) Other jurisdictions

South Australia and New South Wales are the only jurisdictions in Australia with legislation that specifically deals with consent to health care of young people. However, the *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* and the *Minors (Property and Contracts) Act 1970 (NSW)* do not contain any enforcement or penalty provisions. The only incentive for medical practitioners and dentists - who are the only health care providers regulated by the two Acts - to comply with the requirements of each Act is the statutory protection (offered by each Act) from liability that might otherwise arise under the common law or under other legislation (for example, crimes legislation).

For example, in South Australia a medical practitioner who treats a young person on the basis of a valid consent from either the young person or one of the young person's parents, is protected from "civil or criminal liability" other than for negligence. The reference to "civil or criminal liability" is a reference to civil or criminal liability arising otherwise than under the South Australian Act. Depending on the circumstances of the case, that could include criminal liability for assault or false imprisonment, or civil liability for trespass to the person, false imprisonment or breach of statutory duty.

The South Australian and New South Wales Acts do not distinguish between health care that involves physical contact and health care that does not.¹⁰⁹⁹ It is unlikely, however, that a health care provider in either of those jurisdictions would face any liability for assault or battery if he or she carried out non-touching health care on a young person without a valid consent. In rare circumstances, there could be liability for false imprisonment. Accordingly, the statutory protection from liability offered to medical practitioners who seek a valid consent before carrying out non-touching health care on young person may provide medical practitioners with little, if any, incentive to seek a valid consent, given that the potential liability for carrying out non-touching health care without a valid consent is very limited. For that reason, the law in South Australia and New South Wales relating to consent to non-touching health care has not been significantly altered by legislation.

¹⁰⁹⁹ See 207 of this Report for a discussion of how certain non-touching treatments may nevertheless be particularly damaging to a young person.

(b) The Commission's legislative scheme

The success of the Commission's legislative scheme is largely dependent upon the protection from liability offered to health care providers who comply with the scheme.¹¹⁰⁰ To that end, the Commission is of the view that the scheme should contain substantive consequences for treating a young person without a valid consent.

The existing civil causes of action (other than for negligence) that are available in respect of non-touching health care provided without a valid consent are limited. In certain rare circumstances there may be an action for false imprisonment. Where there is a statutory consent requirement, it may also be possible to frame an action in terms of a breach of statutory duty.¹¹⁰¹

A breach of the Commission's proposed legislative scheme may arguably give rise to an action for breach of statutory duty. Any doubt as to the availability of this cause of action could be alleviated if the scheme contained a provision which stated that a breach of the scheme would give rise to an action for damages for breach of statutory duty. One of the statutory duties would presumably be a health care provider's duty to obtain a valid consent before proceeding with treatment.

However, because of the technical difficulties associated with actions for breach of statutory duty, the Commission believes that the scheme should provide for a civil

¹¹⁰⁰ The protection offered is discussed at 210-220 of this Report.

¹¹⁰¹ This is an action in tort in which damages are claimed for the breach of a duty imposed by statute. Civil liability does not arise merely because loss or damage resulted from the commission of an illegal act (*Lonrho Ltd v Shell Petroleum Co Ltd (No 2)* [1982] AC 173), but because of some presumed statutory intent. In *Downs v Williams* (1971) 126 CLR 61 at 74 Windeyer J approved of the following statement by Lord Wright in *London Passenger Transport Board v Upson* [1949] AC 155 at 168:

The statutory right has its origin in the statute, but the particular remedy of an action for damages is given by the common law in order to make effective, for the benefit of the injured plaintiff, his [or her] right to the performance by the defendant of the defendant's statutory duty. It is an effective sanction. It is not a claim in negligence in the strict or ordinary sense ...

In practice, such an intent is more readily attributed to statutes that prescribe specific rules of conduct for greater safety in industry and other situations where the common law already demands observance of reasonable care (Fleming JG, *The Law of Torts* (8th ed 1992) at 188). Nevertheless, there have been some cases where a breach of statutory duty has been found in circumstances where there was no common law duty of care (*Monk v Warbey* [1935] 1 KB 75; *Thornton v Kirklees Metropolitan Borough Council* [1979] QB 626; *Read v Croydon Corp* [1938] 4 All ER 631), and where there was no relationship of employer/employee between the plaintiff and the defendant (*Caif v Sydney County Council* [1972] 2 NSWLR 521; *Martin v Dean* [1971] 2 QB 208; *Puffett v Proprietors of Strata Plan No 121* (1987) 17 NSWLR 372; *Pantalone v Alaouie* (1989) 18 NSWLR 119; *J D Bell (Calool) Pty Ltd v Shortland County Council* (1991) 74 LGRA 398).

There had been some suggestion that the duty created by the legislation must be for the benefit of a defined class of persons, rather than for the public as a whole, and that only members of that class could bring an action for breach of statutory duty (*Bourke v Butterfield & Lewis Ltd* (1926) 38 CLR 354 at 359-360). This is no longer the view of the High Court (*Piro v W Foster & Co Ltd* (1943) 68 CLR 313; *O'Connor v S P Brady Ltd* (1937) 56 CLR 464 at 478, 486-487).

Further, it has been suggested that there is no reason why the tort should be restricted to situations where injury, loss or damage has been suffered, or to situations where the defendant already owes a common law duty of care to the plaintiff (Campbell JC, QC, "Contribution, Contributory Negligence and Section 52 of the Trade Practices Act - Part 1" (1993) 67 ALJ 87 at 106). In the absence of an express provision allowing a right of action for breach of statutory duty, the existence of such a right depends solely on the construction of the statute creating the duty (Campbell JC, QC, "Contribution, Contributory Negligence and Section 52 of the Trade Practices Act - Part 1" (1993) 67 ALJ 87 at 106).

cause of action (for the recovery of damages and/or compensation) that a person on whom unauthorised health care had been carried out could bring against the person who had carried out the health care. This cause of action would be particularly significant in relation to unauthorised prescribed serious non-touching health care,¹¹⁰² where the current law provides little, if any, redress. This would apply to those forms of health care which the Commission has recommended should always be preceded by a valid consent.¹¹⁰³

The Commission recommends that the legislative scheme contain a statutory cause of action that will enable a young person to recover damages and/or compensation from a health care provider who, without lawful excuse, carries out on the young person health care that is not authorised by the legislative scheme or by another law.

In many cases, a person may suffer no pecuniary loss as a result of unauthorised health care. The Commission is, therefore, of the view that damages should not be limited to pecuniary loss; non-pecuniary loss¹¹⁰⁴ should also be compensable by way of damages.

The Commission has also considered whether the statutory cause of action should provide for exemplary damages, in addition to compensatory damages.

At common law, in an action for trespass to the person (that is, assault, battery or false imprisonment) both compensatory (including aggravated) and exemplary damages are available.¹¹⁰⁵ Compensatory damages compensate the plaintiff for injury, loss or damage suffered. Aggravated damages are compensatory by their very nature, as they are intended to compensate the plaintiff for the injury to his or her feelings caused by insult, humiliation and the like.¹¹⁰⁶ Exemplary damages are punitive in nature. They

¹¹⁰² See the Commission's recommendation at 208 of this Report that certain prescribed forms of serious non-touching health care should require a valid consent before they can lawfully be carried out.

¹¹⁰³ See the Commission's recommendation at 208 of this Report.

¹¹⁰⁴ Injury to a young person's feelings, such as humiliation, would be an example of non-pecuniary loss.

¹¹⁰⁵ *Lamb v Cotogno* (1987) 164 CLR 1 at 8; *Fontin v Katapodis* (1962) 108 CLR 177; *Johnstone v Stewart* [1968] SASR 142; *Pearce v Hallett* [1969] SASR 423; *Lackersteen v Jones* (1988) 92 FLR 6 (NT).

¹¹⁰⁶ *Lamb v Cotogno* (1987) 164 CLR 1 at 8. "[A]ggravated damages are given to compensate the plaintiff when the harm done to him [or her] by a wrongful act was aggravated by the manner in which the act was done: exemplary damages, on the other hand, are intended to punish the defendant, and presumably to serve one or more of the objects of punishment - moral retribution or deterrence": *Uren v John Fairfax & Sons Pty Ltd* (1966) 117 CLR 118 per Windeyer J at 149.

require the defendant to have acted in a "high-handed fashion or with malice",¹¹⁰⁷ or with a "contumelious disregard of the plaintiff's rights".¹¹⁰⁸ They are only to be awarded when compensatory damages (including aggravated damages) are insufficient to punish and deter.¹¹⁰⁹

If legislation specifies only that damages by way of compensation are payable, then it is likely that exemplary damages will not be recoverable. The Federal Court has indicated that exemplary damages are not available under section 81 of the *Sex Discrimination Act 1984* (Cth).¹¹¹⁰ That section provides that the Human Rights and Equal Opportunity Commission may make a declaration that the respondent should pay for any loss or damage suffered by the complainant (including injury suffered to the complainant's feelings, or humiliation suffered by the complainant).

In some cases a person may suffer no actual damage (whether pecuniary or non-pecuniary), despite being subjected to health care that is not authorised by the legislative scheme. The Commission recognises, however, that there may be a deterrent effect in permitting exemplary damages to be awarded irrespective of whether a person is able to recover any other damages. For this reason the Commission is of the view that exemplary damages should be able to be awarded whether or not any other damages are awarded.

¹¹⁰⁷ *Fontin v Katapodis* (1962) 108 CLR 177 per Owen J at 187.

¹¹⁰⁸ *Mayne and McGregor on Damages* (12th ed 1961) at 196, cited with approval by the High Court in *Lamb v Cotogno* (1987) 164 CLR 1 at 8.

¹¹⁰⁹ *XL Petroleum (NSW) Pty Ltd v Caltex Oil (Australia) Pty Ltd* (1985) 155 CLR 448 at 463 and 471; *Lamb v Cotogno* (1987) 164 CLR 1 at 8-9. See Freckleton I, "Exemplary Damages in Medico-Legal Litigation" (November 1996) 4 *Journal of Law and Medicine* 103.

¹¹¹⁰ *Hall v A & A Sheiban Pty Ltd* (1989) 20 FCR 217.

(c) The Commission's recommendations

The Commission recommends:

- (a) that if a person, without lawful excuse, carries out on a young person health care that is not authorised by the scheme or another law, the scheme should provide the young person with a statutory cause of action against the person who carried out the unauthorised health care;**
- (b) that the cause of action be in addition to any other cause of action that the young person may have under any other law against the person who carried out the unauthorised health care; and**
- (c) that in a proceeding under the proposed statutory provision, damages for non-pecuniary loss and exemplary damages should be able to be awarded, whether or not other damages are awarded.**

These recommendations are reflected in clause 22 of draft legislation in Chapter 17 of this Report.

The Commission is also of the view that, in addition to any civil liability attaching to the performance of unauthorised health care, it should be a criminal offence for a person, without lawful excuse, to carry out on a young person health care that is not authorised by the legislative scheme or by another law. In some cases of unauthorised health care, there may be no one who is willing to institute civil proceedings against a person who has carried out unauthorised health care. This may be because of the costs involved, or it may be because the person who might ordinarily be expected to bring the action on behalf of the young person, such as a parent, has participated in the unauthorised health care, for example, a sterilisation procedure that does not have Court approval.

The creation of an offence for carrying out unauthorised health care is intended to protect young people. It recognises the important public interest in protecting young people, rather than leaving the issue of enforcement solely to private interests.

The Commission recommends that it should be an offence for a person, without lawful excuse, to carry out on a young person health care that is not authorised by the legislative scheme or by another law.

This recommendation is reflected in clause 23 of the draft legislation in Chapter 17 of this Report.

The Commission's recommendations as to the consequences of treating a young person without a valid consent are set out in the following table.

- (a) **Criminal liability for carrying out health care in the following circumstances:**
- (i) health care involving a touching, given without a valid consent¹¹¹¹ (existing liability under Part V of the *Criminal Code* (Qld) and new liability - so many penalty units);
 - (ii) certain prescribed non-touching health care, given without a valid consent (new liability - so many penalty units);
 - (iii) health care to which a young person can object, if the young person objects to the health care (existing liability under Part V of the *Criminal Code* (Qld) and new liability - so many penalty units).
- (b) **Civil liability for carrying out health care in the following circumstances:**
- (i) health care involving a touching, given without a valid consent (existing liability - that is, action for trespass to the person and liability under a cause of action to be created by the legislative scheme¹¹¹²);
 - (ii) certain prescribed non-touching health care, given without a valid consent (liability under a cause of action to be created by the legislative scheme).

2. CONFIDENTIALITY

In Chapter 6 of this Report, the Commission discussed the importance of confidentiality to the health care of young people.

Although the obligation to maintain confidentiality may be a term of a contract,¹¹¹³ it is not necessary for there to be a contractual relationship between a health care provider

¹¹¹¹ This would include sterilisation of a young person (other than of a competent 16 or 17 year old young person who consents to the procedure) without court approval. Note the Commission's definition of "sterilisation" at 263 of this Report.

¹¹¹² See the discussion of this recommendation at 341-344 of this Report.

¹¹¹³ See 141-142 of this Report.

and patient in order for the law to impose a duty of confidence on the health care provider.

Depending on the circumstances of a particular case, the law may impose a duty not to disclose information that has been communicated in confidence.¹¹¹⁴

[T]he circumstances in which confidential information is supplied may vary widely. To determine the existence of confidentiality and its scope, it may be relevant to consider whether the information was supplied gratuitously or for a consideration; whether there is any past practice of such a kind as to give rise to an understanding; how sensitive the information is; whether the confider has any interest in the purpose for which the information is to be used; whether the confider expressly warned the confidee against a particular disclosure or use of the information - and, no doubt, many other matters.

Although the Commission recognises the practical importance that the issue of confidentiality has when considering young people's access to health care, the Commission has decided not to recommend any legislative changes in this reference to the law relating to confidentiality.

This reference has been primarily concerned with the authorisation of health care and questions of who can provide a valid consent to the health care of a young person. If there is to be a review of the law relating to confidentiality in relation to health care, that review should not be confined to considerations relating only to young people, but should be a review without any age limitations.

However, at this stage the Commission sees certain benefits in the flexibility of the law relating to confidentiality, that might not easily be imported into legislation. For example, a law that recognised confidentiality only if a young person was competent to consent to particular health care could seriously disadvantage a young person who was not competent, but who nevertheless made inquiries about the health care. On the other hand, a law that recognised confidentiality as an absolute duty in relation to a competent young person could place the young person at risk if it prevented a disclosure that might otherwise have been permitted at law.

Health care providers should generally be conscious of, and be encouraged to respect, the confidentiality of their young patients. In deciding how to treat a particular communication with a young patient, the observations of the Full Federal Court in *Smith Kline and French Laboratories (Australia) Ltd v Secretary, Department of Community Services and Health*¹¹¹⁵ should be kept in mind:

[I]t is necessary not to lose sight of the basis of the obligation to respect confidences: "It lies in the notion of an obligation of conscience arising from the circumstances in or through which the information was communicated or obtained." This is quoted from

¹¹¹⁴ *Smith Kline and French Laboratories (Australia) Pty Ltd v Department of Community Services and Health* (1991) 99 ALR 679 at 690.

¹¹¹⁵ *Id* at 691.

Moorgate Tobacco Co Ltd v Philip Morris Ltd (No 2) (1984) 156 CLR 414 at 438; 56 ALR 193 at 203 per Deane J, with whom the other members of the court agreed.

3. NOTIFICATION OF MALTREATMENT¹¹¹⁶

Section 76K of the *Health Act 1937* (Qld)¹¹¹⁷ requires a medical practitioner who suspects maltreatment or neglect of a young person “in such a manner as to subject or be likely to subject the child to unnecessary injury, suffering or danger” to notify an authorised person. Accordingly, a medical practitioner who suspected that his or her young patient had been physically or sexually abused would be required to notify the appropriate authority. Section 76K(6) provides that a medical practitioner incurs no liability in law in respect of providing that information. Section 76K(7) expressly protects a medical practitioner from liability for defamation. Without such protection, a medical practitioner could be civilly liable for breach of confidence, or even for defamation.

The Commission is concerned that section 76K of the *Health Act 1937* (Qld) does not cover the situation of other health care providers who suspect the maltreatment of a young person. For example, a school nurse may have good reason to believe that a young student is in an abusive relationship. The nurse would not be protected from liability for reporting his or her suspicions to the appropriate authority.

The Commission recognises, however, that the mandatory reporting of cases of suspected maltreatment raises many complex issues,¹¹¹⁸ as does the question of whether section 76K of the *Health Act 1937* (Qld) should be amended to require all health care providers, rather than merely medical practitioners, to report cases of suspected maltreatment. The Commission is of the view that Queensland Health and the Department of Families, Youth and Community Care would be the most appropriate bodies jointly to consider whether the application of section 76K of the *Health Act 1937* (Qld) should be extended, so as to apply to all health care providers.

¹¹¹⁶ See also Queensland Law Reform Commission, Research Paper *Medical Examinations in Cases of Suspected Child Abuse* (MP17, June 1996).

¹¹¹⁷ This section is set out in Appendix 6 of this Report.

¹¹¹⁸ See the Community Law Reform Committee of the Australian Capital Territory's Report *Mandatory Reporting of Child Abuse* (Report No 7, November 1993).

The Commission recommends that Queensland Health and the Department of Families, Youth and Community Care jointly consider whether section 76K of the *Health Act 1937* (Qld) should be amended so as to apply to all health care providers.

4. INVOLVEMENT OF YOUNG PEOPLE IN HEALTH CARE DECISIONS

In Chapter 6 of this Report the Commission considered the issue of involving young people in decisions concerning their health. A particular issue that arises out of that is the effect that a young person's objection to health care should have.

The Commission has recommended that, under certain circumstances, a young person's objection to certain specified forms of health care should make ineffective any parental consent given to those forms of health care.¹¹¹⁹ The question remains, however, as to what the effect should be of a young person's objection to any other type of health care.

The Commission is of the view that it is desirable for any expression by a young person of an objection to health care to be taken into account by a health care provider who is treating a young person.

The Commission considered making it a requirement of the scheme for a health care provider to take into account any objection.

However, while the Commission regards it as best practice to have regard to a young person's views about his or her health care (including any objection to the health care), it does not wish to create any liability for a failure to do so. For that reason, the proposed legislative scheme does not include a general obligation to take into account a young person's objection to health care.

5. REVIEW OF LEGISLATION

In the preceding Chapters, the Commission has made a number of recommendations about specific types of health care, namely:

¹¹¹⁹ See 241-242, 264-265 and 283-284 of this Report. The forms of health care to which a young person can object are a termination of pregnancy and contraceptive health care.

- (a) certain prescribed non-touching health care, which should require a valid consent before it is carried out;
- (b) health care (sterilisation) to which a young person under 16 years of age should be unable to provide a valid consent;¹¹²⁰ and
- (c) health care, which can be objected to by a young person, thereby invalidating any parental consent.

In relation to the health care in paragraphs (a) and (c), the Commission recommended that Queensland Health and the Department of Families, Youth and Community Care should identify the types of health care to be so regulated.

The Commission is of the view that it is important that the health care that is to be specifically regulated by the Commission's proposed scheme be periodically reviewed to ensure that it continues to provide effective protection for the health and well-being of young people.

Any review should consider whether the types of health care described in paragraphs (a) and (c) above continue to remain appropriate, and whether any further types of health care should be added to those categories. It should also consider whether, having regard to the operation of the legislation, there are any types of health care, in addition to sterilisation, to which competent young people under 16 years of age should be unable to provide a valid consent.

The Commission recommends that after the legislation has been in operation for three years, the legislation should be reviewed in the following respects:

- (a) the appropriateness of the types of health care regulated by Schedules 2 and 3 of the legislation; and**
- (b) whether there are any types of health care, in addition to sterilisation, to which a competent young person under 16 years of age should be unable to provide a valid consent.**

¹¹²⁰ Note that at common law, a parent cannot consent to the non-therapeutic sterilisation of a child. The Commission has recommended in this Report at 165 that the common law limitations on a parent's power to consent should continue to apply.

6. ADVOCACY FOR YOUNG PEOPLE

(a) Introduction

Most young people have the advantage of having parents who are willing to act as their advocates. Parents are generally better placed than anyone else to act as advocates for their children.

Nevertheless, there are some young people who do not have a parent or other legal guardian willing and able to advocate on their behalf. There are also situations where a young person may not be able to discuss particular health concerns with his or her parents, despite having an otherwise normal relationship with them. This may be because the young person is embarrassed, or because the young person is in a conflict situation with his or her parents.

Four submissions¹¹²¹ to the Discussion Paper¹¹²² suggested the establishment of a statutory office to provide an advocacy service for and on behalf of young people in need of assistance in relation to, among other things, medical treatment.

If there was a dispute between a young person and his or her parents about the need for health care, an advocate could assist the young person to identify the issues and resolve the dispute.

An advocate could be given the legal capacity to make court applications on behalf of a young person, and to represent a young person's interests in court or in any discussions with others involved in the health care of the young person. If a young person refused health care that was considered by others to be in the young person's best interests, an advocate could, on behalf of the young person, investigate alternative forms of health care and offer counselling and support for the young person. An advocate could also undertake systemic advocacy on behalf of young people in need of health care.

A community and welfare service for young people noted:¹¹²³

A statutory position of a Children's Advocate in each State would be a positive step towards improving advocacy for children. This position should have the power to intervene in the legal system and inform Parliament. Its advocacy role could include assistance in education, guardianship and health matters for example, and is particularly important in listening to the needs and wishes of children.

¹¹²¹ Submissions 8A, 56, 57 and 82.

¹¹²² Queensland Law Reform Commission, Discussion Paper *Consent to Medical Treatment of Young People* (WP44, May 1995).

¹¹²³ Submission 82.

(b) Youth advocates in other jurisdictions

Victoria and the Australian Capital Territory both have statutory bodies that fulfil the functions of a youth advocate for certain matters.¹¹²⁴

(i) Victoria

The *Guardianship and Administration Board Act 1986* (Vic) establishes the office of the Public Advocate. Although the functions of the office of the Public Advocate are essentially to assist and support people with a disability, there is no limit on the age of the people who are entitled to assistance. "Disability" is defined to mean "intellectual impairment, mental illness, brain damage, physical disability or senility". Thus, in *Re Michael*,¹¹²⁵ the Full Court of the Family Court of Australia held that the Public Advocate had sufficient statutory standing to institute proceedings in relation to the treatment of an 11 year old boy.

In that case, the Public Advocate instituted an application seeking a declaration authorising him to consent to surgical procedures. The parents argued that the Public Advocate had no power or duty to act as a litigant in the Family Court to cause a person under a disability to undergo treatment. They submitted that the Public Advocate's functions with respect to litigation were limited to proceedings before either the Victorian Guardianship Board or the Administrative Appeals Tribunal. They also argued that the Public Advocate's other main function was to promote the interests of the disabled as a class, and that this did not embrace the Public Advocate acting as a litigant in his or her own right. The parents said that in this case the Public Advocate was not acting for or on behalf of the child and should not be regarded as an ordinary litigant in the proceedings, in which case the Public Advocate had exceeded his statutory powers.

The Full Court of the Family Court held that the Public Advocate did have sufficient standing to institute the proceedings. The Court looked at the objects of the legislation as set out in section 4 of the *Guardianship and Administration*

¹¹²⁴ There is also an Office of the Commissioner for Children in New Zealand. A youth health advocate is employed by the Adelaide Central Mission (SA). The advocate is responsible for both systemic and individual health advocacy for mainly homeless young people (as young as 12 years of age). On a systemic level, the advocate makes representations on behalf of homeless young people for better health services, including the provision of more health care providers who understand that homeless young people - particularly those with a mental illness - can sometimes be ill-mannered, disorganised and late for appointments. On an individual level, the advocate is responsible for explaining to young people the nature and consequences of proposed medical treatment, including alternative treatment options. The advocate also accompanies young people to medical appointments with health care providers who are not attached to the Adolescent Services Branch of the Mission. See also the proposals for an Australian Commissioner for Children in the National Children's and Youth Law Centre's Discussion Paper, *Why Australia Needs a Commissioner for Children* (July 1995). It was not envisaged in that paper that a Commissioner would advocate for individual children and specifically it was not envisaged that a Commissioner would provide an advocacy service for individual children in conflict with their parents. In November 1996 it was announced that a youth health advocate would be employed by the Australian Medical Association. The position will be funded by a grant from a funeral company ("Deaths prompt funeral group to aid youths' health": *The Courier-Mail* (18 November 1996)).

¹¹²⁵ (1994) FLC ¶92-471.

Board Act 1986 (Vic) and, in particular, at the express Parliamentary intention set out in subsection 4(2)(b) that “every function, power, authority, discretion, jurisdiction and duty conferred or imposed by this Act is to be exercised or performed so that ... the best interests of a person with a disability are promoted”.

The power conferred by subsection 16(1)(f) of the Act (“to make representations on behalf of or act for a person with a disability”) was held to be more than sufficient to provide a basis for the Public Advocate to commence the proceedings. The Court rejected the parents’ argument that the Public Advocate was not, in taking the proceedings, either making representations on behalf of, or acting for, a person with a disability. Michael was a disabled person within the meaning of the Act (a physical disability by reason of a congenital condition and the symptoms from which he suffered - either of which was considered to be sufficient to satisfy the definition of physical disability) and the Public Advocate clearly had the power to make “representations” on behalf of, or “act for” a person with a disability. However, age alone is not considered to be a “disability” under the Victorian legislation.¹¹²⁶

The Public Advocate in Victoria was intended to be, among other things, a “general advocate on behalf of the disabled”.¹¹²⁷

(ii) The Australian Capital Territory

The *Community Advocate Act 1991* (ACT) establishes the office of Community Advocate to fulfil a similar role to the Victorian Public Advocate in relation to persons who have a disability, although its jurisdiction in relation to young people generally is slightly clearer. “Disability” is defined in section 3 to mean any of the following:

- (a) a legal disability due to age;
- (b) a physical, mental, psychological or intellectual condition;
- (c) a condition which would render a person a forensic patient;

which gives rise to a need for protection from abuse, exploitation or neglect.

The statutory duties of the Community Advocate are similar to those of the Victorian Public Advocate. For example, the Community Advocate can “protect

¹¹²⁶ See generally Tait D, Carney T and Deane K, Report to the National Youth Affairs Research Scheme, *Young people and guardianship: A ticket to services or a transfer of rights?* (1995).

¹¹²⁷ *Hansard*, Legislative Council (Vic), 22 April 1986 at 559 second reading speech by the then Victorian Attorney-General.

the rights of such persons"¹¹²⁸ and "deal, on behalf of such persons, with persons or bodies providing services".¹¹²⁹ The Community Advocate also has an important role in relation to care and protection proceedings in the Australian Capital Territory. The *Children's Services Act 1986* (ACT), which is the main Act that deals with the welfare of children in the Australian Capital Territory, introduced the concept of a statutory "Youth Advocate".¹¹³⁰ The legislation was based on recommendations made in the Australian Law Reform Commission's Report *Child Welfare*.¹¹³¹

(c) The Australian Law Reform Commission: Report No 18, *Child Welfare*

In 1981, the Australian Law Reform Commission recommended the establishment of the office of the Youth Advocate in the Australian Capital Territory, largely because of the diversity of that Territory's welfare agencies and the way in which they had developed - with no one person or agency being clearly responsible for taking resolute action in respect of young people in need of care. It was envisaged that the Youth Advocate would be independent of the Territory's health and welfare agencies. One of the Advocate's functions would be the initiation of care proceedings. This recommendation was based on the belief that a decision to initiate court proceedings should be made by an independent person, and that welfare agencies should be relieved of the responsibility to take court action.

The Commission believed that a system in which an independent official makes decisions about the initiation of care proceedings would introduce desirable checks and balances into the welfare system.¹¹³²

(d) A youth advocate for Queensland?

The offices of the Public Advocate in Victoria and the Community Advocate in the Australian Capital Territory are interested in all welfare issues relating to young people, including, for example, health, financial, social and personal matters; their role is not confined to issues relating to health care.

¹¹²⁸ *Community Advocate Act 1991* (ACT) s13(1)(e).

¹¹²⁹ *Id* s13(1)(g).

¹¹³⁰ When the *Children's Services Act 1986* (ACT) was amended in 1991, the term "Youth Advocate" was replaced with the current term "Community Advocate".

¹¹³¹ Report No 18, 1981.

¹¹³² The proposed Youth Advocate was seen by the Commission as fulfilling a role very similar to that performed by Scottish reporters under the *Social Work (Scotland) Act 1968* (UK): Australian Law Reform Commission, Report *Child Welfare* (Report No 18, 1981) at 241 (note 182).

There are a number of community-based agencies in Queensland which currently provide advocacy services for young people. However, it appears that advocacy in relation to the provision of health care is rare.¹¹³³

A statutory office of the Children's Commission has recently been established in Queensland.¹¹³⁴ The Commission is controlled by the Children's Commissioner.¹¹³⁵ The functions of the Children's Commissioner, which are set out in section 8 of the *Children's Commissioner and Children's Services Appeals Tribunal Act 1996* (Qld), are as follows:

- (a) monitoring and reviewing, in collaboration with entities that deliver children's services, the provision of the services and suggesting ways of improving the services' quality, adequacy and effectiveness; and
- (b) promoting practices and procedures that uphold the principle that parents or legal guardians of children have the primary responsibility for the upbringing and development of their children; and
- (c) advising the Minister about developing and reviewing standards for child care and foster homes; and
- (d) receiving, and as appropriate, assessing and investigating complaints about the delivery of children's services and alleged offences involving children; and
- (e) monitoring, in cooperation with other entities, the procedures developed and implemented by the entities for handling complaints about the delivery of children's services and alleged offences involving children; and
- (f) cooperating with the Queensland Police Service and the Australian Bureau of Criminal Intelligence in the investigation of allegations about offences involving children, including, for example, sexual abuse of children, child pornography and child sex tourism; and
- (g) cooperating with the Queensland Police Service, the Australian Bureau of Criminal Intelligence and other relevant entities in their endeavours to eradicate sexual abuse of children, child pornography and child sex tourism; and
- (h) implementing and maintaining a program of official visitors to residential facilities; and
- (i) conferring and cooperating with other relevant entities including, for example, the Queensland Police Service, the Criminal Justice Commission and the

¹¹³³ A welfare organisation for young people (Submission 8A) noted, however, that if welfare or youth services around Queensland are used as a possible source of youth advocates and there is no infrastructure to address the accountability of those welfare services or youth services, this may result in workers with very different philosophies in youth work. This may conflict with the purpose of an advocate's role. The organisation also stressed the need to identify a number of training issues if existing welfare services or youth services are to be called upon to provide advocates for young people in the area of health care.

¹¹³⁴ *Children's Commissioner and Children's Services Appeals Tribunals Act 1996* (Qld) (Act No 51 of 1996). The Act was assented to on 20 November 1996.

¹¹³⁵ *Children's Commissioner and Children's Services Appeals Tribunals Act 1996* (Qld) s6(1).

- ombudsman about a matter relating to any of the commissioner's other functions;
and
- (j) liaising with the ombudsman about the exercise by the commissioner and the ombudsman of their respective functions in relation to complaints about the delivery of children's services; and
 - (k) establishing tribunals to hear appeals of reviewable decisions; and
 - (l) at the Minister's request, inquiring into any matter relating to children's services; and
 - (m) conducting research and inquiring into matters relating to any of the commissioner's other functions; and
 - (n) doing anything else -
 - (i) incidental, complementary or helpful to the commissioner's other functions; or
 - (ii) likely to enhance the effective and efficient performance of the commissioner's other functions.

The legislation was initially developed out of a perceived need for an independent authority in Queensland to investigate fully complaints of paedophilia in Queensland. The concept of a Children's Commissioner was mooted which, among other functions, would accept and investigate complaints of paedophilia and child abuse. An advocacy role was also suggested.¹¹³⁶

Although the primary focus of the legislation is the investigation of complaints of paedophilia and child abuse, in his second reading speech, the Minister for Families, Youth and Community Care, the Honourable E R Lingard MLA acknowledged a broader advocacy role for the Children's Commission.¹¹³⁷

Queensland is at the cutting edge in advancing children's issues to the forefront of public consciousness through the setting up of the Children's Commission. With this legislation we have recognised the need for a children's voice, or a children's advocate, that will be beneficial to children in this State. [emphasis added]

It is not clear, however, that the role of the Children's Commissioner would extend to advocacy in relation to health care of young people. Although many of the Commissioner's functions listed in section 8 relate to the delivery of "children's services", "children's services" is defined in schedule 2 to the *Children's Commissioner and Children's Services Appeals Tribunals Act 1996* (Qld) to mean "a service provided under or in relation to children's services legislation". "Children's services legislation" is defined in schedule 2 to mean:

¹¹³⁶ See *Hansard*, Legislative Assembly (Qld), 1 May 1996 at 864 and 873.

¹¹³⁷ *Hansard*, Legislative Assembly (Qld), 4 September 1996 at 2419. See also the Explanatory Notes accompanying the Bill.

- (a) the *Adoption of Children Act 1965*; or
- (b) the *Child Care Act 1991*; or
- (c) the *Children's Services Act 1965*; or
- (d) the *Family Services Act 1987*.

The definition of "children's services" would not, therefore, seem to encompass the provision of assistance with, or advocacy in relation to, decisions about consent to health care for young people.

Further, the functions in section 8 of the Act are framed in terms of reviewing and/or investigating complaints about the delivery of children's services, rather than in terms of the provision of either individual or systemic advocacy in relation to those services.

The Commission considers that it would be appropriate for the Queensland Government to investigate the merits of specifically conferring jurisdiction on the office of the Children's Commission to provide advocacy services from a welfare perspective for young Queenslanders generally (including in relation to health matters, but not limited to the four Acts defined as "children's services legislation"). The investigation of that possibility is, in the Commission's view, preferable to recommending the establishment of a separate office for the provision of assistance with, and advocacy in relation to, health care decisions only.

Health care is only one of many matters with which young people may need assistance. Further, the health care concerns of a young person may highlight a young person's need for assistance with a broader range of matters, which a general, but possibly not a specialised, advocate could provide.

The Commission recommends that the Queensland Government investigate the merits of conferring specific jurisdiction on the office of the Children's Commission to provide an advocacy service for young people, including, among other things, an advocacy service for young people in need of assistance with health care decisions.

7. THE ISSUE OF MEDICARE CARDS

During some of the Commission's consultation meetings, concern was expressed about the policy of the Health Insurance Commission in issuing Medicare cards to young people. Although the Medicare system is designed to cover all Australians, the usual practice is for a family unit to be issued with a single Medicare card, rather than for

individual members of a family to be issued with separate cards. It was felt that one result of this policy is that it is often difficult for some young people to seek the health care they need without first approaching their parents for permission to use the family Medicare card. The card is needed to facilitate bulk-billing and to be able to claim for the cost of a consultation or treatment. If a young person would prefer not to inform his or her parents about the need for health care (through embarrassment or for some other reason), then one consequence of the Health Insurance Commission's policy may be that the young person will not receive the health care that is required.

The policy of the Health Insurance Commission is that from 15 years of age young people are entitled to their own Medicare cards. Consideration is given to the issue of separate cards for young people under the age of 15 if they are homeless, in foster care or attending boarding school. Documentation is required to confirm the need for the issue of a separate card. The documentation should confirm the young person's identity and personal circumstances, and should be in the form of a letter from one of the following persons:¹¹³⁸

- parent
- teacher
- social worker
- minister of religion
- youth refuge worker
- member of the legal profession.

The Health Insurance Commission's policy does not readily cover the situation of a young person living at home, who is in need of health care, but does not wish to ask for the family Medicare card if this would necessarily entail informing his or her parents in order to obtain it.¹¹³⁹ This could easily occur in an otherwise functional family as a result of the young person's embarrassment or because of a desire for independence or privacy.

In a survey of 57 Victorian general practitioners 68 percent of the general practitioners considered that the need to procure the family Medicare card was sometimes a deterrent to adolescents wishing to attend a clinic (19 percent were unsure and 13 percent disagreed).¹¹⁴⁰ Seventy-eight percent of the general practitioners believed that

¹¹³⁸ Letter from the Health Insurance Commission's Medicare Customer Service Manager to the Commission dated 11 December 1996.

¹¹³⁹ It is possible for a medical practitioner to bulk bill a patient who has presented without a Medicare card. The practitioner can telephone the Health Insurance Commission, identify himself or herself and provide the patient's personal details. The Medicare number will then be given to the practitioner. Alternatively, the practitioner can notate the patient's details on the assignment form. When the claim is received, the Medicare number is found by using the personal details during the processing of the claim. However, this is a time consuming process: Letter from the Health Insurance Commission's Medicare Customer Service Manager to the Commission dated 11 December 1996.

¹¹⁴⁰ Veit FCM, Sanci LA, Coffey CMM, Young DYL and Bowes J "Barriers to effective primary health care for adolescents" (1996) 165 *Medical Journal of Australia* 131.

adolescents would be able to access health care more freely if they were automatically issued with their own Medicare cards at the age of 16 years. The authors suggested that their results were similar to other studies that have found the lack of access to Medicare cards to be a significant barrier to adolescents' access to health care.¹¹⁴¹

The authors concluded that the automatic issuing of Medicare cards to adolescents at the age of 16, as well as recognition of the need for longer consultations with adolescents experiencing psychological problems, and clarification of the Health Insurance Commission's powers and purposes of investigations, would overcome some of the main structural barriers to adolescents' access to quality primary health care.¹¹⁴²

Although it is possible that some health care providers will treat young people without charging for their services, and that some young people will seek free treatment at a public hospital, the Commission believes that all young people should have access to their own Medicare card so that they can seek and obtain health care whenever they require it.

The Commission requests the Health Insurance Commission to reconsider its policy in relation to the issue of separate Medicare cards to young people. Young people of any age should be able to apply for and receive their own Medicare card.¹¹⁴³

8. PUBLIC EDUCATION

The effectiveness of the Commission's proposed legislative scheme is very much dependent upon the key players being aware of the legislation, and of their rights, entitlements and responsibilities under the legislation.

It is unlikely that the scheme will produce the desired outcome unless:

- health care providers are aware of the protection from liability which is available if they comply with the scheme;
- health care providers are aware of the circumstances in which they can rely

¹¹⁴¹ *Id* at 132.

¹¹⁴² *Ibid.*

¹¹⁴³ The health care that could be provided to a young person with a Medicare card would still be required to be given in accordance with the Commission's scheme.

upon the consent of a young person;

- health care providers are aware of the circumstances in which consent is not required before carrying out health care on a young person;
- young people know the circumstances in which they will be able to consent to their own health care; and
- parents are aware of their powers and obligations under the scheme.

The Commission believes it is vital that a comprehensive and ongoing education program aimed at the key players be established. Queensland Health would be the most effective co-ordinator of the program given its experience in public health education.

One of the shortcomings of the current law on consent to health care of young people is that very few people know or understand the law. This is partly a result of the confused state of the law, but is also a result of the fact that there is no one body with responsibility for keeping the public informed about the law and its operation. The Queensland Law Reform Commission would be willing to assist in the development of an appropriate education program.

The Commission recommends that, prior to the commencement of the proposed legislative scheme, Queensland Health, in consultation with the Queensland Law Reform Commission instigate an education program on the content and effect of the legislation. The program should be directed to the key players in the area of young people's health including, for example, young people, health care providers and parents. The education program should be ongoing.

CHAPTER 17

DRAFT LEGISLATION

This Chapter contains draft legislation, prepared by the Office of the Queensland Parliamentary Counsel, for implementing the Commission's recommendations. The Commission gratefully acknowledges the contribution made to the formulation of its recommendations by the drafting process and, in particular, wishes to thank Ms Theresa Johnson, First Assistant Parliamentary Counsel, for her assistance.

As noted earlier in this Report, the proposed legislative scheme is not intended to be a codification of the law relating to consent to health care for young people.¹¹⁴⁴ Rather, the proposed legislative scheme is a modification of the existing law.

The draft legislation preserves a number of aspects of the common law applying to consent to health care for young people. For example, the common law limitations on the power of a parent to consent to health care for a child and the *parens patriae* jurisdiction of the Supreme Court of Queensland are not affected by the draft legislation.¹¹⁴⁵

¹¹⁴⁴ See 165 of this Report.

¹¹⁴⁵ See clause 12(3) of the draft legislation in this Chapter.

DRAFT

Queensland



**HEALTH CARE
AUTHORISATION FOR
YOUNG PEOPLE BILL 1996**

Queensland



HEALTH CARE AUTHORISATION FOR YOUNG PEOPLE BILL 1996

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1996

1

A BILL

2

FOR

3

**A Bill for an Act regulating authorisation of health care of young
people, and for other purposes**

4

5

6

7

The Parliament of Queensland enacts—	1
CHAPTER 1—PRELIMINARY	2
Short title	3
1. This Act may be cited as the <i>Health Care Authorisation for Young People Act 1996</i> .	4 5
Act binds all persons	6
2.(1) This Act binds all persons, including the State, and, so far as the legislative power of the Parliament permits, the Commonwealth and the other States.	7 8 9
(2) Nothing in this Act makes the State liable to be prosecuted for an offence.	10 11
Philosophy	12
3.(1) This Act deals with the law on the authorisation of health care of young people under 18 years.	13 14
(2) It acknowledges the following—	15
(a) the desirability of minimising legal impediments to young people's access to appropriate health care;	16 17
(b) the psychological and health advantages to young people of their being involved in decision making affecting their own health;	18 19
(c) the developing autonomy of the individual young person;	20
(d) the need to protect vulnerable young people from inappropriate or exploitative health care;	21 22
(e) the vital role parents have in the health care of their children;	23
(f) the need to ensure, if parental support is not readily available, other accessible and appropriate mechanisms are available to	24 25

Health Care Authorisation for Young People

facilitate health care of a young person;	1
(g) the desirability of minimising uncertainty about the legal liability of health care providers who carry out health care of young people.	2 3 4
Purpose to achieve balance	5
4. This Act seeks to strike a balance between—	6
(a) ensuring the law does not hinder young people’s access to health care; and	7 8
(b) ensuring the law protects young people from inappropriate health care.	9 10
Way purpose achieved—under 12	11
5. For health care, of a young person who is under 12 years, requiring consent, this Act generally authorises only a parent ¹ of the young person to consent. ²	12 13 14
Way purpose achieved—12 to 15	15
6. For health care, of a young person who is 12 to 15 years, requiring consent, this Act generally—	16 17
(a) authorises a parent of the young person to consent to health care of the young person; and	18 19
(b) also authorises the young person, if the young person understands the nature and consequences of particular health care, to consent to the health care of himself or herself (other than sterilisation ³) even if a parent refuses the health care. ⁴	20 21 22 23

¹ The definition of “parent” is wider than its common meaning—section 21.

² See section 24 (Health care generally—under 12).

³ “Sterilisation” is defined—schedule 1, section 10.

⁴ See section 30 (Health care generally—12 to 15).

Health Care Authorisation for Young People

Way purpose achieved—16 or 17	1
7. For health care, of a young person who is 16 or 17 years, requiring consent, this Act generally—	2 3
(a) treats as an adult, a young person who understands the nature and consequences of particular health care so only the young person may consent to, or refuse, the health care of himself or herself; ⁵ and	4 5 6 7
(b) authorises a parent of a young person who does not understand the nature and consequences of particular health care to consent to the health care of the young person. ⁶	8 9 10
Way purpose achieved—health care without consent	11
8. This Act—	12
(a) does not regulate the authorisation of health care of a young person not involving a touching (other than certain serious non-touching health care); ⁷ and	13 14 15
(b) authorises certain health care of a young person to be carried out	16

⁵ See section 36 (Health care generally—16 or 17 and competent).

⁶ See section 37 (Health care generally—16 or 17 and non-competent).

⁷ See section 18 (Meaning of health care); schedule 1, section 1 (Non-touching health care); and schedule 2 (Scheduled non-touching health care). The Law Reform Commission has adopted this approach because the existing law does not generally impose any liability for assault for non-touching health care carried out without consent.

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without consent; ⁸ and	1
(c) amends the <i>Transplantation and Anatomy Act 1979</i> , in relation to blood transfusions to young people without consent, to give effect to a refusal of a blood transfusion, by a young person who is 16 or 17 years old and who understands the nature and consequences of a blood transfusion, by removing the protection from liability for assault if the young person refuses the blood transfusion. ⁹	8
Way purpose achieved—young parents	9
9. For particular health care of a young person, whose parent is under 18 years and understands the nature and consequences of the health care, this Act treats the young parent in the same way as it treats an adult parent so the young parent may consent to, or refuse, the health care. ¹⁰	13
Way purpose achieved—significant carers	14
10. In certain circumstances, this Act treats a person with the significant care of a young person as a parent of the young person. ¹¹	16

⁸ For a young person under 12 years—see sections 26 to 29; for a 12 to 15 year old—see sections 32 to 35; and for a 16 or 17 year old who is not competent—see sections 39 to 42. These sections authorise health care required without delay, minor health care, STD health care and contraceptive health care to be carried out without consent in certain limited circumstances.

Except as provided by this Act, the common law about emergency health care for young people under 18 years, as it exists from time to time, applies—section 12(4) (Act's relationship with other law). In the Law Reform Commission's view, consent is not relevant to the provision of emergency health care under the common law. So, emergency health care of a young person may always be carried out without a consent. Sections 25, 31 and 38 then provide protection from liability for assault for a person who carries out emergency health care without a consent in certain circumstances.

⁹ See chapter 6 (Consequential amendments), part 2 (Amendment of *Transplantation and Anatomy Act 1979*).

¹⁰ See section 21 (Meaning of parent, guardian and significant carer), particularly subsections (1) and (6).

¹¹ See section 21 (Meaning of parent, guardian and significant carer), particularly subsections (2) and (4).

Way purpose achieved—safeguards	1
11. This Act also—	2
(a) generally authorises only health care of a young person that is in the best interests of the young person’s health and wellbeing; ¹² and	3 4 5
(b) provides that a young person’s objection ¹³ to certain serious types of health care makes a parental consent to the health care ineffective; ¹⁴ and	6 7 8
(c) encourages health care providers and others to comply with this Act by—	9 10
(i) protecting health care providers and others who carry out health care of young people under ¹⁵ this Act from liability for assault; ¹⁶ and	11 12 13
(ii) providing criminal and civil consequences for carrying out health care not authorised under this Act or another law. ¹⁷	14 15

¹² See, for example, section 30(3).

¹³ “Objects” is defined in schedule 1 (Additional Health Care Concepts), section 12.

¹⁴ For an objection to scheduled objectionable health care, see sections 24(2)(b) and (e), 30(2)(c) and (g) and 37(2)(b) and (e). For an objection to contraceptive health care, see sections 29(1)(c) and (f), 35(1)(c) and (f) and 42(1)(b) and (d).

¹⁵ ‘ “Under”, for an Act or a provision of an Act, includes ... in accordance with’—*Acts Interpretation Act 1954*, section 36.

¹⁶ “liable for assault” means—

- (a) civilly liable for assault or battery or under section 22; and
- (b) criminally liable for assault or under section 23.

See— section 43 (Protection for health care under Act)
section 44 (Protection if mistaken belief)
section 45 (Protection for health care by court order)
section 46 (Protection if unaware of court order)
section 47 (Protection for supervised health care provider).

¹⁷ See sections 22 (Civil action if unauthorised health care) and 23 (Offence to carry out unauthorised health care).

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Act's relationship with other law

12.(1) To remove any doubt, this section makes the following declarations.

(2) This Act is not intended to operate as a code and the common law, as it exists from time to time, about authorisation and confidentiality of health care for young people under 18 years continues to apply to the extent it is not inconsistent with this Act.

(3) Without limiting subsection (2), this Act does not affect any common law limitation on the power of a parent to consent to health care of a young person.

Example—

A young person's parents cannot consent, without court approval, to the young person's sterilisation—*Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

(4) Also, without limiting subsection (2), except as provided by sections 25, 31 and 38, the common law, as it exists from time to time, about emergency health care for young people under 18 years applies.¹⁸

(5) This Act is not intended to displace any of the following jurisdictions—

- the *parens patriae* jurisdiction of the Supreme Court for young people under 18 years;¹⁹
- the jurisdiction of the Family Court of Australia by virtue of the *Commonwealth Powers (Family Law—Children) Act 1990* for

¹⁸ The Law Reform Commission recommends a review of all Queensland laws on emergency health care.

¹⁹ By way of background, the Law Reform Commission advises as follows—
The *parens patriae* jurisdiction is based on a need to protect those who lack the capacity to protect themselves. Although the jurisdiction has been likened to a parental role (*R v Gyngall* [1893] 2 QB 232), a court acting in its *parens patriae* jurisdiction has wider powers than those of a natural parent (see, for example, *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218 at 258-259). Accordingly, the court may override the wishes both of a young person's parents and of a legally competent young person (*In re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 at 25 and *In re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64 at 81).

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young people under 18 years. ²⁰	1
(6) Also, a consent or refusal given under this Act may be varied or overridden by a court order or may be subject to another law.	2 3
<i>Example—</i>	4
Parental consent is subject to Commonwealth law if a parent's power to consent to health care has been removed or reduced by a parenting order made under the <i>Family Law Act 1975</i> (Cwlth), pt VII, div 6—see <i>Family Law Act 1975</i> (Cwlth), s 61D(2).	5 6 7 8
(7) If a person carries out health care, of a young person, that could have been, but was not, authorised under this Act, the <i>Criminal Code</i> , section 282 ²¹ does not relieve the person from liability for assault.	9 10 11
(8) Finally, this Act does not affect a person's liability under another law, for example, in contract or negligence, for carrying out health care authorised under this Act.	12 13 14

CHAPTER 2—INTERPRETATION AND CONCEPTS	15 16
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PART 1—CONCEPTS	17
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Explanation	18
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13. Generally, the authorisation of health care of a young person under this Act varies according to the following factors—	19 20
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²⁰ The Law Reform Commission notes this Act could not affect the Family Court's jurisdiction under Commonwealth law.

²¹ The Criminal Code, section 282 provides as follows—

'Surgical operations

282. 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 the circumstances of the case.'

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- the type of health care 1
- the type of person to carry out the health care 2
- the age group to which the young person belongs 3
- the competency of the young person to understand the nature and consequences of the health care and to communicate a decision. 4
5

Types of health care 6

14.(1) The authorisation of health care of a young person under this Act varies according to which of the following types of health care²² is involved— 7
8
9

- health care generally 10
- emergency health care 11
- health care required without delay 12
- minor health care 13
- STD health care 14
- contraceptive health care. 15

(2) This Act also mentions the following types of health care— 16

- blood transfusion 17
- non-touching health care and scheduled non-touching health care²³ 18
19
- sterilisation, termination of a pregnancy and health care primarily to treat organic malfunction or disease²⁴ 20
21
- scheduled objectionable health care. 22

²² Schedule 1 contains definitions of the types of health care.

²³ Of non-touching health care, only scheduled non-touching health care is regulated by this Act.

²⁴ Health care primarily to treat organic malfunction or disease is only mentioned in the definitions of sterilisation and termination of a pregnancy.

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Type of person carrying out health care	1
15. This Act distinguishes between health care carried out by the following people—	2 3
<ul style="list-style-type: none"> • health care providers²⁵ • authorised health care providers²⁶ • people who are not health care providers. 	4 5 6
Age groups	7
16. This Act divides young people into the following age groups—	8
<ul style="list-style-type: none"> • under 12 years • 12 to 15 years • 16 or 17 years. 	9 10 11
PART 2—INTERPRETATION	
Dictionary	12 13
17. The dictionary in schedule 4 defines particular words used in this Act. ²⁷	14 15

²⁵ See section 19 (Meaning of health care provider).

²⁶ See schedule 4, dictionary, “authorised health care provider”.

²⁷ In some Acts, definitions are contained in a dictionary that appears as the last schedule and forms part of the Act—*Acts Interpretation Act 1954*, section 14(4). Words defined elsewhere in the Act are generally signposted by entries in the dictionary. However, if a section has a definition applying only to the section, or a part of the section, it is generally not signposted by an entry in the dictionary and is generally set out in the last subsection of the section. Signpost definitions in the dictionary alert the reader to the terms defined elsewhere and tell the reader where the definitions can be found. For example, the definition “health care” see section 18’ tells the reader there is a definition of health care in the section.

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Meaning of health care	1
<p>18. “Health care” of a young person is care or treatment of, or a service or procedure for, the young person to assess, diagnose, maintain or treat the young person’s physical or mental condition, but does not include—</p> <p style="margin-left: 40px;">(a) a blood transfusion under the <i>Transplantation and Anatomy Act 1979</i>;²⁸ or</p> <p style="margin-left: 40px;">(b) non-touching health care.²⁹</p>	<p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p>
 Meaning of health care provider	 8
<p>19. A “health care provider” is a person who provides health care in the practice of a profession or the ordinary course of business.³⁰</p>	<p>9</p> <p>10</p>
 Meaning of competent	 11
<p>20.(1) A young person is “competent” for his or her own particular health care if the young person understands the nature and consequences of the health care and communicates his or her decision about the health care in some way.³¹</p> <p style="margin-left: 40px;">(2) A young person’s ability to understand the nature and consequences</p>	<p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p>

²⁸ Blood transfusions to young people are regulated under this Act and the *Transplantation and Anatomy Act 1979*. A blood transfusion with consent may be authorised, and protection from liability for assault given, under section 24 (Health care generally—under 12), section 30 (Health care generally—12 to 15), section 36 (Health care generally—16 or 17 and competent) or section 37 (Health care generally—16 or 17 and non-competent). For a blood transfusion without consent, the *Transplantation and Anatomy Act 1979*, part 2A (Blood transfusions to children without consent) protects a person who carries it out from liability for assault in certain limited circumstances.

²⁹ Schedule 1 explains the types of health care used in this Act.

³⁰ See also schedule 4, dictionary, “**authorised health care provider**”.

³¹ This standard of competency has been developed by the Law Reform Commission from the *Gillick* test. [*Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112]. The Commission considers that, in order to assess a young person’s competency, a health care provider would probably need to explain to the young person the nature and consequences of, and alternatives to, the health care.

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of health care may vary according to the particular health care involved or the young person's circumstances.	1 2
<i>Example—</i>	3
At a given time, a young person may be a competent young person for certain health care but not for other health care.	4 5
 Meaning of parent, guardian and significant carer	 6
21.(1) A “parent” for particular health care of a young person is a person who is—	7 8
(a) either—	9
(i) a natural parent, adoptive parent or guardian of the young person; or	10 11
(ii) a step-parent or foster parent of the young person who has full-time care of the young person; and	12 13
(b) competent for the health care.	14
(2) If there is no parent under subsection (1) who is reasonably contactable for particular health care of a young person, a “parent” for the health care also includes a significant carer of the young person.	15 16 17
(3) A “guardian” of a young person is—	18
(a) a person, appointed by operation of law or under a deed or will, with responsibility for the young person's welfare; or	19 20
(b) a person appointed under a court order with responsibility for the young person's welfare; or	21 22
(c) a legally authorised representative or delegate, of a person appointed under a court order with responsibility for the young person's welfare, who actually discharges the responsibility; or	23 24 25
(d) a person who has custody of the young person under the	26

Health Care Authorisation for Young People

Children's Services Act 1965, section 49(2), (2B) or (2C).³²

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| | 1 |
| (4) A “ significant carer ” for particular health care of a young person is a person who— | 2
3 |
| (a) is 16 years or more; and | 4 |
| (b) has full-time or significant care of the young person; and | 5 |
| (c) is competent for the health care. | 6 |
| <i>Examples—</i> | 7 |
| The head of a boarding school caring for a young person who boards 5 days a week during the school year is a significant carer of the young person. | 8
9 |
| A young person’s casual baby sitter, who has only the temporary care of the young person, is not a significant carer of the young person. | 10
11 |
| (5) An adult is “ competent ” for particular health care of a young person if the adult broadly understands the nature of the health care and communicates his or her decision about the health care in some way. ³³ | 12
13
14 |
| (6) A young person is “ competent ” for particular health care of another young person, if the young person first mentioned understands the nature | 15
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³² *Children's Services Act 1965, section 49—*

‘(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.

(2B) Pending determination by the Children’s Court of such an application the child shall be cared for in a manner consistent with the child’s best interests—

(a) by a person chosen by the court; or

(b) in the absence of such a choice, by the person who took the child into custody or by a person chosen by the person;

and for this purpose the person entrusted with the child may retain custody of the child.

(2C) If under subsection (2) the court chooses the director to care for a child it shall remand the child into the temporary custody of the director.’

³³ The Law Reform Commission has based this standard of competency on *Chatterton v Gerson* [1981] QB 432 per Bristow J at 443.

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and consequences of the health care and communicates his or her decision
about the health care in some way.³⁴

CHAPTER 3—UNAUTHORISED HEALTH CARE

Civil action if unauthorised health care

22.(1) If, without lawful excuse, a person carries out health care of a
young person not authorised under this Act or another law, the young
person has a cause of action for damages against the person for the
unauthorised health care.

(2) The cause of action is in addition to any cause of action the young
person may have under another law.

(3) In a proceeding under this section, exemplary damages, or damages
for non-pecuniary loss, may be awarded, whether or not other damages are
awarded.

Offence to carry out unauthorised health care

23.(1) A person must not, without lawful excuse, carry out health care of
a young person not authorised under this Act or another law.

Maximum penalty—

(2) This offence is in addition to any offence under another law and the
Acts Interpretation Act 1954, section 45(1) does not apply to this section.³⁵

³⁴ The Law Reform Commission considers that, in order to assess a young person's
competence, a health care provider would probably need to explain to the young
person the nature and consequences of, and alternatives to, the health care.

³⁵ *Acts Interpretation Act 1954*, section 45(1) (Offence punishable only once)—
'(1) If an act or omission is an offence under each of 2 or more laws, the
offender may be prosecuted and punished under any of the laws, but the offender
may not be punished more than once for the same offence.'

**CHAPTER 4—AUTHORISATION OF HEALTH
CARE BY AGE GROUP AND TYPE OF HEALTH
CARE**

PART 1—UNDER 12

Health care generally—under 12

24.(1) In this section—

“health care” does not include—

- (a) emergency health care;³⁶ or
- (b) STD health care;³⁷ or
- (c) contraceptive health care.³⁸

(2) For health care,³⁹ of a young person who is under 12 years, by a health care provider—

- (a) a parent⁴⁰ of the young person may consent to, or refuse, the health care;⁴¹ and
- (b) if the health care is scheduled objectionable health care,⁴² the

³⁶ See schedule 1 (Additional health care concepts), section 4 for definition.

³⁷ See schedule 1 (Additional health care concepts), section 7 for definition.

³⁸ See schedule 1 (Additional health care concepts), section 8 for definition. Also, sections 25, 28 and 29 deal specifically with emergency health care, STD health care and contraceptive health care of a young person who is under 12 years.

³⁹ See section 18 for definition.

⁴⁰ The definition of “parent” is wider than its common meaning—section 21.

⁴¹ However, this Act does not affect any common law limitation on the power of a parent to consent to health care of a young person—section 12(3). For example, a young person’s parents cannot consent, without court approval, to the young person’s sterilisation—*Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

⁴² Scheduled objectionable health care is listed in schedule 3.

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young person may object ⁴³ to the health care; and	1
(c) the young person may not consent to, or refuse, the health care; and	2
	3
(d) a consent by 1 parent is effective even if another parent refuses the health care; and	4
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(e) a consent by a parent to scheduled objectionable health care is ineffective if the young person objects to the health care.	6
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(3) Health care, of a young person who is under 12 years, may be carried out by a health care provider with a consent if the health care is in the best interests of the young person's health and wellbeing. ⁴⁴	8
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Emergency health care—under 12	11
25.(1) Before a health care provider carries out emergency health care, of a young person who is under 12 years, the health care provider is encouraged to take reasonable steps to contact a parent of the young person about the health care.	12
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(2) Subsection (1) does not apply if the health care provider honestly and reasonably believes the delay associated with taking the steps would not be in the best interests of the young person's health and wellbeing.	16
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	18
(3) A person is not liable for assault for carrying out health care of a young person who is under 12 years if—	19
	20
(a) the health care should be carried out urgently to meet imminent risk to the young person's life or health; and	21
	22
(b) the health care is in the best interests of the young person's health and wellbeing. ⁴⁵	23
	24

⁴³ See schedule 1 (Additional health care concepts), section 12 for definition.

⁴⁴ For protection from liability for assault for health care carried out under this Act, see section 43.

⁴⁵ Except as provided by this section, the common law, as it exists from time to time, about emergency health care for young people under 12 years applies—section 12(4) (Act's relationship with other law). In the Law Reform Commission's view, consent is not relevant to the provision of emergency health care under the common law. So, emergency health care of a young person may always be carried out without a consent.

Health Care Authorisation for Young People

(4) Subsection (3) applies even if a parent of the young person refuses the health care or the young person objects to the health care.⁴⁶

Health care required without delay—under 12

26.(1) This section does not apply for particular health care required without delay, by an authorised health care provider,⁴⁷ if the authorised health care provider knows a parent of the young person previously indicated the health care of the young person is not to be carried out and, since then, the parent has not indicated otherwise.

Example—

This section does not apply to the administration by a school doctor or nurse of an injection of a particular drug to a school student if the student's parent had previously told the doctor or nurse not to administer the drug to the student.

(2) Health care required without delay,⁴⁸ of a young person who is under 12 years, may be carried out by an authorised health care provider without a consent if—

- (a) either—
 - (i) the delay associated with taking reasonable steps to contact a parent of the young person for parental consent to the health care would not be in the best interests of the young person's health and wellbeing; or
 - (ii) reasonable steps have been taken to contact a parent of the young person for parental consent to the health care, but no parental consent to, or parental refusal of, the health care is given; and
- (b) the health care is in the best interests of the young person's health and wellbeing.

⁴⁶ Subsections (3) and (4) reflect the Law Reform Commission's understanding of the common law.

⁴⁷ See schedule 4 (Dictionary) for definition.

⁴⁸ See schedule 1 (Additional health care concepts), section 5 for definition.

Health Care Authorisation for Young People

carried out by an authorised health care provider with a consent if the health care is in the best interests of the young person's health and wellbeing. 1
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(3) Further, STD health care, of a young person who is under 12 years and not competent for the health care, may be carried out by an authorised health care provider without a consent, even if a parent of the young person refuses the health care, if— 3
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(a) the health care is in the best interests of the young person's health and wellbeing; and 7
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(b) the young person does not object to the health care.⁵³ 9

Contraceptive health care—under 12 10

29.(1) For contraceptive health care, of a young person who is under 12 years, by an authorised health care provider— 11
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(a) a parent of the young person may consent to, or refuse,⁵⁴ the health care; and 13
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(b) if the young person is competent for the health care, the young person may consent to the health care; and 15
16

(c) the young person may object to, but not refuse, the health care;⁵⁵ and 17
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(d) a consent by the young person is effective even if a parent refuses the health care; and 19
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(e) a consent by 1 parent is effective even if another parent refuses the health care; and 21
22

(f) a consent by a parent is ineffective if the young person objects to the health care. 23
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⁵³ If a young person objects to STD health care and there is no parental consent to the health care, the health care may be authorised by an order made under the *Health Act 1937*, section 36, as amended by this Act—see section 50.

⁵⁴ However, a parental refusal is ineffective if a competent young person consents to the contraceptive health care (subsection (1)(b) and (d)) or a non-competent young person asks for the contraceptive health care (subsection (3)).

⁵⁵ However, the young person's objection makes a parental consent ineffective—see paragraph (f).

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- (2) Contraceptive health care, of a young person who is under 12 years, may be carried out by an authorised health care provider with a consent if the health care is in the best interests of the young person's health and wellbeing. 1
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- (3) Further, contraceptive health care, of a young person who is under 12 years and not competent for the health care, may be carried out by an authorised health care provider without a consent, even if a parent of the young person refuses the health care, if— 5
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8
- (a) the health care is in the best interests of the young person's health and wellbeing; and 9
10
- (b) the young person asks for the health care. 11

PART 2—12 TO 15 YEARS 12

- Health care generally—12 to 15** 13
- 30.(1)** In this section— 14
- “health care” does not include— 15
- (a) emergency health care; or 16
- (b) STD health care; or 17
- (c) contraceptive health care.⁵⁶ 18
- (2) For health care, of a young person who is 12 to 15 years, by a health care provider— 19
20
- (a) a parent⁵⁷ of the young person may consent to, or refuse, the 21

⁵⁶ Sections 31, 34 and 35 deal specifically with these types of health care of a young person who is 12 to 15 years.

⁵⁷ The definition of “parent” is wider than its common meaning—section 21.

Health Care Authorisation for Young People

health care; ⁵⁸ and	1
(b) if the young person is competent for the health care, the young person may consent to the health care (except if the health care is sterilisation ⁵⁹); and	2 3 4
(c) if the health care is scheduled objectionable health care, ⁶⁰ the young person may object to the health care; and	5 6
(d) the young person may not refuse the health care; and	7
(e) a consent by the young person is effective even if a parent refuses the health care; and	8 9
(f) a consent by 1 parent is effective even if another parent refuses the health care; and	10 11
(g) a consent by a parent to scheduled objectionable health care is ineffective if the young person objects to the health care.	12 13
(3) Health care, of a young person who is 12 to 15 years, may be carried out by a health care provider with a consent if the health care is in the best interests of the young person's health and wellbeing. ⁶¹	14 15 16
 Emergency health care—12 to 15	 17
31.(1) Before a health care provider carries out emergency health care, of a young person who is 12 to 15 years, the health care provider is encouraged to take reasonable steps to contact a parent of the young person about the health care.	18 19 20 21
(2) Subsection (1) does not apply if the health care provider honestly and reasonably believes the delay associated with taking the steps would not be	22 23

⁵⁸ However, this Act does not affect any common law limitation on the power of a parent to consent to health care of a young person—section 12(3). For example, a young person's parents cannot consent, without court approval, to the young person's sterilisation—*Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

⁵⁹ See schedule 1 (Additional health care concepts), section 10 for definition.

⁶⁰ Scheduled objectionable health care is listed in schedule 3.

⁶¹ For protection from liability for assault for health care carried out under this Act, see section 43.

Health Care Authorisation for Young People

in the best interests of the young person's health and wellbeing.	1
(3) A person is not liable for assault for carrying out health care of a young person who is 12 to 15 years if—	2 3
(a) the health care should be carried out urgently to meet imminent risk to the young person's life or health; and	4 5
(b) the health care is in the best interests of the young person's health and wellbeing. ⁶²	6 7
(4) Subsection (3) applies even if a parent of the young person refuses the health care or the young person objects to the health care.	8 9
Health care required without delay—12 to 15 and non-competent	10
32.(1) This section does not apply for particular health care required without delay, by an authorised health care provider, if the authorised health care provider knows a parent of the young person previously indicated the health care of the young person is not to be carried out and, since then, the parent has not indicated otherwise.	11 12 13 14 15
<i>Example—</i>	16
This section does not apply to the administration by a school doctor or nurse of an injection of a particular drug to a school student if the student's parent had previously told the doctor or nurse not to administer the drug to the student.	17 18 19
(2) Health care required without delay, of a young person who is 12 to 15 years and not competent for the health care, may be carried out by an authorised health care provider without a consent if—	20 21 22
(a) either—	23
(i) the delay associated with taking reasonable steps to contact a parent of the young person for parental consent to the health care would not be in the best interests of the young person's health and wellbeing; or	24 25 26 27

⁶² Except as provided by this section, the common law, as it exists from time to time, about emergency health care for young people who are 12 to 15 years applies—section 12(4) (Act's relationship with other law). In the Law Reform Commission's view, consent is not relevant to the provision of emergency health care under the common law. So, emergency health care of a young person may always be carried out without a consent.

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- (ii) reasonable steps have been taken to contact a parent of the young person for parental consent to the health care, but no parental consent to, or parental refusal of, the health care is given; and
- (b) the health care is in the best interests of the young person's health and wellbeing.

Minor health care—12 to 15 and non-competent

33. Minor health care, of a young person who is 12 to 15 years and not competent for the health care, may be carried out by a person without a consent if the health care is in the best interests of the young person's health and wellbeing.⁶³

STD health care—12 to 15

34.(1) For STD health care, of a young person who is 12 to 15 years, by an authorised health care provider—

- (a) a parent of the young person may consent to, or refuse,⁶⁴ the health care; and
- (b) if the young person is competent for the health care, the young person may consent to the health care; and
- (c) the young person may object to, but not refuse, the health care; and
- (d) a consent by the young person is effective even if a parent refuses the health care; and

⁶³ For minor health care by a health care provider carried out with a consent—see section 30 (Health care generally—12 to 15). Minor health care by another person carried out with a consent is subject to the common law, as it exists from time to time, about authorisation of health care for young people—see section 12(2).

⁶⁴ However, a parental refusal has very little effect. It is ineffective if a competent young person consents to the health care (paragraphs (b) and (d)) or a non-competent young person does not object to the health care (subsection (3)). Finally, if not authorised under this Act, the health care may be authorised by an order made under the *Health Act 1937*, section 36, as amended by this Act—see section 50.

Health Care Authorisation for Young People

(e) a consent by 1 parent is effective even if another parent refuses the health care; and	1 2
(f) a consent by a parent is effective even if the young person objects to the health care.	3 4
(2) STD health care, of a young person who is 12 to 15 years, may be carried out by an authorised health care provider with a consent if the health care is in the best interests of the young person's health and wellbeing.	5 6 7
(3) Further, STD health care, of a young person who is 12 to 15 years and not competent for the health care, may be carried out by an authorised health care provider without a consent, even if a parent of the young person refuses the health care, if—	8 9 10 11
(a) the health care is in the best interests of the young person's health and wellbeing; and	12 13
(b) the young person does not object to the health care.	14
 Contraceptive health care—12 to 15	 15
35.(1) For contraceptive health care, of a young person who is 12 to 15 years, by an authorised health care provider—	16 17
(a) a parent of the young person may consent to, or refuse, ⁶⁵ the health care; and	18 19
(b) if the young person is competent for the health care, the young person may consent to the health care; and	20 21
(c) the young person may object to, but not refuse, the health care; ⁶⁶ and	22 23
(d) a consent by the young person is effective even if a parent refuses the health care; and	24 25
(e) a consent by 1 parent is effective even if another parent refuses	26

⁶⁵ However, a parental refusal is ineffective if a competent young person consents to the contraceptive health care (subsection (1)(b) and (d)) or a non-competent young person asks for the contraceptive health care (subsection (3)).

⁶⁶ However, the young person's objection makes a parental consent ineffective—see paragraph (f).

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PART 3—16 OR 17 YEARS

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⁶⁷ Section 38 deals specifically with emergency health care of a young person who is 16 or 17 years.

Health Care Authorisation for Young People

Health care generally—16 or 17 and non-competent	1
37.(1) In this section—	2
“health care” does not include—	3
(a) emergency health care; or	4
(b) STD health care; or	5
(c) contraceptive health care. ⁶⁸	6
(2) For health care, of a young person who is 16 or 17 years and not competent for the health care, by a health care provider—	7 8
(a) a parent ⁶⁹ of the young person may consent to, or refuse, the health care; ⁷⁰ and	9 10
(b) if the health care is scheduled objectionable health care, ⁷¹ the young person may object to the health care; and	11 12
(c) the young person may not consent to, or refuse, the health care; and	13 14
(d) a consent by 1 parent is effective even if another parent refuses the health care; and	15 16
(e) a consent by a parent to scheduled objectionable health care is ineffective if the young person objects to the health care.	17 18
(3) Health care, of a young person who is 16 or 17 years and not competent for the health care, may be carried out by a health care provider	19 20

⁶⁸ Sections 38, 41 and 42 deal specifically with these types of health care of a young person who is 16 or 17 years and not competent for the health care.

⁶⁹ The definition of “parent” is wider than its common meaning—section 21.

⁷⁰ However, this Act does not affect any common law limitation on the power of a parent to consent to health care of a young person—section 12(3). For example, a young person’s parents cannot consent, without court approval, to the young person’s sterilisation—*Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

⁷¹ Scheduled objectionable health care is listed in schedule 3.

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with a consent if the health care is in the best interests of the young person's health and wellbeing.⁷² 1
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Emergency health care—16 or 17 3

38.(1) Before a health care provider carries out emergency health care, of a young person who is 16 or 17 years and not competent for the health care, the health care provider is encouraged to take reasonable steps to contact a parent of the young person about the health care. 4
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(2) Subsection (1) does not apply if the health care provider honestly and reasonably believes the delay associated with taking the steps would not be in the best interests of the young person's health and wellbeing. 8
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(3) A person is not liable for assault for carrying out health care of a young person who is 16 or 17 years if— 11
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(a) the health care should be carried out urgently to meet imminent risk to the young person's life or health; and 13
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(b) the health care is in the best interests of the young person's health and wellbeing.⁷³ 15
16

(4) Subsection (3) applies even if a parent of the young person refuses the health care or the young person objects to the health care. 17
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(5) However, subsection (3) does not apply to a health care provider who knows, or ought reasonably to know, that— 19
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(a) the young person has refused the health care; and 21

(b) at the time the young person refused the health care, the young person was 16 or 17 years and competent for the health care; and 22
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(c) the young person has not subsequently withdrawn the refusal. 24

⁷² For protection from liability for assault for health care carried out under this Act, see section 43.

⁷³ Except as provided by this section, the common law, as it exists from time to time, about emergency health care for young people who are 16 or 17 years applies—section 12(4) (Act's relationship with other law). In the Law Reform Commission's view, consent is not relevant to the provision of emergency health care under the common law. So, emergency health care of a young person may always be carried out without a consent.

Health Care Authorisation for Young People

Health care required without delay—16 or 17 and non-competent	1
39.(1) This section does not apply for particular health care required without delay, by an authorised health care provider, if the authorised health care provider knows a parent of the young person previously indicated the health care of the young person is not to be carried out and, since then, the parent has not indicated otherwise.	2 3 4 5 6
<i>Example—</i>	7
This section does not apply to the administration by a school doctor or nurse of an injection of a particular drug to a school student if the student’s parent had previously told the doctor or nurse not to administer the drug to the student.	8 9 10
(2) Health care required without delay, of a young person who is 16 or 17 years and not competent for the health care, may be carried out by an authorised health care provider without a consent if—	11 12 13
(a) either—	14
(i) the delay associated with taking reasonable steps to contact a parent of the young person for parental consent to the health care would not be in the best interests of the young person’s health and wellbeing; or	15 16 17 18
(ii) reasonable steps have been taken to contact a parent of the young person for parental consent to the health care, but no parental consent to, or parental refusal of, the health care is given; and	19 20 21 22
(b) the health care is in the best interests of the young person’s health and wellbeing.	23 24
 Minor health care—16 or 17 and non-competent	 25
40. Minor health care, of a young person who is 16 or 17 years and not competent for the health care, may be carried out by a person without a	26 27

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consent if the health care is in the best interests of the young person's health and wellbeing.⁷⁴ 1
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STD health care—16 or 17 and non-competent 3

41.(1) For STD health care, of a young person who is 16 or 17 years and not competent for the health care, by an authorised health care provider— 4
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(a) a parent of the young person may consent to, or refuse,⁷⁵ the health care; and 6
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(b) the young person may object to, but not refuse, the health care; and 8
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(c) a consent by 1 parent is effective even if another parent refuses the health care; and 10
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(d) a consent by a parent is effective even if the young person objects to the health care. 12
13

(2) STD health care, of a young person who is 16 to 17 years and not competent for the health care, may be carried out by an authorised health care provider, if the health care is in the best interests of the young person's health and wellbeing— 14
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(a) with the consent of a parent of the young person; or 18

(b) without a consent, even if a parent of the young person refuses the health care, unless the young person objects to the health care. 19
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Contraceptive health care—16 or 17 and non-competent 21

42.(1) For contraceptive health care, of a young person who is 16 or 22

⁷⁴ For minor health care by a health care provider carried out with a consent—see section 37. (Health care generally—16 or 17 and non-competent). Minor health care by another person carried out with a consent is subject to the common law, as it exists from time to time, about authorisation of health care for young people—see section 12(2).

⁷⁵ However, a parental refusal has very little effect. It is ineffective if the young person does not object to the health care (subsection (2)(b)). If not authorised under this Act, the health care may be authorised by an order made under the *Health Act 1937*, section 36, as amended by this Act—see section 50.

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17 years and not competent for the health care, by an authorised health care provider—	1 2
(a) a parent of the young person may consent to, or refuse, ⁷⁶ the health care; and	3 4
(b) the young person may object to, but not refuse, the health care; ⁷⁷ and	5 6
(c) a consent by 1 parent is effective even if another parent refuses the health care; and	7 8
(d) a consent by a parent is ineffective if the young person objects to the health care.	9 10
(2) Contraceptive health care, of a young person who is 16 or 17 years and not competent for the health care, may be carried out by an authorised health care provider, if the health care is in the best interests of the young person's health and wellbeing—	11 12 13 14
(a) with the consent of a parent of the young person; or	15
(b) without a consent, even if a parent of the young person refuses the health care, if the young person asks for the health care.	16 17

CHAPTER 5—MISCELLANEOUS 18

Protection for health care under Act 19

43. A person is not liable for assault for carrying out health care of a young person under this Act. 20
21

Example— 22

With a young person's consent, a health care provider carries out health care (as defined for section 30, but not sterilisation) of the young person. The young person is 15 years old and competent for the health care. Under section 30(3), the health care 23
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⁷⁶ However, a parental refusal is ineffective if a young person asks for the contraceptive health care (subsection (2)(b)).

⁷⁷ However, the young person's objection makes a parental consent ineffective—see paragraph (d).

Health Care Authorisation for Young People

provider may carry out the health care, if—	1
(a) the health care is in the best interests of the young person's health and wellbeing; and	2 3
(b) either—	4
(i) a parent of the young person consents to the health care and, for scheduled objectionable health care, the young person does not object to the health care (section 30(2)(a) and (g)); or	5 6 7
(ii) the young person consents to the health care (section 30(2)(b)).	8
So, assuming the health care is in the best interests of the young person's health and wellbeing, the health care provider has carried out the health care of the young person under this Act and is not liable for assault for carrying it out.	9 10 11
Also, if the health care provider has an honest and reasonable, but mistaken, belief about something, the health care provider is still protected from liability for assault because of section 44.	12 13 14
 Protection if mistaken belief	 15
44. A person who carries out health care of a young person under an honest and reasonable, but mistaken, belief in the existence of any state of things is not liable for assault to any greater extent than if the real state of things had been as the person believed.	16 17 18 19
<i>Example—</i>	20
A health care provider carries out health care (as defined for section 30, but not sterilisation) of an 11 year old on the basis of the young person's consent. The health care provider honestly and reasonably believes the young person is a 12 year old who is competent for the health care—see section 30 requirements. Under this section, the health care provider's liability is no more than if his or her beliefs about these matters were correct.	21 22 23 24 25 26
Assuming the health care was not sterilisation and the health care provider also honestly and reasonably believed the health care was in the best interests of the young person's health and wellbeing, then the health care provider does not incur any liability for assault because of section 30, particularly subsections (2)(b) and (3), and this section.	27 28 29 30 31

Health Care Authorisation for Young People

Protection for health care by court order	1
45. A health care provider is not liable for assault for carrying out health care of a young person in accordance with a court order. ⁷⁸	2 3
Protection if unaware of court order	4
46.(1) A person who carries out health care of a young person contrary to a court order ⁷⁹ is not liable for assault to any greater extent than if there were no court order.	5 6 7
(2) Subsection (1) does not apply if the person knew, or ought reasonably to have known, of the court order.	8 9
Protection for supervised health care provider	10
47.(1) A health care provider who carries out health care of a young person under the supervision of another health care provider is not liable for assault to any greater extent than the supervising health care provider.	11 12 13
(2) Subsection (1) does not apply if the supervised health care provider knew, or ought reasonably to have known, the carrying out of the health care was not authorised under this Act.	14 15 16
<i>Example—</i>	17
If a nurse knows a 16 year old who is competent for health care refuses the health care, but the doctor supervising the nurse does not know, subsection (1) does not apply to protect the nurse from liability for assault. Under section 36, the young person may consent to, or refuse, his or her own health care.	18 19 20 21
Regulation-making power	22
48. The Governor in Council may make regulations under this Act.	23

⁷⁸ See section 12 (Act's relationship with other law).

⁷⁹ For example, a parenting order may be made under the *Family Law Act 1975* (Cwlth), pt VII, div 6 removing or reducing a parent's power to consent to health care—see particularly section 61D.

CHAPTER 6—CONSEQUENTIAL AMENDMENTS	1
PART 1—AMENDMENT OF HEALTH ACT 1937	2
Act amended in pt 1	3
49. This part amends the <i>Health Act 1937</i> .	4
Amendment of s 36 (Removal and detention of person suffering from notifiable disease)	5
50. Section 36(1)—	6
<i>insert—</i>	7
‘(c) is under 18 years and the notifiable disease is a sexually transmitted disease, the health care for which is not authorised under the <i>Health Care Authorisation for Young People Act 1996</i> ;’.	8
	9
	10
	11
	12
PART 2—AMENDMENT OF TRANSPLANTATION AND ANATOMY ACT 1979	13
	14
Act amended in pt 2	15
51. This part amends the <i>Transplantation and Anatomy Act 1979</i> .	16
Amendment and relocation of s 20 (Blood transfusions to children without consent)	17
52.(1) Section 20(1), ‘criminal liability’—	18
<i>omit, insert—</i>	19
‘liability for assault’.	20
(2) Section 20(3)—	21
	22

Health Care Authorisation for Young People

<i>renumber</i> as section 20(4).	1
(3) After section 20(2)—	2
<i>insert</i> —	3
‘(3) However, for a medical practitioner administering, or a person acting in aid of a medical practitioner and under the medical practitioner’s supervision in administering, a blood transfusion to a 16 or 17 year old patient, subsections (1) and (2) do not apply if the medical practitioner, or the person, as the case may be, knows, or ought reasonably to have known—	4 5 6 7 8 9
(a) the patient has refused the blood transfusion; and	10
(b) the patient was a competent 16 or 17 year old at the time the patient refused the blood transfusion; and	11 12
(c) the patient has not subsequently withdrawn the refusal.’.	13
(4) Section 20 (as amended)—	14
<i>relocate</i> to part 2A and renumber as section 21B.	15
Insertion of new pt 2A	16
53. After part 2—	17
<i>insert</i> —	18
‘PART 2A—BLOOD TRANSFUSIONS TO CHILDREN WITHOUT CONSENT	19 20
‘Definitions for pt 2A	21
‘21A. In this part—	22
“blood transfusion” see section 16.	23
“competent 16 or 17 year old”, for administration of a blood transfusion, means an individual who—	24 25
(a) is 16 or 17 years; and	26
(b) understands the nature and consequences of the administration; and	27 28

Health Care Authorisation for Young People

- (c) communicates his or her decision about the administration in some way. 1
2
- “liability for assault” means—** 3
- (a) civil liability for assault or battery; and 4
- (b) criminal liability for assault.’ 5
6

SCHEDULE 1	1
ADDITIONAL HEALTH CARE CONCEPTS	2
schedule 4	3
Non-touching health care	4
1. "Non-touching health care" is health care not involving a touching or the application of force, whether direct or indirect, other than scheduled non-touching health care. ⁸⁰	5 6 7
<i>Examples—</i>	8
Counselling is an example of non-touching health care. On the other hand, X-raying a person is not an example of non-touching health care because it involves the application of force.	9 10 11
Scheduled non-touching health care	12
2. "Scheduled non-touching health care" means health care specified in schedule 2.	13 14
Scheduled objectionable health care	15
3. "Scheduled objectionable health care" means health care specified in schedule 3.	16 17
Emergency health care	18
4. "Emergency health care" does not include a blood transfusion.	19
Health care required without delay	20
5. "Health care required without delay" is health care that should be carried out without delay, but does not include—	21 22

⁸⁰ Scheduled non-touching health care is health care set out in schedule 2.

SCHEDULE 1 (continued)

(a) scheduled objectionable health care; or	1
(b) emergency health care; or	2
(c) a blood transfusion; or	3
(d) STD health care; or	4
(e) contraceptive health care.	5
<i>Example—</i>	6
If a young person is in severe pain following a serious accident, administration of pain relief might be health care required without delay.	7 8
Minor health care	9
6. “Minor health care” is—	10
(a) first aid; or	11
(b) a non-intrusive examination for diagnostic purposes; or	12
(c) the administration of a pharmaceutical drug if—	13
(i) a prescription is not needed to obtain the drug; and	14
(ii) the administration is for a recommended purpose and at a recommended dosage level;	15 16
but does not include—	17
(d) scheduled objectionable health care; or	18
(e) emergency health care; or	19
(f) a blood transfusion; or	20
(g) health care required without delay; or	21
(h) STD health care; or	22
(i) contraceptive health care.	23
STD health care	24
7. “STD health care”, of a young person, is health care of the young person for a sexually transmitted disease.	25 26

SCHEDULE 1 (continued)

Contraceptive health care	1
8. “Contraceptive health care” is health care primarily intended to prevent pregnancy and does not include sterilisation or termination of a pregnancy.	2 3 4
Health care primarily to treat organic malfunction or disease	5
9. “Health care primarily to treat organic malfunction or disease”, of a young person, is health care without which an organic malfunction or disease of the young person is likely to cause serious or irreversible damage to the young person’s physical health.	6 7 8 9
<i>Examples—</i>	10
1. Health care involving sterilisation may be primarily to treat organic malfunction or disease if the young person has cancer affecting the reproductive system or cryptorchidism.	11 12 13
2. Health care involving termination of a pregnancy may be primarily to treat organic malfunction if a pregnant young person requires abdominal surgery for injuries suffered in an accident.	14 15 16
Sterilisation	17
10. “Sterilisation” is health care carried out on a young person (other than health care primarily to treat organic malfunction or disease) that—	18 19
(a) if the young person is not yet, or is reasonably likely to not yet be, fertile—is intended, or reasonably likely, to prevent the young person ever becoming, or to ensure the young person does not ever become, fertile; or	20 21 22 23
(b) if the young person is, or is reasonably likely to be, fertile—is intended, or reasonably likely, to make the young person, or to ensure the young person is, permanently infertile.	24 25 26
Termination	27
11. “Termination”, of a pregnancy of a young person, does not include	28

SCHEDULE 1 (continued)

health care primarily to treat organic malfunction or disease of the young person.	1 2
Objection to health care	3
12.(1) A young person “objects” to health care if—	4
(a) the young person—	5
(i) indicates (for example, in writing, orally or by conduct) the young person does not wish to have the health care; or	6 7
(ii) previously indicated, in similar circumstances, the young person did not then wish to have the health care and since then the young person has not indicated otherwise; and	8 9 10
(b) the indication is not ineffective because of subsection (2).	11
(2) An indication is ineffective if the health care provider proposing to carry out the health care honestly and reasonably believes—	12 13
(a) the young person has minimal or no understanding of 1 or both of the following—	14 15
(i) what the health care involves;	16
(ii) why the health care is required; and	17
(b) the health care is likely to cause the young person—	18
(i) no distress; or	19
(ii) temporary distress that is outweighed by the benefit to the young person of the health care.	20 21
	22

SCHEDULE 2	1
SCHEDULED NON-TOUCHING HEALTH CARE	2
schedule 1, section 2	3
[Note—The Law Reform Commission recommends that the Department of Families, Youth and Community Care and the Department of Health would be the most appropriate bodies jointly to devise and review this schedule.]	4 5 6 7

SCHEDULE 3	1
SCHEDULED OBJECTIONABLE HEALTH CARE (WHERE YOUNG PERSON'S OBJECTION MAKES PARENT'S CONSENT INEFFECTIVE)	2 3 4
sections 24, 30 and 37	5
schedule 1, section 3	6
1. termination of a pregnancy	7 8

SCHEDULE 4	1
DICTIONARY	2
section 17	3
“authorised health care provider” means a health care provider who is—	4
(a) a doctor; ⁸¹ or	5
(b) a dentist; or	6
(c) a registered nurse; or	7
(d) a person of a type prescribed by regulation as an authorised health care provider.	8 9
“blood transfusion” see <i>Transplantation and Anatomy Act 1979</i> , section 16. ⁸²	10 11
“competent” (other than for section 21 ⁸³) see section 20.	12
“contraceptive health care” see schedule 1, section 8.	13
“dentist” see <i>Dental Act 1971</i> , section 4. ⁸⁴	14
“emergency health care” see schedule 1, section 4.	15
“health care” see section 18.	16
“health care primarily to treat organic malfunction or disease” see	17

⁸¹ “**Doctor**” means medical practitioner within the meaning of the *Medical Act 1939—Acts Interpretation Act 1954*, section 36.

⁸² “**blood transfusion**” means the transfusion of human blood, or any of the constituents of human blood, into a person and includes the operation of removing all or part of the blood of a person and replacing it with blood taken from another person.

⁸³ Section 21 (Meaning of parent, guardian and significant carer).

⁸⁴ *Dental Act 1971*, section 4 states—

‘**“Dentist”** means a person registered as a dentist under this Act and whose name remains upon the register of dentists.’

SCHEDULE 4 (continued)

schedule 1, section 9.	1
“health care provider” see section 19.	2
“health care required without delay” see schedule 1, section 5.	3
“liable for assault” means—	4
(a) civilly liable for assault or battery or under section 22; ⁸⁵ and	5
(b) criminally liable for assault or under section 23. ⁸⁶	6
“minor health care” see schedule 1, section 6.	7
“non-touching health care” see schedule 1, section 1.	8
“objects”, by a young person to health care, see schedule 1, section 12.	9
“parent” see section 21.	10
“registered nurse” see <i>Nursing Act 1992</i> , section 4. ⁸⁷	11
“scheduled non-touching health care” see schedule 1, section 2.	12
“scheduled objectionable health care” see schedule 1, section 3.	13
“STD health care” see schedule 1, section 7.	14
“sterilisation” see schedule 1, section 10.	15
“termination”, of a pregnancy, see schedule 1, section 11.	16
“young person” means an individual who is under 18 years.	17
	18

⁸⁵ Section 22 (Civil action if unauthorised health care)

⁸⁶ Section 23 (Offence to carry out unauthorised health care)

⁸⁷ *Nursing Act 1992*, section 4—

‘“registered nurse” means a person who is registered under this Act as a registered nurse.’

APPENDIX 1

LIST OF RESPONDENTS TO THE INFORMATION PAPER

Alick, Ms P
Allen-Ankins, Mr S
Anonymous
Appleton, Dr D B
Aquinas College, (Parents and Friends Assoc)
Arkadieff, Mr and Mrs
Badke, Mrs
Barone, Ms S
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Beer, Mrs N (The Patient's Friend)
Bennett, Mrs E
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Best, Ms D (Children's Community Health Services)
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Conway, R J (Biloela Right to Life)
Cook, Mr G (Austrn Festival of Light (Qld))
Cooper, Ms K (Youth Health Policy Unit Qld Health)
Coyle, Dr T F
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Cronin, Mr Brian
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Eastgate, Ms J (National President, Citizens Commission on Human Rights)
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Johnson, Ms R and Woodford, Ms K (Innisfail State High School)
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Judd, Ms C
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Mann, Mrs C
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List of Respondents to the Information Paper

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Monsour, Mr M P
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Parents and Friends Assn)
Murphy, Ms A
Murray, Mr and Mrs R
Naske, Mr P
Nehmer, Ms J (Mereeba State High
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O'Meara, Mr M
Osmak, Mr R
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Petrie, Ms K J
Prescott, Ms R (Somerset College)
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Queensland's Health Sector
Queensland Right to Life Association
Qld Right to Life, Tableland Branch
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Right to Life Australia
Russell-Hall, Ms S (Redbank Plains State
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Sadler, Dr T
Samuels, Ms M (Unicare)
Savage, Ms S
Schultz, Dr D (Australian Association for
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Shanahan, Mr J
Shellshear, Dr I
Shepherd, Mr H
Smith, Mr B (The Assn of Independent
Schools of Qld)
Smith, Mr G W (Canegrowers, Invicta Area)
Sorenson, Mrs C
Stephens, Ms L
Sultana, Mrs J
Svendsen, Mrs R
Tento, Ms S A
Thiedeman, P (Woody Point Special School)
Tomoum, Mohammad (President, Islamic
Council of Queensland)

Torkington, B (St Francis Primary School)
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Wallace, Mr/Ms D
Wallace, Mr L
Wallace, Mrs M
Waller, Ms S
Walsh, Mrs M (Australian Parent
Advocacy)
Warner MLA, Ms A (Minister for Family
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Weller, Ms M
Whitton, Mrs S
Wickham, Mrs
Wigg, Ms V
Wilkey, Dr I S
Wilkie, Ms S (President, Association of
Private Practising Psychologists)
Williams, AM (Bundaberg Community
Council Incorporated)
Wilson, Dr G L
Wilson, Mrs M
Wilson, Mr T (Youth Affairs Network of Qld Inc)
Wood, R
Zischke, Mr and Mrs W D

APPENDIX 2

QUEENSLAND LAW REFORM COMMISSION

CONSENT TO MEDICAL TREATMENT OF YOUNG PEOPLE

QUESTIONNAIRE

Please return to:
Wayne Briscoe, Commissioner
Qld Law Reform Commission
PO Box 312, Roma Street Qld 4003
or by fax: (07) 3247 9045

YOUNG PERSON is defined as anyone under 18.

TREATMENT is health care by doctors, dentists, drug and alcohol counsellors and other health care providers.

THE LAW AT THE MOMENT

At the moment the law is very confusing and we want to make it clearer for everyone to be able to understand - including doctors, young people and parents.

If you fully understand the treatment and what the treatment will do to you then you can consent to that treatment without your parents being told. But the doctor has to be sure that you are mature enough.

If a doctor or other health care provider touches you without your permission, without a court order or without the permission of one of your parents then that could be called an assault and the person who touched you could be liable for doing so without a proper consent.

We have heard that some doctors and others will not treat young people except with the consent of their parents.

We have also heard that some young people will not go to a doctor or other health care provider for treatment because they think that their parents will be told.

HOW YOU CAN HELP

We need to hear from young people about any hassles they have had with getting treatment without their parents knowing.

We also need your help to find out when young people should be able to go to a doctor or other health care provider, without parents knowing.

We want to make sure that the law does not stop young people from getting the treatment they need and we need help from young people to understand the types of treatment they need and the problems they have had getting it.

- * Age of person answering questions
(or range of ages of people in a group session)

.....

Questionnaire

* Sex of person answering question
(or numbers of males and females in group session)

QUESTIONS

- 1 have you ever tried to see a doctor, dentist or someone else for treatment without your parents knowing? (what age were you; what sort of treatment)
- 2 has a doctor or a dentist or other person told you that they would not treat you unless your parents are told about it? (what age were you; what sort of treatment)
- 3 do you know of this happening to any of your friends?
- 4 have you ever been afraid to get treatment for something because you thought that your parents might be told? (what type of treatment)
- 5 have you had problems trying to get treatment? (what type of problems)
- 6 what type of health problems have you had and did not want your parents to know about?
- 7 when do you think young people should be able to get treatment without their parents knowing about it?
- 8 do you think parents should be able to stop their children from getting treatment?
- 9 do you think your own parents should be able to stop you getting treatment?
- 10 when do you think you should be able to say no to treatment which your parents or others want you to have?
- 11 are there any types of treatment that young people should be able to consent to having, whatever their age and maturity and without parents being told? (what are they)

Appendix 2

- 12 when a teenager has a baby - should the teenager always be able to consent to the baby's treatment - or only if the teenager is able to fully understand the treatment?
- 13 do you have any other comments to make on the current law or on what the law should be?

Thankyou very much for your help

APPENDIX 3

CONSULTATION MEETINGS FOLLOWING RELEASE OF THE DISCUSSION PAPER

1	Sunnybank	5 July 1995	High school nurses
2	Gold Coast	11 July 1995	Health care providers and people working with young people
3	Cairns	23 July 1995	Organiser of meetings with Aboriginal people in Cairns
4	Cairns	24 July 1995	Aboriginal groups including Cape York Health Council and Cape York Land Council
5	Cairns	24 July 1995	Cairns Base Hospital
6	Longreach	27 July 1995	Regional Directors of Nursing
7	Longreach	27 July 1995	Youth workers
8	Townsville	27 July 1995	Aboriginal health workers, Sexual Health workers and Juvenile Justice Centre representative
9	Townsville	27 July 1995	Health care providers and Parents & Citizens representative
10	Mt Isa	28 July 1995	Aboriginal organisations
11	Mt Isa	28 July 1995	Health care providers and youth workers
12	Hervey Bay	1 August 1995	Health care providers
13	Redcliffe	3 August 1995	Health care providers
14	Caboolture	3 August 1995	Adolescent and Young Peoples Mental Health Service
15	Nambour	3 August 1995	Health care providers
16	QEII Hosp	4 August 1995	School health nurses
17	Upper Mt Gravatt	8 August 1995	Health care providers
18	Royal Childrens Hospital	9 August 1995	Health care providers
19	Southport	11 August 1995	Child & Adolescent Community Psychiatry Service
20	Rockhampton	14 August 1995	Health care providers and youth workers
21	Rockhampton	14 August 1995	Health care providers

Appendix 3

22	Mackay	15 August 1995	Health care providers
23	Toowoomba	24 August 1995	Mental health workers and youth workers
24	Ipswich	25 August 1995	Health care providers
25	Royal Childrens Hospital	28 August 1995	Ethics Committee
26	Mooloolaba	5 September 1995	Child guidance officers
27	Brisbane	7 September 1995	Burleigh Heads Child & Adolescent Psychiatry Team

APPENDIX 4

LIST OF RESPONDENTS TO THE DISCUSSION PAPER

Anglicare Social Responsibilities Committee
Anonymous
Australian Acupuncture Association Ltd
Australian College of Paediatrics, The
Australian Hypnotherapists' Association
Australian Physiotherapy Association
Australian Psychological Society Inc
Barber, Mrs P
Batten, Dr D A (East Gloucestershire NHS Trust)
Bell, Ms M
Brisbane Youth Service
Centacare (Central Queensland)
Clifton High School (P&C Association)
Collings, Dr N
Courtney, Mrs E M
Doherty, Mr M
Endeavour Foundation
Family and Community Services, Dept of Gardiner, D (Mater Misericordiae Hospital)
Girgenti, Mr and Mrs S
Gladstone West State School
Hannan, Mr J (Mooloolaba & Area School Support Centre)
Harrington, Dr P
Hartwig, Dr A
"Illegible"
Jago, A
Jones, C
Jordan, Dr A
Kennedy, Mr J
Kerr, D (Qld Right to Life Association)
King, Mrs F E
MacFarlane, P (QUT)
McKay, J
MacPherson, D and L
Marrinon, Mr M J (Cootharinga Society of Northern Queensland)
Muller, J H
Nash, Mrs Yvonne
National Children's and Youth Law Centre
O'Connor, Ms K
Paediatric Society of Queensland
Planned Parenthood of Australia
Provincial Medico Moral Committee
Public Policy Assessment Society Inc, The
Purcell, Dr D (MBBS)
Qld Advocacy Inc
Qld Ambulance Service
Qld Health (Child Health Services - Brisbane North Region)
Qld Health (Child Health Services - South Coast Region)
Qld Health (Brisbane South Region)
Qld Health (Central Office)
Qld Health (Darling Downs Region)
Qld Health (Mackay Region)
Qld Health (Speech Pathology - Brisbane South Region)
Qld Health (Toowoomba Branch)
Qld Right to Life
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St Joseph's College (P&A Association)
Sullivan, Dr K
Tucker, L (Director Nursing, Eidsvold Hospital)
Tourism, Sport & Youth, Dept of
Waley, Mrs C A
Wickham, Mrs M
Wilson, Mrs M
Youth and Family Services (Logan City) Inc
Youthlink (14 questionnaires filled out)

APPENDIX 5

HEALTH CARE PROVIDERS' ETHICAL DUTY OF CONFIDENTIALITY: A SAMPLE OF DUTIES

AUSTRALIAN MEDICAL ASSOCIATION: CODE OF ETHICS

- 1.3(d) Keep in confidence information derived from your patient, or from a colleague regarding your patient, and divulge it only with the patient's permission. Exceptions may arise where the health of others is at risk or you are required by order of a court to breach patient confidentiality.

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.

THE ETHICS OF THE AUSTRALIAN HYPNOTHERAPISTS' ASSOCIATION

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 formula.

THE AUSTRALIAN OPTOMETRICAL ASSOCIATION: PATIENT RIGHTS

Patients have the right to ... have information relating to them kept confidential and released to others only with the patient's permission or when the law or the safety of the public requires release.

PHARMACEUTICAL SOCIETY OF AUSTRALIA: CODE OF PROFESSIONAL CONDUCT

Code 5 A pharmacist shall respect the trust and confidentiality of professional relationships with patients.

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 6

STATUTORY PROVISIONS RELATING TO CONSENT TO HEALTH CARE IN AUSTRALIAN JURISDICTIONS

Queensland

Health Act 1937

Notication of maltreatment

- 76K(1) A medical practitioner who suspects on reasonable grounds the maltreatment or neglect of a child in such a manner as to subject or be likely to subject the child to unnecessary injury, suffering or danger shall, within 24 hours after first so suspecting, notify by the most expeditious means available to the medical practitioner a person authorised under a regulation to be so notified.
- (2) Where notification is given to an authorised person pursuant to subsection (1), the medical practitioner so notifying shall, within 7 days after doing so, forward to the chief health officer a further notification in the approved form.
 - (3) An authorised person who receives a notification from a medical practitioner under this section shall act in such manner as will best ensure the safety and well being of the child in question and, in so doing, may communicate the notification in the approved form to other persons for the purpose of having investigations or inquiries made or other things done to enable full effect to be given to the provisions of this division.
 - (4) A notification given pursuant to subsection (1) or subsection (2) shall state the observations and opinions upon which the medical practitioner's suspicion is based.
 - (5) In addition to receiving the notification pursuant to subsection (2), the chief health officer may require the medical practitioner so notifying or any other medical practitioner associated with treatment of the child in question to forward to the chief health officer any statement or further information that the child health officer considers the chief health officer should have concerning the child; and the medical practitioner concerned shall comply with such requirement.
 - (6) Where in compliance or purported compliance with this section a notification is given or a statement or further information furnished in good faith by a medical practitioner -
 - (a) no liability at law is incurred in respect of the giving or furnishing thereof by the medical practitioner;
 - (b) the giving or furnishing thereof shall not in any proceedings before any court or tribunal or in any other respect be held to constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct.
 - (7) A person does not incur any liability as for defamation by the publication of any defamatory matter contained in a notification or statement or further information as aforesaid where such publication is made in good faith and pursuant to any provision of or otherwise in the execution of this division.

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.

Children (Care and Protection) Act 1987

Emergency medical treatment

- 20A(1) A registered medical practitioner may carry out medical treatment on a child without the consent of:
- (a) the child; or
 - (b) a parent or guardian of the person of the child,

if the medical practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child in order to save the child's life or to prevent serious damage to the child's health.

(2) A registered dentist may carry out dental treatment on a child without the consent of:

- (a) the child; or
- (b) a parent or guardian of the person of the child,

if the dentist is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child in order to save the child's life or to prevent serious damage to the child's health.

(3) Medical or dental treatment carried out on a child under this section shall, for all purposes, be taken to have been carried out with the consent of:

- (a) in the case of a child who is under the age of 16 years - a parent or guardian of the person of the child; or
- (b) in the case of a child who is of or above the age of 16 years - the child.

(4) Nothing in this section relieves a registered medical practitioner or registered dentist from liability in respect of the carrying out of medical or dental treatment on a child, being a liability to which the medical practitioner or dentist would have been subject had the treatment been carried out with the consent of:

- (a) in the case of a child who is under the age of 16 years - a parent or guardian of the person of the child; or
- (b) in the case of a child who is of or above the age of 16 years - the child.

South Australia

Consent to Medical Treatment and Palliative Care Act 1995

Legal competence to consent to medical treatment

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.

Administration of medical treatment to a child

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.

Emergency medical treatment

- 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.
- (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.

Medical practitioner's duty to explain

- 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.

Protection for medical practitioners, etc.

- 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.

Consent to Medical and Dental Treatment Act 1985 (repealed by the Consent to Medical Treatment and Palliative Care Act 1995)

- 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.

Commonwealth

Family Law Rules

Order 23B - Special Medical Procedures

[O 23B r 1] Approval of medical procedures for children

- 1 This Order applies to applications for a declaration that a person is authorised to consent to a medical or surgical procedure for a child.

[O 23B r 2] Who may apply for a medical procedure order?

- 2(1) An application may be made to a Family Court for:
 - (a) a declaration that the applicant or another named person is authorised to consent to the carrying out of a medical or surgical procedure for a child; and
 - (b) any necessary consequential orders.
- (2) An application may be made by:
 - (a) a parent of the child; or
 - (b) a person who has a parenting order in relation to the child; or
 - (c) any other person who has an interest in the care, welfare and development of the child.

[O 23B r 3] Form of application

- 3 Despite any other provision of these Rules, an application must be made in accordance with Form 8 with any appropriate modifications.

[O 23B r 4] Respondent to application

- 4 If a parent of a child in relation to whom an application is made, or a person who has a parenting order in relation to the child, is not an applicant, the person must be joined as a respondent to the application.

[O 23B r 5] Affidavits supporting the application

- 5(1) The applicant must file with the application an affidavit or affidavits to which are annexed relevant reports by medical, psychological or other experts.
- (2) An affidavit or report must set out:
 - (a) the exact nature and purpose of the proposed medical or surgical procedure; and
 - (b) the likely long term social and psychological effects of the procedure on the child; and

- (c) that:
 - (i) alternative and less invasive procedures or treatments would be, or have proved to be, inadequate; and
 - (ii) the procedure proposed is necessary for the welfare of the child; and
 - (iii) the child is incapable of making his or her own decision about undergoing the procedure; and
 - (iv) the child is unlikely to develop sufficiently to be able to make an informed judgment about undergoing the procedure within the time in which the procedure should be carried out, or within the foreseeable future; and
- (d) any other reasons for granting the application.

[O 23B r 6] Return date of application

- 6 An application must be made returnable before a judge of a Family Court as soon as possible and in any case, if possible, within 14 days after the date of issue.

[O 23B r 7] Proceedings on return day

- 7 On the return day of an application the court may:
 - (a) make the child a party and appoint a person as the next friend of the child; or
 - (b) appoint a child's representative; or
 - (c) join any other appropriate person as a respondent; or
 - (d) direct service of the application and affidavits on any other person or persons, as the court thinks proper; or

fix a date for the hearing of the application before a Judge of a Family Court; or make any orders or give any other directions, as the court thinks proper; or hear and determine the application.

[O 23B r 8] Hearing an application

- 8 On hearing the application the court may:
 - (a) grant the application; or
 - (b) refuse the application; or
 - (c) grant an injunction or any other relief the court thinks proper; or
 - (d) make any declaration or order the court thinks proper.

[O 23B r 9] Reasons for decision

- 9 At, or as soon as practicable after, the conclusion of the final hearing of an application, the judge before whom the application was heard must give reasons, in writing, for the decision.

APPENDIX 7

AUSTRALIAN HEALTH MINISTERS' ADVISORY WORKING GROUP

CRITERIA FOR ASSESSMENT OF REGULATORY REQUIREMENTS FOR UNREGULATED HEALTH OCCUPATIONS

Criterion 1

Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?

Criterion 2

Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

The following should be considered when assessing whether there is significant risk of harm to the public:

- the nature and severity of the risk to the client group
- the nature and severity of the risk to the wider public
- the nature and severity of the risk to the practitioner

Areas which could be explored to identify a risk to public health and safety are:

- To what extent does the practice of the occupation involve the use of equipment, materials or processes which could cause a serious threat to public health and safety?
- To what extent may the failure of a practitioner to practice in particular ways (ie follow certain procedures, observe certain standards, or attend to certain matters), result in a serious threat to public health and safety?
- Are intrusive techniques used in the practice of the occupation which can cause a serious or life threatening danger?
- To what extent are certain substances used in the practice of the occupation which can cause a serious or life threatening danger?
- Is there significant potential for practitioners to cause damage to the environment or to cause substantial public health and safety risk?

Epidemiological or other data (eg coroners cases, trend analysis, complaints), will be the basis for determining the demonstration of risk/harm.

Criterion 3

Do existing regulatory or other mechanisms fail to address health and safety issues?

Once the particular health and safety issues have been identified, are they addressed through:

- other regulations, eg risk due to skin penetration addressed via regulations governing skin

penetration and/or the regulation of the use of certain equipment or industrial awards?

- supervision by registered practitioners of a related occupation?
- self regulation by the occupation?

Criterion 4

Is regulation possible to implement for the occupation in question?

When considering whether regulation of the occupation is possible the following need to be considered:

- Is the occupation well defined?
- Does the occupation have a body of knowledge that can form a basis of its standards of practice?
- Is this body of knowledge, with the skills and abilities necessary to apply the knowledge, teachable and testable?
- Where applicable, have functional competencies been defined?
- Do the members of the occupation require core and government accredited qualifications?

Criterion 5

Is regulation practical to implement for the occupation in question?

When considering whether regulation of the occupation is practical the following should be considered:

- Are self regulation and/or other alternatives to registration practical to implement in relation to the occupation in question?
- Does the occupational leadership tend to favour the public interest over occupational self interest?
- Is there a likelihood that members of the profession will be organised and seek compliance with regulation from their members?
- Are there sufficient numbers in the occupation and are those people willing to contribute to the cost of statutory regulation?
- Is there an issue of cost recovery in regulation?
- Do all Governments agree with the proposal for regulation?

Criterion 6

Do the benefits to the public clearly outweigh the potential negative impact of such regulation?

APPENDIX 8

TABLE OF CASES

Allcroft v Lord Bishop of London [1891] AC 666
Attorney-General v Guardian Newspapers Ltd (No 2) [1990] 1 AC 109
Attorney-General for the State of Queensland (Ex rel Kerr) v T (1983) 57 ALJR 285
Australian Metropolitan Life Assurance Co Ltd v Ure (1923) 33 CLR 199
B v Croydon Health Authority [1995] Fam 133
Baker v Campbell (1983) 153 CLR 52
Baltic Shipping Company v Dillon (1993) 176 CLR 344
Bennet v Bennet (1879) 10 Ch D 474
Bolam v Friern Hospital Management Committee [1957] 1 WLR 582
Bouhey v The Queen (1986) 161 CLR 10
Bourke v Butterfield & Lewis Ltd (1926) 38 CLR 354
Calf v Sydney County Council [1972] 2 NSWLR 521
Carey v Population Services International (1977) 431 US 678
Carseldine v The Director of the Department of Children's Services (1974) 133 CLR 345
CES v Superclinics (Australia) Pty Ltd (1995) 38 NSWLR 47
Chatterton v Gerson [1981] QB 432
Cole v Turner (1704) 6 Mod 149; 87 ER 907
Collins v Wilcock [1984] 1 WLR 1172
Director-General of Social Welfare v B [1994] NZFLR 516
Downs v Williams (1971) 126 CLR 61
Duncan v Medical Practitioners Disciplinary Committee [1986] 1 NZLR 513
Ellis v Wallsend District Hospital (1989) 17 NSWLR 553
F v R (1983) 33 SASR 189
Faulkner v McPherson (1995) 120 FLR 64
Fontin v Katapodis (1962) 108 CLR 177
Fountain v Alexander (1982) 150 CLR 615
Fowkes v Pascoe (1875) 10 Ch App 343
Furniss v Fitchett [1958] NZLR 396
Gillick v West Norfolk and Wisbech Area Health Authority [1984] QB 581 (QBD)
Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112 at 116 to 150 (CA)
Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112 at 150-207 (HL)
GWW v GMW (Unreported, Family Court of Australia, HB 1447/1996, 21 January 1997)
Hall v A & A Sheiban Pty Ltd (1989) 20 FCR 217
Harlowe's Nominees Pty Ltd v Woodside (Lakes Entrance) Oil Co NL (1968) 121 CLR 483
Hart v Herron (1984) Aust Torts Reports ¶80-201
Hewer v Bryant [1970] 1 QB 357
Hinch v Director of Public Prosecutions [1996] 1 VR 683
Horan v Ferguson [1995] 2 Qd R 490
Hospital Products Ltd v United States Surgical Corporation (1984) 156 CLR 41
Hunt v National & General Insurance Co Ltd [1974] Qd R 157
H v W (1995) FLC ¶92-598
In re F (Mental Patient: Sterilisation) [1990] 2 AC 1
In re J (A Minor) (Child in Care: Medical Treatment) [1993] Fam 15
In re N (Infants) [1967] Ch 512
In re R (A Minor) (Wardship: Consent to Treatment) [1992] Fam 11
In re T (Adult: Refusal of Treatment) [1993] Fam 95
In re Taylor (1876) 4 Ch D 157
In re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1993] Fam 64
In the Marriage of F and R (1992) 15 Fam LR 533
J v Lieschke (1987) 162 CLR 447
JD Bell (Calool) Pty Ltd v Shortland County Council (1991) 74 LGRA 398
Johnson v The Director-General of Social Welfare (Victoria) (1976) 135 CLR 92

Re V [1993] NZFLR 369
Re X (a minor) [1975] 1 All ER 697
Read v Croydon Corp [1938] 4 All ER 631
Rogers v Whitaker (1992) 175 CLR 479
Royal Brunei Airlines v Tan [1995] 2 AC 378
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
Secretary of State for the Home Department v Robb [1995] Fam 127
Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1984] QB 493
Slater v Bissett (1986) 85 FLR 118
Smith Kline and French Laboratories (Australia) Ltd v Secretary, Department of Community Services and Health (1991) 99 ALR 679
Stone v Carr (1799) 3 Esp 1; 170 ER 517
Symes v Mahon [1922] SASR 447
T v T [1988] 2 WLR 189
Thornton v Kirklees Metropolitan Borough Council [1979] QB 626
Tournier v National Provincial and Union Bank of England [1924] 1 KB 461
Uren v John Fairfax & Sons Pty Ltd (1966) 117 CLR 118
Veivers v Connolly [1995] 2 Qd R 326
W v Director-General of Social Welfare [1990] 1 NZLR 378
W v Edgell [1990] Ch 359
Walker v Bradley (Unreported, District Court of New South Wales, Kirkham J, 15 December 1993)
Walker v Region 2 Hospital Corp 116 DLR (4th) 477 (CA)
Watson v Marshall (1971) 124 CLR 621
Wilson v Pringle [1987] QB 237
XL Petroleum (NSW) Pty Ltd v Caltex Oil (Australia) Pty Ltd (1985) 155 CLR 448

Table of Cases

Johnston v Wellesley Hospital (1971) 17 DLR (3d) 139
Johnstone v Stewart [1968] SASR 142
K v Minister for Youth and Community Services [1982] 1 NSWLR 311
K v T [1983] 1 Qd R 396
Lackersteen v Jones (1988) 92 FLR 6
Lamb v Cotogno (1987) 164 CLR 1
London Passenger Transport Board v Upson [1949] AC 155
Lonrho Ltd v Shell Petroleum Co Ltd (No 2) [1982] AC 173
Lowns v Woods (1996) Aust Torts Reports ¶81-376
Mackinlay v Wiley [1971] WAR 3
Malette v Shulman (1990) 67 DLR (4th) 321
Marshall v Curry [1933] 3 DLR 260
Martin v Dean [1971] 2 QB 208
Meering v Grahame-White Aviation Co Ltd (1919) 122 LT Rep 44
Minister of State for Immigration and Ethnic Affairs v Teoh (1995) 183 CLR 273
Mohr v Williams 104 NW 12 (1905) (USA)
Monk v Warbey [1935] 1 KB 75
Murray v Ministry of Defence [1988] 2 All ER 521
Myer Stores Ltd v Soo [1991] 2 VR 597
Nash v Commissioner for Railways [1963] SR (NSW) 357
Ney v Attorney-General of Canada (1993) 102 DLR (4th) 136
Oakey v Jackson [1914] 1 KB 216
O'Connor v SP Brady Ltd (1937) 56 CLR 464
P and P (1995) FLC ¶92-615
P v P (1994) 181 CLR 583
Pagliariella and Pagliariella (1993) FLC ¶92-400
Pantalone v Alaouie (1989) 18 NSWLR 119
Parry-Jones v Law Society [1969] 1 Ch 1
Pearce v Hallett [1969] SASR 423
Permanent Building Society (In Liq) v Wheeler (1994) 11 WAR 187
Piro v W Foster & Co Ltd (1943) 68 CLR 313
Powys v Mansfield (1837) 3 My & Cr 359; 40 ER 964
Provident International Corporation v International Leasing Corporation Ltd [1969] 1 NSWLR 424
Pufflett v Proprietors of Strata Plan No 121 (1987) 17 NSWLR 372
R v Bayliss and Cullen (1986) 9 Queensland Lawyer Reps 8
R v Cambridge Health Authority; ex parte B [1995] 1 WLR 898
R v Davidson [1969] VR 667
R v Gyngall [1893] 2 QB 232
R v Macdonald [1904] St R Qd 151
R v Raabe [1985] 1 Qd R 115
R v Slade [1995] 1 Qd R 390
R v Wald [1971] 3 NSW DCR 25
R v Watson [1987] 1 Qd R 440
Re A (1993) 16 Fam LR 715
Re Adoption of J (An Infant) (1990) 102 FLR 152
Re Bayliss (Unreported, Sup Ct of Qld, OS 326/1985, 24 May 1985)
Re D (A Minor) (Wardship: Sterilisation) [1976] Fam 185
Re Elizabeth (1989) 96 FLR 248
Re K (1994) FLC ¶92-461
Re Marion (1990) 14 Fam LR 427
Re Marion (No 2) (1992) 17 Fam LR 336
Re Michael (1994) FLC ¶92-471
Re Riley [1996] 1 Qd R 209
Re S (Unreported, High Court, Wellington, CP 430 91, 16 July 1991)
Re S [1992] 1 NZLR 363
Re Schneider and Secretary to the Department of Social Security (1986) ASSC 92-085

APPENDIX 9

TABLE OF LEGISLATION

AUSTRALIA

Queensland (Qld)

Age of Majority Act 1974
Ambulance Service Act 1991
Children's Services Act 1965
Commonwealth Powers (Family Law - Children) Act
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Health Act 1937
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Jurisdiction of Courts (Cross-vesting) Act 1987
Juvenile Justice Act 1992
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Medical Act 1939
Mental Health Act 1974
Nurses Act 1992
Penalties and Sentences Act 1992
Police Service Administration Act 1990
Psychologists Act 1977
Quarantine Act 1908
Status of Children Act 1978
Statute Law Revision Act 1995
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Voluntary Aid in Emergency Act 1973

Commonwealth (Cth)

Corporations Law
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Family Law Amendment Act 1983
Family Law Reform Act 1995
Family Law Rules
Jurisdiction of Courts (Cross-vesting) Act 1987
Privacy Act 1988

Australian Capital Territory (ACT)

Children's Services Act 1986
Community Advocate Act 1991
Transplantation and Anatomy Act 1978

New South Wales (NSW)

Ambulance Services Act 1990
Children (Care and Protection) Act 1987
Children (Care and Protection - General)
Regulation 1988
Guardianship Act 1987
Medical Practitioners Act 1938
Mental Health Act 1990
Minors (Property and Contracts) Act 1970
Public Health Act 1902

Northern Territory (NT)

Criminal Code
Emergency Medical Operations Act 1973
Human Tissue and Transplant Act 1982

South Australia (SA)

Consent to Medical and Dental Treatment Act 1985
Consent to Medical Treatment and Palliative Care
Act 1995
Emergency Medical Treatment of Children Act 1960
Guardianship and Administration Act 1993

Tasmania (Tas)

Criminal Code
Human Tissue Act 1985

Victoria (Vic)

Guardianship and Administration Board Act 1986
Human Tissue Act 1982

Western Australia (WA)

Family Court Act 1975
Human Tissue and Transplant Act 1982

CANADA

British Columbia

Infants Act (RSBC 1979, c 196)

New Brunswick

Medical Consent of Minors Act (RSNB 1973 c M-6.1)

Ontario

Consent to Treatment Act 1992

Hospital Management Regulation 1990 re 965

Public Hospitals Act 1990

Substitute Decisions Act 1992

Quebec

Civil Code

NEW ZEALAND

Guardianship Act 1968

New Zealand Bill of Rights Act 1990

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

Children (Scotland) Act 1995

Family Law Reform Act 1969

Social Work (Scotland) Act 1968

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