THE LAW REFORM COMMISSION
OF WESTERN AUSTRALIA

Project No 77 – Part I

Medical Treatment For Minors

DISCUSSION PAPER

JUNE 1988

The Law Reform Commission of Western Australia was established by the *Law Reform Commission Act 1972*.

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Preface

The Law Reform Commission has been asked to consider and report on a number of aspects of the law relating to medical treatment for minors.

The Commission has not formed a final view on the issues raised in this discussion paper and welcomes the comments of those interested in the topic. It would help the Commission if views were supported by reasons.

The Commission requests that comments be sent to it by 31 October 1988.

Unless advised to the contrary, the Commission will assume that comments received are not confidential and that commentators agree to the Commission quoting from or referring to their comments, in whole or part, and to the comments being attributed to them. The Commission emphasises, however, that any desire for confidentiality or anonymity will be respected.

The research material on which this paper is based can be studied at the Commission's office by anyone wishing to do so.

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Chapter 1

GENERAL

1. INTRODUCTION

1.1 The Commission has been asked to examine the law relating to medical treatment for minors. The terms of reference require the Commission to enquire into and report on the adequacy of the existing civil and criminal law in Western Australia as to -

(a) the age at which minors should be able to consent, or refuse to consent, to medical treatment;

(b) the means by which such consent, or refusal of consent, to treatment should be given;

(c) the extent to which, and the circumstances in which, the parents, guardians or other persons or institutions responsible for the care or control of minors should be informed of such consent, or refusal of consent, to treatment;

(d) the extent to which, and the circumstances in which, the persons referred to in (c) should be able to consent, or to refuse to consent, to treatment on behalf of a minor.

1.2 In 1981 the Commission was asked to undertake a wider enquiry, a national project intended to produce recommendations for uniform Australian legislation governing the provision of medical and allied services for minors. The original terms of reference specifically referred to a number of special areas of concern, for example the special health care needs of young people, and to specific types of medical and related services.[1] Though the original terms of reference were broader than the present reference, they nonetheless indicate the possible variety and scope of the current reference, albeit on a more limited State-wide basis. The Commission has therefore taken into account in the preparation of the

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[1] The original terms of reference are set out in Appendix I. They were withdrawn in 1984 because the Commission did not have sufficient resources to conduct a uniform project on this scale. They were replaced by more limited terms of reference restricted to a consideration of the law in Western Australia.

discussion paper the preliminary submissions made in response to its invitation to make them on the earlier reference.[2]

1.3 This discussion paper is intended to promote discussion of the issues and the possible reforms presently being considered by the Commission. It is hoped that the community will take the opportunity to contribute to the law reform process by responding to the suggestions contained in the paper. This paper is not an interim report and the views expressed in it may be changed.

2. AMBIT OF THE REFERENCE

(a) Minors

1.4 A "minor" is a person who has not reached the age at which the law presently accords a person full adult status, rights and responsibilities. A minor is also a "child", and both these terms are used in this paper.

1.5 In Australia the age of majority for general purposes is 18 years. In Western Australia the age of majority was reduced from 21 to 18 by the *Age of Majority Act 1972*.[3]

1.6 The provision of a statutory age of majority does not mean that at common law anyone under that age is incapable of taking legal responsibility for at least some purposes.[4] Nor does it resolve conflicts between minors claiming an entitlement to exercise some degree of autonomy and others (such as parents) who claim the right to exercise that decision-making power for them "in their best interests" or otherwise. Such conflicts may occur in decisions about medical treatment, and the question of how they should be resolved is one of the major issues dealt with in this paper.

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2 The names of those who made submissions appear in Appendix II.

3 Passed to implement the report of the Law Reform Committee (predecessor of the Commission) *Legal capacity of minors* (Project No 25 Part I 1972).

4 Eg in Western Australia a child of 7 may be charged with any criminal offence but will not be criminally responsible without proof that the child knew that he or she ought not to do the act in question: *Criminal Code* s 29. At 14 a child will be criminally responsible without such proof: ibid. Girls may marry at 16, or at 14 with judicial approval: *Marriage Act 1961* (Cth) ss 11-12, but otherwise the age of consent for the purposes of sexual relations is 16: see *Criminal Code* s 187.

1.7 There may be speculation about when minority begins. One definition of a "child" would include an "unborn or newborn human being".[5] The position of the unborn child raises complex issues which are not within the subject matter of this paper.[6]

1.8 For present purposes the Commission has defined a "minor" as a person who has not attained the statutory age of majority of 18 years, but who has, by being born, the potential of attaining that age.

(b) "Medical treatment"

1.9 Various attempts have been made to define "medical treatment" for statutory purposes. The United Kingdom *Family Law Reform Act 1969*,[7] for example, in defining "surgical, medical or dental treatment", expressly includes specific procedures such as diagnostic and anaesthetic procedures and procedures ancillary to surgical, medical or dental treatment. Other statutory definitions have been interpreted judicially as including ancillary services: for example, "treatment"[8] has been held to include nursing

> "…in the sense that the subject or patient is looked after and attended to by persons professionally trained to look after and attend to the sick."[9]

1.10 Medical, dental, surgical, obstetric and psychiatric services, and diagnostic and other procedures performed by registered medical practitioners or dentists for therapeutic purposes are clearly included within the terms of reference.

1.11 The Commission also intends that its discussions should extend to a range of services performed by people who are not "doctors" in this sense. People normally understand the term "medical treatment" to involve the traditional doctor/patient relationship, and this is the

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5 Concise Oxford Dictionary (7th ed 1982); cf Shorter Oxford English Dictionary (3rd ed, reprinted 1966): "foetus, infant".

6 For example, abortion and preventing a child from being born alive may be offences under the *Criminal Code* ss 199, 200 and 290, but a child does not become a person capable of being killed until the process of its birth is complete: ss 269, 271. A foetus has no standing to prevent the mother seeking an abortion: *C v S* [1988] QB 135, and there is no cause of action for pre-natal injury until the child is born alive: *Watt v Rama* [1972] VR 353. An unborn foetus cannot be the subject of wardship proceedings*: In Re F (In utero)* [1988] 2 WLR 1288. See generally J E S Fortin *Legal protection for the unborn child* (1988) 51 MLR 54.

7 S 8(2). Except in certain particular respects, the Act applies to England and Wales only: s 28(4).

8 As used in the definition of "hospital" in the *National Health Service Act 1946* (UK) s 79(1).

9 *Minister of Health v Royal Midland Counties Home for Incurables* [1954] Ch 530, 541 per Evershed MR.

relationship from which most of the reported judicial decisions on consent to medical treatment have arisen. But in recent years the way in which medicine is practised has changed: registered nurses, paramedical personnel and technicians have come to perform essential or routine health care procedures which were once either carried out by registered doctors or dentists or were not considered to be "medical" treatment. Many, but not all, of these procedures are carried out under the direction or supervision of a registered doctor or dentist. Many of these other health care professionals possess a high degree of training and expertise and some are required to be registered by the State. To reflect this change the Commission intends that health professionals who purport to carry out "medical treatment" as defined in the following paragraph should be included within the term "doctor" (unless the context indicates otherwise).

1.12 "Medical treatment" is given a broad meaning in this paper. Clearly services provided by health professionals such as nurses, whose professional training is intended to train them for the duty of caring for the sick and who perform those duties at the direction and under the supervision of a registered doctor or dentist, are included. It is not so obvious that other services are included: for example, many people other than doctors offer confidential counselling and advice services which aim to prevent or alleviate the effect of behaviour injurious to health, such as premature or indiscriminate sexual activity, drug abuse or violence. A popular definition of medical treatment would probably exclude counselling or advice to a perfectly healthy patient, for example professional counselling to a physically and mentally fit adolescent about the consequences of engaging in sexual activity or the resolution of the common emotional problems of adolescence. These sorts of therapies may be seen by parents or guardians as neither "medical" nor treatment, though sound advice and knowledge is one of the best means of prevention of disease. Such services do not involve a touching of the person or administration of drugs but are nevertheless "medical treatment" when they are provided by health professionals. Other services provided by such people can and should be included if they are ancillary to treatment provided by a registered doctor or dentist (such as physiotherapy, "group therapy" and acupuncture).

(c) Special cases

1.13 The Commission has had to make decisions as to whether a number of particular matters fall within the terms of reference.

(i) Handicapped children

1.14 The Commission also considered whether or not to address the major problem of the care of the critically ill or grossly impaired or deformed newborn child, the so-called "defective neonate". A decision to treat in a particular way or to withhold or withdraw treatment may have the effect of terminating the life of the infant, either immediately or prematurely. Significantly different issues arise in these cases, not only as to who should lawfully be competent to consent to the giving or withholding of medical treatment, but also as to what the content of that decision should be. These questions are discussed in chapter 10 below. The special considerations relating to treatment of terminally ill patients, including minors, are addressed in the Commission's discussion paper on *Medical treatment for the dying*.[10]

(ii) Termination of pregnancy

1.15 The discussion of termination of pregnancy in this paper is limited to the consent necessary to perform this procedure upon a minor, insofar as termination of pregnancy may be lawful in some circumstances.[11] It is not within the Commission's terms of reference to discuss the circumstances in which abortion is lawful under Western Australian law.[12]

(iii) Tissue or organ donation

1.16 The Commission has also considered the issue of tissue donations. The Australian Law Reform Commission reported on human tissue transplants in 1977[13] and its recommendations have been accepted in all States and Territories. In Western Australia they were enacted in the *Human Tissue and Transplant Act 1982*.

1.17 The distress caused to the families of seriously ill children is immense. In some cases it is possible to prolong or improve the quality of life of a family member by the donation of body tissue of a close relative. The procedure is not therapeutic for the donor of the tissue.

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10 Project No 84 1988.
11 See paras 6.12-6.16 below.
12 Cf para 1.7 above.
13 Australian Law Reform Commission *Human tissue transplants* (Report No 7 1977).

Often the decision about donation is made in an emergency and under severe emotional stress. In some cases the donor whose tissue is least likely to be rejected by the host is a child. The Act empowers a child's parent[14] to consent in writing to the removal of specified regenerative tissue from the child's body for transplanting to the body of a member of the child's family or of a relative of the child where both the parent and the child have been given medical advice about the nature and effect of the removal and the nature of the transplantation, the child has the mental capacity to understand the nature and effect of the removal and the nature of the transplantation, and the child has agreed to the removal of the regenerative tissue for that purpose.[15]

1.18 If these conditions are satisfied, the doctor is provided with "sufficient authority" to remove the tissue for the purpose in question.[16] Without such authority the doctor would be criminally and civilly liable since the procedure is not intended to benefit the donor child.

1.19 The parent of a child may also consent to removal of blood from the body of a child for therapeutic, medical or scientific purposes if a doctor advises that the removal should not be prejudicial to the health of the child and the child agrees to the removal.[17]

1.20 The Act also authorises blood transfusions for children without parental consent where the parent fails or refuses to authorise the transaction, or cannot be found, and two doctors agree that the blood transfusion is a reasonable and proper treatment for the condition from which the child is suffering and that without it the child is likely to die.[18]

1.21 The 1982 Act is the only Western Australian statutory provision which specifically requires the agreement of a child to a medical procedure. It does so, in the case of transplants, where the child has "the mental capacity to understand the nature and effect" of the procedure.[19] The Act does not provide any form or procedure for giving or proving such consent, and does not provide any procedural safeguards to ensure that a child's apparent consent is not obtained by duress, coercion, undue influence or other improper pressure, and yet at the time the decision has to be made one would expect the emotional stress on that child

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14 This does not include a guardian or a person standing in the place of a parent: s 11.
15 S 13. The removal of non-regenerative tissue from a minor is not permitted by the legislation.
16 S 17.
17 S 19.
18 S 21.
19 S 13.

and the whole family to be severe. Significantly, the Act does not provide any statutory age at or below which a child may be presumed not to have the mental capacity to understand what is proposed.

1.22 Because this aspect of medical treatment for children has been dealt with in recent legislation, the Commission has not addressed the particular issue of human tissue transplantation and donation, but the recommendations in the Commission's final report will be as relevant to this area as to any other medical treatment performed on children.

3. ORDER OF DISCUSSION

1.23 Chapters 2 to 7 cover paragraphs (a) and (d) of the terms of reference.

1.24 Chapter 2 examines the question of consent to medical treatment, with particular reference to medical treatment of minors. When medical treatment is involuntary, a doctor will usually be liable in damages, either for trespass or for negligence (if the conduct constitutes negligence), and may also be subject to criminal or professional disciplinary liability.

1.25 Where the medical treatment of children is concerned, the major problem is who has the right and the duty of consenting - the child, the parent or another person or body exercising parental rights. This depends on the age and maturity of the child and the nature of the treatment, as well as other factors. Where there are disputes about who has the right to consent to medical treatment, a means of resolving those conflicts is needed. In chapters 3 to 7 the Commission discusses these problems and puts forward some provisional proposals for dealing with them.

1.26 The question of the form in which consent is given is referred to in paragraph (b) of the terms of reference, and is dealt with in chapter 8. The Commission is mindful of the fact that, whatever the theoretical basis of principles governing consent, to date there has been no systematic research into the circumstances in which consent is sought, the practices of hospitals or doctors in seeking consent, the forms by which consent is obtained and the method of recording such consent. The Commission proposes to review these practices in conjunction with the issue of this paper.

1.27 There are many situations in which a doctor may give medical treatment to a minor without the knowledge or consent of the minor's parent. When treating adults, it would ordinarily be part of the doctor's duty not to divulge confidential matters communicated in the course of the doctor-patient relationship, or even the existence of that relationship, to others. It is usually suggested that the doctor's obligation is not the same when treating a child, particularly where parents also have some right to consent to the treatment. This issue, raised by paragraph (c) of the terms of reference, is dealt with in chapter 9.

1.28 The special problems and dilemmas raised by the need to make decisions about the medical treatment of severely impaired or defective children who cannot speak for themselves are dealt with in chapter 10.

Chapter 2

CONSENT AND MEDICAL TREATMENT

1. INTRODUCTION

2.1 Health care professionals are increasingly concerned about civil and criminal liability for alleged malpractice or the possibility of disciplinary proceedings. Chapters 3 to 7 of this discussion paper deal with the problem of who has the right to consent to the medical treatment of minors. As an introduction to that discussion, this chapter deals with the legal consequences of treating a patient without consent, with emphasis on the special position of minors.

2.2 In the literal sense, it is only medical treatment which involves bodily touching which is unlawful in the absence of consent. Much medical practice lies in the area of diagnosis, counselling and the prescription of drugs for self-administration. Nonetheless the courts have been prepared to discuss treatment of this kind in terms of consent, at least for the purpose of determining whether parents or children have the right to seek such treatment.[1] This discussion paper, which adopts a wide view of what is meant by medical treatment,[2] adopts a similar approach.[3]

2. CIVIL REMEDIES

2.3 The major civil remedies for treatment without consent are the torts of trespass and negligence.[4]

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1 For example, in the leading case of *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (discussed at paras 3.13-3.26 below) the court discussed the right to seek contraceptive advice and treatment in terms of consent.

2 See para 1.12 above.

3 The relevance of consent in matters of medical treatment is pursued further in Appendix III.

4 An action for medical treatment without consent could also be brought in contract, but contractual remedies have little relevance to the treatment of minors. At common law there are special difficulties for children who might wish to sue for breach of contract for improper medical treatment. These have been addressed in some jurisdictions, see eg *Minors (Property and Contracts) Act 1970* (NSW). For the Commission's recommendations for reform of the law in Western Australia, see its report on *Minors' contracts* (Project No 25 Part II 1988).

(a) Trespass to the person

2.4 At an early stage the common law developed the tort of trespass to the person to deal with wrongful (intentional) interferences with the plaintiff's person. Trespass to the person comprises three separate torts: assault, battery and false imprisonment, each of which may have some relevance in the provision of medical treatment. Assault may be defined as conduct by the defendant which causes the plaintiff to apprehend the infliction of bodily harm. Battery is the actual application of force to the person of the plaintiff.[5] False imprisonment is the wrongful detention of a person against that person's will. The early law favoured strict liability in relation to assault and battery, but the modern law requires proof of intentional aggression or at least negligence.[6]

2.5 The advantages of suing in trespass rather than negligence have been well documented but little applied in the medical context.[7] The advantages are a more favourable burden of proof,[8] the fact that trespass is actionable without proof of damage, a broader base for damages[9] and the avoidance of complex causal and conceptual issues.[10] However, there may

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Other causes of action are largely of theoretical interest; for example, breach of fiduciary duty and enticement. An action for breach of fiduciary duty is not likely to arise in the medical context. The relationship between doctor and patient is not fiduciary in nature: see *Sidaway v Bethlem Royal Hospital* [1985] AC 871, 884, per Lord Scarman. As to enticement, a counselling service which persuaded a teenage girl to leave her parents' home in order to live with her boyfriend might be said to have "enticed" the child from the parents' custody, but although the tort of enticement has not been abolished it is all but defunct: see P B Kutner *Law reform in tort: Abolition of liability for intentional interference with family relationships* (1987) 17 UWAL Rev 25.

5 "The least touching of another's person willfully, or in anger, is a battery; for the law cannot draw the line between different degrees of violence and therefore totally prohibits the first and lowest stage of it: every man's person being sacred, and no other having a right to meddle with it, in any the slightest manner." W Blackstone *Commentaries* Book III para 148.

6 Where the defendant inflicts harm negligently rather than intentionally, the action will ordinarily be brought in negligence. Negligence will lie for harm caused unintentionally whether it is inflicted directly or indirectly: *Williams v Holland* (1833) 10 Bing 112: 131 ER 848; see M J Prichard *Trespass, case and the rule in Williams v Holland* [1964] Camb LJ 234. It can be argued that the remedy for negligence where harm is directly caused is negligent trespass and not negligence. Negligent trespass is a distinct cause of action in Australia: *Williams v Milotin* (1957) 97 CLR 465, although in England it appears to have been expunged by the Court of Appeal decision in *Letang v Cooper* [1965] 1 QB 232. See generally F A Trindade and P Cane *Law of Torts in Australia* (1985) 263-274.

7 For a discussion in the medical context, see H Teff *Consent to medical procedures: Paternalism, self-determination or therapeutic alliance?* (1985) 101 LQR 432, 438-440. For a recent discussion of the general question of trespass and negligence, see *Platt v Nutt* [1988] Aust Torts Reports 67-514.

8 S K N Blay *Onus of proof of consent in an action for trespass to the person* (1987) 61 ALJ 25.

9 Exemplary damages are recoverable for trespass to the person: *Fontin v Katapodis* (1962) 108 CLR 177; *Lamb v Cotogno* (1987) 74 ALR 188. In relation to negligence the matter is unsettled: but see the recent case of *Rabenalt v Midalco Pty Ltd* (unreported), Supreme Court of Victoria, 23 May 1988, in which a worker who contracted mesothelioma was awarded exemplary damages (see The Australian, 24 May 1988, 5). In addition damages in trespass are not limited to the foreseeable consequences of the act; if the

also be disadvantages in suing in trespass rather than in negligence. For example, under the present law in Western Australia the limitation period is shorter in trespass.[11]

2.6 Where the patient is a child there is a special problem: who is responsible for giving the consent to what would otherwise be a trespass. If the child is capable of consenting, and does so, then there will be no liability in trespass even if the parents do not consent. If a child is capable of consenting but does not do so, the fact that the parents consented will not prevent the child from suing in trespass. If the child is not capable of consenting, it is the consent of the parents which excuses liability in trespass.[12] The question whether the child had the capacity to give consent is discussed in chapters 3 to 5 below.

(b) Negligence

(i) Generally

2.7 Today most medical malpractice claims are brought in negligence. In negligence the plaintiff alleges that the defendant owed the plaintiff a duty of care, and by acting carelessly breached that duty, causing damage. In medical negligence cases the standard adopted to determine whether a doctor is in breach of the duty of care is the "reasonable doctor" test laid down in *Bolam v Friern Hospital Management Committee*[13] in which McNair J directed the jury that

> "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art . . . . [A] doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view."

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act of touching was intentional, the fact that the consequences were not intended is immaterial: see J G Fleming *Law of Torts* (7th ed 1987) 24.

10 Such as those relating to foreseeability, proximity, reliance, and in general, the question of when a duty of care exists. In trespass there is no need to establish that a duty of care was owed to the patient.

11 *Limitation Act 1935* s 38 (four years for trespass, six years for negligence).

12 Any action in trespass will be brought by the child (with the parents as next friend). A non-consensual contact with the person of the child does not constitute a trespass actionable at the suit of the parents.

13 [1957] 2 All ER 118, 122. In a recent case involving an unsuccessful sterilisation leading to pregnancy, the judge attempted to depart from this test and allow the court to determine the question of negligence by reference to the ordinary principles governing negligent advice, on the ground that the case involved contraceptive advice given in a non-therapeutic context, rather than therapeutic treatment: *Gold v Haringey Health Authority* The Times, 17 June 1986. The decision was reversed by the Court of Appeal [1987] 2 All ER 888 on the ground that the standard of care required by the doctor did not depend on the context in which advice was given.

2.8 Though lack of consent is not an element of negligence, a doctor who treats a patient without consent may well be in breach of the duty of care owed to the patient. A possible defence to negligence is that the plaintiff voluntarily assumed the risk of harm, but this involves consent to the risk of harm rather than consent to the harm itself.

(ii) The duty of disclosure and "informed consent"

2.9 The tort of negligence has experienced remarkable growth in the twentieth century. In the medical sphere, the standard action of negligence alleges carelessness in carrying out some part of the treatment. Recent developments have widened the net by focusing upon a doctor's duty at the earlier, pre-treatment stage. In such cases the courts have begun to formulate a doctrine of "informed consent".[14]

2.10 In *Sidaway v Bethlem Royal Hospital*,[15] a decision of the House of Lords in England, the plaintiff underwent an operation on her spine to relieve pain in her neck and suffered partially paralysis due to damage to the spinal column. She claimed damages for negligence against the hospital and the deceased surgeon's estate, alleging negligence in the surgeon for failing to warn her of the possibility of paralysis. At first instance, it was found that the surgeon did not tell her that the operation was one of choice not necessity, nor did he mention any danger of damage to the spinal column although he had mentioned the possibility of damage to a nerve root, which was far less critical. The judge found that his failure to mention those two factors was in accordance with responsible neurosurgical practice. The judge applied the test laid down in *Bolam v Friern Hospital Management Committee*,[16] and held that the surgeon was not negligent. The decision was upheld by the House of Lords, but the views of the members of the court were not unanimous. Lord Diplock approved the Bolam test.[17] Lord Bridge and Lord Templeman endorsed it in principle, but suggested that doctors might have some obligation to inform in certain circumstances.[18] Lord Scarman rejected the Bolam test.[19]

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14 See generally Victorian Law Reform Commission *Informed consent to medical treatment* (Discussion Paper No 7 1987). See also the further discussion and references in Appendix III paras 3-7.

15 [1985] AC 871.

16 [1957] 2 All ER 118, 122: quoted in para 2.7 above.

17 [1985] AC 871, 892.

18 Lord Bridge (with whom Lord Keith agreed) said: "[T]he judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary to an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it": id 900. Lord Bridge

2.11 In *F v R*[20] the question of informed consent came before the Full Court of the Supreme Court of South Australia. The plaintiff underwent a tubal ligation to avoid a future pregnancy, but subsequently became pregnant. She sued the doctor for failing to advise her as to the remote possibility of the operation being a failure. Although the action failed on the facts, it provides some support for a doctrine of informed consent, and has been considered on at least two other occasions by the same court.[21]

2.12 The law may be summarised as follows. An action may succeed if the plaintiff can show that the defendant's failure to disclose a known risk was inconsistent with a substantial body of responsible medical opinion, or that there was evidence of a substantial risk of grave adverse consequences,[22] or a failure to respond to direct questioning for information.[23] Expert medical evidence of accepted practice is invariably required. A doctor must disclose all extraordinary risks associated with the particular treatment. Non-specific risks (those which are inherent in every treatment such as the usual risks of anaesthesia in surgery) need not be addressed. To be safe, a doctor should advise as to likely consequences of alternative treatments and non-treatment.

2.13 In exercising judgment, a doctor should consider factors personal to the patient such as personality and temperament, desire to know,[24] intelligence and apparent understanding[25] (which is also likely to be affected by the nature of the proposed treatment and the complexity of the explanation being given) and the possibility of alternative sources of advice (especially relevant where the patient is a child who may seek advice from parents or guardians). A particular patient may waive the duty of disclosure.

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cited the ten per cent risk in *Reibl v Hughes* (1980) 114 DLR (3d) 1 as an example. Lord Templeman said that though normally a patient who failed to ask for more information could not later complain, there might be an obligation to inform if there were "some danger which by its nature or magnitude or for some other reason requires to be separately taken into account by the patient in order to reach a balanced judgment": [1985] AC 871, 902.

19 Id 883-890.

20 (1983) 33 SASR 189.

21 *Battersby v Tottman* (1985) 37 SASR 524; *Gover v State of South Australia* (1985) 39 SASR 543.

22 *Sidaway v Bethlem Royal Hospital* [1985] AC 871; cf *F v R* (1983) 33 SASR 189, 192 per King CJ.

23 *Sidaway v Bethlem Royal Hospital* [1985] AC 871, 902 per Lord Templeman; *F v R* (1983) 33 SASR 189, 206 per Bollen J; *Smith v Auckland Hospital Board* [1965] NZLR 191. In *Hatcher v Black* The Times, 2 July 1954 (see also Lord Denning *The Discipline of Law* (1979) 242) Denning LJ expressed the extreme view that deception may be justified if the doctor considers specific information to be harmful to a patient.

24 *Sidaway v Bethlem Royal Hospital* [1985] AC 871, 902 per Lord Templeman.

25 See *Gover v State of South Australia* (1985) 39 SASR 543, 558.

2.14 The law does not require disclosure at any cost. The doctor possesses a professional discretion not to inform the patient if the doctor believes that the patient is unable, through physical, emotional or psychological factors, to cope with the information. This is sometimes called the doctrine of "therapeutic privilege".[26] The duty of disclosure is greater where the patient asks questions, and the doctor should not lightly infer that the patient does not wish to be fully informed.[27]

2.15 A major hurdle for the plaintiff in proceedings for negligence is the need to prove a causal connection between the act or omission relied upon and the damage.[28] Where the action is put in terms of the failure to warn of possible consequences the plaintiff is required to prove two separate matters: (1) that the injury was the foreseeable consequence of the act or omission and (2) that the plaintiff would not have had the treatment had such information been provided. The second matter raises difficult questions of what might have been. Such authority as there is suggests a subjective approach, namely, whether the particular patient would have undertaken the treatment had the risks been known.[29]

2.16 In general, the defendant owes a duty only to the immediate accident victim and not to those within the victim's family circle who suffer injury in consequence,[30] but there are a number of circumstances in which a parent might have a direct cause of action in negligence.[31] The parent may suffer financial loss, for example through having to pay medical expenses or the cost of travel to make hospital visits. The parent may claim damages for loss of the child's services (in theory, although this cause of action is now regarded as archaic). If the child dies as the result of negligence the parents and certain other relatives can claim damages for wrongful death.[32] A parent may also be able to claim damages for shock, as for example where patient information is wrongly given to the parent, causing alarm and anxiety.[33]

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26 See A Meisel *The "exceptions" to the informed consent doctrine: Striking a balance between competing values in medical decisionmaking* [1979] Wis LRev 413, 460-470.

27 *F v R* (1983) 33 SASR 189, 193 per King CJ.

28 See eg *Wilsher v Essex Area Health Authority* [1988] 1 All ER 871.

29 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118; *Chatterton v Gerson* [1981] QB 432. The matter has been more fully considered in Canada: in *Reibl v Hughes* (1981) 114 DLR (3d) 1 the Supreme Court adopted an objective approach, namely whether a reasonable person in the plaintiff's position would have had the treatment if properly advised.

30 *Kirkham v Boughey* [1958] 2 QB 338.

31 See P R Handford *Relatives' rights and Best v Samuel Fox* (1979) 14 UWAL Rev 79.

32 Under the *Fatal Accidents Act 1959*.

33 *Barnes v Commonwealth* (1937) 37 SR (NSW) 511; *Brown v Mount Barker Soldiers' Hospital* [1934] SASR 128; *Furniss v Fitchett* [1958] NZLR 396. See P R Handford *Wilkinson v Downton and acts calculated to cause physical harm* (1985) 16 UWAL Rev 31, 49-53.

3. CRIMINAL LIABILITY

2.17 In general, a doctor who provides treatment or advice to a patient will be immune from criminal liability providing the patient consented. There are some exceptional cases in which there may be criminal liability despite the patient's consent.[34]

(a) Assault

2.18 Assault[35] is a criminal offence as well as a civil wrong, and lack of consent is an essential element of the offence as defined in the Criminal Code.[36] The Code does not define consent except in relation to sexual assault where it provides that consent means:

> ". . . a consent freely and voluntarily given and, without in any way affecting or limiting the meaning otherwise attributable to those words, a consent is not freely and voluntarily given if it is obtained by force, threat, intimidation, deception or fraudulent means."[37]

Exceptionally, the application of force by one person to the person of another may be unlawful although it is done with the consent of that other person,[38] for example in sexual offences involving a person of immature age.[39]

2.19 The Code provides specific occasions on which what would otherwise be an assault is justified. Some are relevant to doctors. A legally qualified medical practitioner[40] may at the request of a police officer examine a person who is in lawful custody upon a charge of committing any offence in order to ascertain the facts which may afford evidence of the offence, and to use such force as is reasonably necessary for that purpose.[41] The Code also protects from criminal responsibility a person who performs:

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34 As to which see Appendix III paras 8-10.

35 In criminal law, "assault" usually means applying force of any kind to the person of another: see eg the definition in s 222 of the Criminal Code. Compare its meaning in the civil law: see para 2.4 above.

36 S 222.

37 S 324G.

38 S 223.

39 Ss 185-193; or where a person consents to the causing of his or her own death: s 261. However, in relation to medical treatment, consent will always be a defence to assault; see *R v Donovan* [1934] 2 KB 498, 507; see D O'Connor and P A Fairall *Criminal Defences* (2nd ed 1988) 92-95.

40 Ie one registered under the provisions of the *Medical Act 1894* (WA).

41 *Criminal Code* s 236.

> ". . . in good faith and with reasonable care and skill a surgical operation upon any person for his 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."[42]

There are also a number of general defences.[43]

(b) Counselling, procuring and inciting

2.20 The Code provides that every person who does or omits to do any act for the purpose of enabling or aiding another person to commit the offence, aids another person in committing the offence, or counsels or procures any other person to commit the offence is deemed to have taken part in committing the offence and can be charged with actually committing the offence.[44] In the last of these cases the person can also be charged with counselling or procuring the commission of the offence.[45] Inciting another person to commit an indictable offence is now also an indictable offence under the Code.[46]

2.21 Some doctors are wary of treating or counselling female minors below the age of 16 in relation to their sexual activities. Some fear that contraceptive advice, prescription or treatment may cause them to be charged with counselling, procuring or otherwise being a party to the commission of those offences in the *Criminal Code* which were created with the intention of protecting adolescent women from premature sexual experience or sexual exploitation.[47] It appears that this fear of liability is not soundly based.[48] Unless a doctor treats, counsels or advises with the purpose of enabling an unlawful activity to be carried out he or she has committed no offence. It would be quite different if a doctor treated a minor in order to allow an offence to be committed. An example would be a case where the doctor is

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42 S 259. S 324F of the Code excludes penetration which is carried out for "proper medical purposes" from the definition of "sexual penetration". If not excluded the definition would have made a doctor liable for sexual assault in some cases.

43 Eg mistake of fact (s 24), compulsion (s 31).

44 S 7.

45 Ibid. The mode of execution of the offence is immaterial: s 9.

46 S 553.

47 Eg unlawful carnal knowledge of a girl under 13 (s 185), unlawful carnal knowledge of a girl under 16 (s 187). It is not clear whether the same principles are applied to medical treatment or advice sought by other "law breakers" in relation to their activities, such as homosexual adult men.

48 See *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (discussed in paras 3.12-3.23 below).

consulted by a person who desired to facilitate sexual activity with a child by, for example, the provision of contraceptive advice or other treatment.[49] Advice or other medical treatment on a proper professional basis to a child would not normally make a doctor liable to prosecution for an offence.

(c) Child welfare offences

2.22 Under the *Child Welfare Act 1947*:

> "Any person who has, either by wilful misconduct or habitual neglect, or by any wrongful or immoral act or omission encouraged or contributed to the commission of any offence by any child or of any act by a child under the age of fourteen years which act, if it were committed by a child over fourteen years of age, would be an offence, or caused or suffered any child to become, or to continue to be, a child in need of care and protection, or contributed to any child becoming, or continuing to be, a child in need of care and protection shall be guilty of an offence."[50]

A "child in need of care and protection" is defined to include one who "is living under such conditions, or is found in such circumstances, or behaves in such a manner, as to indicate that the mental, physical or moral welfare of the child is likely to be in jeopardy."[51]

2.23 It is doubtful whether a doctor who treats or counsels any underage minor in relation to his or her sexual activities would be charged under this provision. The elements of the offence require wilful misconduct, habitual neglect, or a wrongful or immoral act or omission. Charges might conceivably be laid if it could be established that the doctor did not act in good faith and with an appropriate level of professional skill and discrimination.

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49 The laws controlling the sexual activity of children are intended to protect them, but children commit no offence merely by being sexually active under the "age of consent" stipulated by the *Criminal Code* unless there exists a Code offence defined in terms of the child's age. For example a male child might commit the offence of unlawful carnal knowledge of a female child under 16 (s 187).

50 S 31A(1).

51 S 4(1).

4. DISCIPLINARY ACTION

2.24 Registered medical practitioners are subjected to the supervision of the Medical Board established under the *Medical Act 1894*. The Act regulates the circumstances in which a medical practitioner's right of practice may be restricted or suspended. It is not difficult to imagine cases where a complaint by a patient of treatment against his or her will or without consent would call for an inquiry.[52]

[52] For example, a person may be charged with "infamous or improper conduct in a professional respect": *Medical Act 1894* s 13(1)(a), or "gross carelessness or incompetency": s 13(1)(c).

Chapter 3

RESPONSIBILITY FOR MAKING DECISIONS ABOUT MEDICAL TREATMENT

1. INTRODUCTION

3.1 Minors are persons under a disability.[1] There are many acts which they cannot do because of their physical or emotional immaturity or economic, social or political powerlessness, or which have no legal effect because the law presumes that minors lack the capacity to do them. That is why the law makes provision for legally competent persons to act on their behalf. There are also special provisions enabling courts and other authorities to exercise a protective jurisdiction over children.[2]

3.2 Most children have at least one person authorised to act on their behalf. That person is the child's "guardian". If a child has no guardian, the *Child Welfare Act 1947* permits the appointment of one,[3] as do the Commonwealth *Family Law Act 1975*[4] and the Western Australian *Family Court Act 1975*.[5]

3.3 "Guardians" are ordinarily the child's natural parents. They have responsibility for a whole range of matters affecting children - their custody, education, choice of religion, maintenance and financial support, arranging and paying for medical attention, consenting to marriage, dealing with or protecting their property, determining choice of name, giving or withholding access to passports and international travel, and appointing persons to act in their place.[6]

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1 Persons whom the law considers to be incapable of looking after their own interests. See for example Order 70 of the *Rules of the Supreme Court 1971*, which provides for the appointment of competent representatives in legal proceedings involving "infants" and "patients" incapable of managing their affairs.

2 See paras 3.28-3.31 below.

3 Ss 10, 30, 47A-47D.

4 Ss 63, 63F and 64.

5 Ss 34, 36A, 38.

6 The Latin phrase sometimes used in this context is "in loco parentis".

3.4 Parental powers relating to medical treatment for their children are vested in both parents jointly if the child is a child of a marriage since both parents have, in law, joint guardianship and custody.[7] In practice doctors usually act on the consent of one parent. When there is apparently no dispute they may assume that the other's consent is implied. A child whose parents were not married to each other is, in law, deemed to be in the guardianship and custody of the mother. A child's guardianship can be altered by court order; the Family Court exercises most of this power in practice, though the Supreme Court retains its inherent power to do so. The Minister for Community Services and the Children's Court may also alter guardianship.[8]

2. PARENTS AND CHILDREN

(a) The Problem

3.5 Though the statutory age of majority throughout Australia is 18, somewhere under that age children begin to dispense with parental control over at least some portions of their lives.

3.6 At common law there are limits on parental rights to control or exploit a child. The courts have recognised this for many years, and may refuse to sanction parental powers uncritically and allow older and more mature children, even if they are still in their parents' custody, to choose how and where they will live. For example in *Hawkins v Hawkins*[9] the Supreme Court of Western Australia refused to make an order that a child be declared "uncontrollable" when there was no evidence of delinquency and the father's sole complaint was that the boy (aged 16) had left his home without the father's consent to live with another relative, refusing to submit to his control. In *Stanton v R*[10] the Western Australian Court of Criminal Appeal declined to find that a man should be convicted of abducting a 13 year old girl from her home and out of her mother's custody[11] when it was shown that the child wished to leave, did so without encouragement and remained away of her own volition. The court apparently acted on the assumption that a child of just under 14 was able to make such a choice.

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7 A guardian of a child has responsibility for the long-term welfare of the child and all the powers, rights and duties vested by law or custom in a guardian; if that person also has custody he or she also has the right and responsibility to make decisions concerning the daily care and control of the child: *Family Law Act 1975* (Cth) s 63E*; Family Court Act 1975* s 34.

8 See paras 3.28-3.29 below.

9 (1940) 42 WALR 86.

10 [1981] WAR 185.

11 *Criminal Code* s 330.

3.7 There is no rule that the consent of a parent is either always required or always sufficient authority for the performance of medical treatment upon a minor. One view is that the minor's incapacity is fixed not by age but by the minor's actual incapacity to understand and come to a decision about a particular medical procedure.[12] Another view is that even if a minor does understand the full implications of a decision there may still be circumstances where a parent or the State might wish to overrule the decision in the minor's "best interests". Accordingly, at the present time the responsibility for decision-making in matters of medical care is shared between the child, the parent and doctors exercising professional discretions, subject to overview by the State through welfare authorities and the courts. In consequence, a doctor dealing with a child may be left in doubt as to whether a child can give consent, whether anybody else's consent is necessary, and when and how to obtain it.

(b) Welfare and autonomy

3.8 The modern assumption is that all power over children is or ought to be exercised for the child's good and in a manner consistent with the child's welfare or "best interests".[13] There may be differences of perception as to what is in a child's best interests and whether a particular decision will promote the child's welfare, and disagreement as to how these issues should be resolved. Differences arise as to whether treatment decisions should be based exclusively on "welfare" considerations or whether the autonomy of the child should be duly recognised and, in the appropriate case, conclusive.

3.9 The welfare approach is a paternalistic one which may give some recognition to the obligation to consult and listen to the child but does not give the child a right to decide his or her own treatment. It depends on a perception of what is good for children, which is socially defined and therefore changes from time to time.

3.10 On the other hand, the principle of individual autonomy protects individuals' rights to choose how they will live their lives. The principle underlies the legal rule that medical

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12 P D G Skegg *Consent to medical procedures on minors* (1973) 36 MLR 370.

13 See eg s 25 of the *Child Welfare Act 1947* which provides that the court is to "have regard to the future welfare of the child"; s 60D of the *Family Law Act 1975* (Cth) and s 28(2) of the *Family Court Act 1975*, which require the Court to "have regard to the welfare of the child as the paramount consideration".

treatment cannot ordinarily be imposed on a patient.[14] This principle has been extended to mature children, but not to other children.[15]

3.11 Recognising that children acquire rights before they become adults means balancing the "objective" assessment of their needs and best interests with their right to make their own assessment and effective decisions about their own welfare. In this chapter and the following chapter the Commission looks at whether it is possible to combine an assessment of "best interests" with an approach based on recognition of a child's autonomy, and, if so, whether it is possible to identify a time at which autonomy alone should determine the issue.

3. THE GILLICK CASE: PARENTS' CONTROL OVER CHILDREN

(a) The facts

3.12 In *Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security,*[16] the House of Lords in England has given detailed consideration to the question when children become capable in law of consenting to their own medical treatment. There is no authoritative Australian decision on the rights of children to make their own decisions or when they become capable of consenting to their own medical treatment, but *Gillick* has recently been referred to the High Court in terms which recognise its persuasive authority in Australia,[17] and it has been relied upon as the authority for guidelines for the treatment of children, for example in the clinics run by the Family Planning Association in Western Australia.[18] *Gillick* is thus presently the leading authority in Australia on children's rights to consent to their own medical treatment.[19]

3.13 In *Gillick* the House of Lords reviewed the circumstances in which a minor could seek medical treatment without the knowledge or approval of a parent. Mrs Gillick wanted to prevent Department of Health and Social Security medical personnel from giving

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14 See Appendix III.

15 See *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112, dealt with in paras 3.12-3.23 below.

16 [1986] AC 112 - hereinafter referred to as *Gillick*.

17 *J v Lieschke* (1987) 162 CLR 447, 452 per Wilson J: see paras 3.24-3.26 below.

18 A copy of these guidelines appears in Appendix IV.

19 The case has also been followed in Canada, where in *C v Wren* (1986) 35 DLR (3d) 419 the Alberta Court of Appeal dismissed a parent's appeal against the court's refusal to grant an injunction to prohibit a therapeutic abortion sought by their 16 year old daughter, on the ground that the child had sufficient intelligence and understanding, both of the nature of the proposed treatment and of her obligations to her parents, to make up her own mind.

contraceptive advice or treatment without her consent to any of her daughters who were under the age of 16. Section 8 of the United Kingdom *Family Law Reform Act 1969* provides that:

> "(1) The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; . . .
>
> (3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted."

3.14 Section 8 did not resolve whether a consent to medical treatment by a minor under 16 could be effective, but the assumption underlying guidelines issued by the Department[20] was clearly that it could. Mrs Gillick objected to this assumption. The guidelines stressed that the doctor, acting through the child, should try to involve the child's parent, and that it would be unusual to give advice or treatment without parental consent, but that in "exceptional" cases a doctor could, in the exercise of his or her clinical judgment, do so without consulting the parents.

3.15 The House of Lords rejected the argument that parental authority was paramount, except in emergencies or where legislation specifically provided otherwise or where a court exercised a wardship jurisdiction over a child. Four of the five judges agreed that some minors under 16 have capacity to consent to some medical treatments, and the majority[21] applied this to contraceptive treatment specifically. Accordingly it was held that the guidelines were not unlawful.

3.16 Lord Scarman clearly based his opinion on the "mature minor" concept; that is, that a child with sufficient understanding and intelligence to understand fully what is proposed could consent.[22] Parental rights to control the child exist not for the benefit of the parent, but for the child, and they are only as broad as is necessary for that purpose. Lord Fraser agreed[23] with Lord Denning MR in *Hewer v Bryant*[24] that:

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20 The guidelines, and the amended guidelines issued after the case, are set out in Appendix V.
21 Lords Fraser, Scarman and Bridge.
22 [1986] AC 112, 188-189.
23 Id 172.
24 [1970] 2 QB 357, 369.

> "The common law can, and should, keep pace with the times. . . . the legal right of a parent to the custody of a child ends at the eighteenth birthday: and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, and the more so the older he is. It starts with a right of control and ends with little more than advice."

Lord Fraser was more inclined to introduce "welfare" provisos, for example, that the doctor could not persuade the child to tell her parents or let the doctor tell them she was seeking contraceptive advice, that she was very likely to begin or continue having sexual intercourse with or without contraceptive treatment, that unless she received that advice or treatment her physical or mental health or both were likely to suffer, and that her best interests required that she be treated without parental consent.[25] Lord Bridge agreed with both Lord Scarman and Lord Fraser.[26] Even one of the minority judges, Lord Templeman, agreed that parental consent was not always necessary, and that a doctor might lawfully treat without parental consent and even in the face of parental opposition, depending on the nature of the treatment and the age and understanding of the child.[27]

(b) Interpretations

3.17 The decision in *Gillick* has not made the law or its operation certain. It is open to a number of interpretations which relate to the significance of particular factors in deciding a child's capacity.

(i) The ambit of maturity

3.18 There is no clear statement in *Gillick* that a "mature" minor will necessarily acquire "sufficient understanding" for all medical treatment. The majority concluded that a child under the age of 16 might be sufficiently mature to consent to contraceptive advice or treatment specifically. The nature of the treatment proposed was the determining factor for both Lord Templeman (who dissented), and Lords Scarman and Fraser, who based their decision in part on the basis of new understandings of the improved status of women,

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25 [1986] AC 112, 174.
26 Id 195.
27 Id 201.

scientific advances and improved contraceptive techniques. If the test case had been about different treatment, perhaps something with serious or permanent effects such as major surgery, the decision might have been different.[28] The treatment under consideration was not intrusive, nor would it necessarily involve touching the person of the patient. An assessment of a minor's "intelligence and understanding" might be affected by the nature and likely consequences of the treatment or by an adult's assessment of what the child's "best interests" required.

3.19 A wider interpretation of *Gillick* is possible. On this view the case decided that a child may acquire capacity not only to make decisions about medical treatment but also to make other decisions without parental approval or authority, simply on attaining "maturity" in a general sense.[29] "Maturity" would presumably include not only the specific capacity to understand what was proposed, but also some comprehension of a broader range of matters, such as the social and emotional responsibilities and risks of asserting the right to make the decision, beyond the mere details of the particular treatment.[30] At the point of "maturity", parental consent is unnecessary for parental powers are either extinct or suspended.[31] It is not clear whether a court exercising a wardship or protective jurisdiction over children might have wider powers than parents do.[32]

(ii) The assessment of maturity: autonomy or best interests?

3.20 If Lord Fraser's views in *Gillick* are adopted, the doctor would acquire substantial rights to decide what medical treatment a child should have, without parental consent, depending on his or her own assessment of the child's "best interests". The opinion of the doctor might be substituted for the consent of the parent. The child's "consent" is still

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28 For example, in *Re B (A Minor) (Wardship: Sterilisation*) [1988] AC 199 Lord Templeman suggested that sterilisation of a minor was of such a nature that a court's approval must always be obtained.

29 For discussions of the wider implications of the decision, see A Bainham *The balance of power in family decisions* [1986] Camb LJ 262; J Eekelaar *Gillick: further limits on parents' rights to punish* 1986 Childright, Aug, p 9.

30 In *C v Wren* (1986) 35 DLR (4th) 419 (fn 19 above) the Alberta Court of Appeal considered the 16 year old girl's understanding, not only of the treatment proposed but also of her obligations to her parents, to be relevant to a determination of her maturity and thus her capacity to consent to an abortion.

31 See para 3.23 below.

32 Wardship is "a paternal jurisdiction, a judicially administrative jurisdiction, in virtue of which the Chancery Court was put to act on behalf of the Crown, as being the guardian of all infants, in the place of a parent and as if it were the parent of the child thus superseding the natural guardianship of the parent." *R v Gyngall* [1893] 2 QB 232, 239 per Lord Esher MR. See also N V Lowe and R A H White *Wards of Court* (2nd ed 1986) 1-9; J Morgan *Controlling minors' fertility* (1986) 12 Monash U L Rev 161, 165-166.

necessary, for Lord Fraser did not suggest that the child could be coerced, but the child's "right" is dependent on the doctor's assessment of best interests.[33] This interpretation would confer a decision-making power on a medical practitioner which he or she was not previously thought to have had.

3.21 Because *Gillick* can be interpreted in several ways the balance between the child's autonomy and the parent's rights to control "in the interests" of the child is not clear, and accordingly the doctor must make difficult decisions, or avoid them. For example, if a parent still has a right to control a child the doctor might be required to consult the parent unless his or her independent assessment of the child's "best interests" militated against it. He or she might think that it is inappropriate to make a value-judgment about a child's welfare which is likely to be based on non-medical considerations, and might wish to avoid doing it.[34] Some children, perhaps those most in need of professional advice and treatment because of their risk-taking behaviour or other health risks, might not seek medical treatment or advice at all if they feared that a possible outcome of their visit to the surgery could be notification to parents or welfare authorities "in their best interests" as a doctor saw them.

3.22 There is an additional problem if a doctor has wide discretions. A doctor who did not seek to ascertain the express or known wishes of the parents, or disregarded their wishes, or failed to try to persuade a child to consult or compromise with the parents, might be failing in his or her professional duties. This could make the doctor liable to professional disciplinary action. If he or she has a duty to assess the child's "best interests", the decision might also expose him or her to civil liability at the suit of a parent, or even a child who later repented of a youthful decision. And if a mature child can give consent, then that consent is necessary even if the parent consents, so a medical practitioner must consider a child's maturity in every case. On any reading of *Gillick* doctors who have to make such decisions are left with considerable, and perhaps unwelcome, discretionary power.

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33 This would not authorise a medical practitioner to treat a very young or severely impaired child without consent. See ch 10 for a discussion of special considerations attaching to treatment of such children.

34 Degrees of skill, learning, sensitivity and communication ability vary among doctors. Their interest in decisions about medical treatment for children is related to their professional duty of care to the patient: see B Selinger *Expert evidence and the ultimate question* (1986) 10 Crim LJ 246. It is not normally their responsibility to decide the overall "best interests" of a patient except in the context of their duty and the standard of care they owe to that patient within the professional relationship.

(iii) The effect of maturity: extinct or suspended parental rights?

3.23 Different consequences could follow depending on whether parental rights are extinguished or merely suspended by the determining event. It would seem more reasonable to accept the extinction of parental rights if "maturity" means something so significant that once it is attained the child's autonomy to make all life decisions is settled. If "maturity" is limited to a child's capacity to relieve the doctor of liability for treating without parental consent, because the child understands the nature and effect of a particular treatment but not the broader range of matters referred to earlier,[35] extinction of parental rights seems less reasonable. This latter sense of "maturity" seems to be related more to the doctor's obligations to inform the patient than to any common law notion of capacity.

(i) If parental rights are extinguished some residual parental powers may remain. These might include the power to consent to a surgical operation for a "mature" child who is actually incapable of consenting because he or she is unconscious, which would be lost once the child asserts or reasserts autonomy. The parent would otherwise lose most of the rights of custodianship, including the right to use force, coercion or restraint to impose his or her wishes on a child, whatever the parent's opinion of the child's best interests, and (presumably) also the right to punish a child.

(ii) If parental rights are only suspended upon a child's attaining "maturity" they might presumably revive, for example if the child's "best interests" (which one would have to assume could be objectively ascertained) required it, because the suspended parental right co-exists with the child's right.

4. THE AUSTRALIAN POSITION

3.24 Though Australian courts have not addressed the general issues relating to the right of children to consent, or refuse to consent, to their own medical treatment, in the High Court decision in *J v Lieschke*[36] in 1987 Wilson J referred to the House of Lords decision in *Gillick* in a different context, an appeal concerning the rights of parents to be heard in proceedings in which their guardianship rights could be removed.

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35 See para 3.19 above.

36 (1987) 162 CLR 447.

3.25 In *J v Lieschke* the High Court considered the claim of a mother of five children (alleged to be guilty of neglecting or abusing them) to be heard, as of right, in an application for care and protection brought in a Children's Court. The High Court held that she had a right to be heard based on the principles of natural justice. It took into account the special nature of the wardship jurisdiction[37] which modified the rules of natural justice in the interests of the welfare of the child.[38]

3.26 In relation to the balance to be struck between parents' and children's rights, and in the particular circumstances of the case, it was suggested that the parents had the right to arrange the legal representation of their children before the Children's Court. In words reminiscent of Lord Scarman in *Gillick*,[39] Wilson J said:

> "In a case where a parent has taken no steps to arrange for the child to be represented, I see no reason why a child having the capacity to do so should not avail himself or herself of the services of the duty solicitor. The child will have that capacity if he or she is of sufficient intelligence and understanding to appreciate the circumstances and to make a rational judgment as to what his or her welfare requires . . . . It is possible that a parent may arrange for the child to be represented and may give instructions which do not accord with the wishes of the child . . . . The question would then be whether the right of the parent to arrange for the representation of the child operates to exclude any independent right in the child. In former times, that question would undoubtedly have been answered in the affirmative. However, *that may no longer be so in a society which recognises the growing autonomy of the child in areas where it has sufficient maturity and understanding to make decisions touching its own welfare:*[40] *see Gillick v West Norfolk and Wisbech Area Health Authority,* particularly per Lord Scarman."

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37 See *Re K (Infants*) [1965] AC 201, 219 per Lord Evershed.

38 Brennan J said: "There is a natural reciprocity between the duty and authority of parents with respect to the nurturing, control and protection of their child and the child's rights and its interests in being nurtured, controlled and protected. The natural reciprocity between the interests of parents and child means that both the parents and the child have an interest in proceedings leading to the exercise of a power which is apt to affect the relationship between them. As a parent holds his or her authority over a child primarily for the benefit of the child, parental authority is to be regarded more as a trust than as a power, but that is not to say that parental duty and authority are burdens of which parents can be relieved against their wishes and without their being heard when it is practicable to hear them. The natural parental right to discharge parental duties and to exercise parental authority cannot be taken away without giving the parents an opportunity to be heard where it is practicable to do so.": (1987) 162 CLR 447, 458. See also id 463 per Deane J.

39 [1986] AC 112, 184.

40 Emphasis added.

3.27 On this view parents' rights might co-exist with children's rights in the sense that although there would be no power to override a mature child's decision in the best interests of the child there might remain power in a parent (or a court acting on the initiative of a parent or a State welfare authority) to make the decision if the child did not.

5. THE ROLE OF THE STATE

(a) Wardship and care proceedings

3.28 The State acts as a protector of the child and in the interests of society. It may displace the natural guardian and assume the role of surrogate decision-maker for the child. In so doing it may displace or disrupt the relationship between the parent and the child. When a child is made a ward or placed under the care and protection or control of the Department for Community Services the Director-General acts in place of the parent and exercises similar rights and responsibilities.

3.29 In Western Australia this power is exercised by the Department for Community Services under the provisions of the *Child Welfare Act 1947*.[41] The Act provides for the care or control of children in the guardianship or under the control of the Department and gives special authority to the Director-General to act for the child. Section 50 gives specific authority to the Director-General to "give consent" in any case where the consent of a parent or guardian of a child is required "or is customarily sought" on behalf of a ward or any child placed under the control of the Department, or where the parent or guardian of that child is unwilling or unable to do so. The Act specifically authorises the Director-General to give consent to "surgical operations or anaesthesia".

3.30 There is also a "wardship" jurisdiction in the Supreme Court which derives from an ancient feudal jurisdiction to protect the property of heirs to land. In addition the Family Court of Western Australia exercises a broad jurisdiction over children under the terms of Commonwealth and State legislation. The origin of the courts' modern overseeing role lies in the acceptance of the principle that the sovereign head of State has a duty to protect his or her

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41 See eg the definition of "child in need of care and protection" in s4 (1).

subjects, and particularly those, such as children, who are unable to protect themselves.[42] Decisions are to be made on the basis of the welfare of the child. According to Kay LJ in *R v Gyngall*:[43]

> "[T]he term 'welfare' in this connection must be read in its largest possible sense, that is to say, as meaning that every circumstance must be taken into consideration, and the Court must do what under the circumstances a wise parent acting for the true interests of the child would or ought to do."

3.31 In each court exercising a jurisdiction which may affect the status of a child, that court is obliged either to take the child's future welfare into account or to treat the child's welfare as the paramount consideration. In the Children's Court a child who is the subject of an application for an order that the child is in need of care and protection is deemed to be a party to the proceedings as much as his or her parent or guardian[44] but a child who is the subject of Family Court proceedings must, in order to be heard, either institute his or her own proceedings or seek leave to intervene or be the subject of a separate representation order.[45]

3.32 If it is assumed that a court has no more rights than a parent,[46] and a "mature" child loses all parental restraint on attaining maturity, courts exercising a guardianship or protective jurisdiction would be obliged to ascertain the child's maturity, rather than the child's best interests.[47] If maturity is sufficient, the child's "best interests" become irrelevant because it would be assumed that mature persons can make adequate decisions about their own welfare. The issue would be the same as for adults, namely whether it is proper in some circumstances to allow the State to interfere with civil liberties.

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42 See eg *Johnstone v Beattie* (1843) 10 Cl and Fin 42, 120: 8 ER 657, 687. Proceedings may be brought under the Commonwealth *Family Law Act* or the Western Australian *Family Court Act* to require the provision of medical treatment to a child, based on the need to protect the child or the protection of the marital relationship: *Family Law Act 1975* (Cth) ss 70C(1)(a), 114(1)(d); *Family Court Act 1975* ss 28, 28A. The original *parens patriae* jurisdiction of the Supreme Court of Western Australia is still intact, although since the creation of the Family Court of Western Australia (which usually exercises civil jurisdiction over children) it is not likely to be exercised.

43 [1893] 2 QB 232, 248.

44 *Child Welfare Act 1947* s 30 (3)(b).

45 *Family Law Act 1975* (Cth) s 65.

46 See para 3.19 above.

47 S 64(1)(b) of the *Family Law Act 1975* (Cth) presently requires only that the court shall consider any wishes expressed by the child in relation to the custody or guardianship of, or access to, the child.

(b) Other State intervention

3.33 The right of the State to intervene in matters involving medical treatment of children is not confined to the situations discussed above. There are many instances where the State requires preventive or protective medical treatment of children and consent is not a prerequisite.[48] Some statutes provide that parental consent may be dispensed with where a child is suspected on reasonable grounds to have been the subject of an offence and either parental consent is not forthcoming or is not sought because of the circumstances in which the child has come to the attention of the medical practitioner or statutory agency. The *Child Welfare Act 1947*[49] provides for the detention of a child under the age of six in a hospital for a period not exceeding 48 hours for observation, assessment or treatment. The South Australian *Community Welfare Act 1972* contains much wider powers: any child may be detained in such circumstances for a period not exceeding 96 hours, during which time the child may "receive such medical treatment as the person in charge thinks necessary or desirable".[50]

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48 Eg *Health Act 1911* ss 251(5) (infectious diseases), 308-309 (venereal disease), 337-338 (school medical and dental examinations); *Human Tissue and Transplant Act 1982* s 21 (blood transfusions).

49 S29 (3a).

50 S 94. Cf *Children's Services Act 1965* (Qld) s 145; *Child Protection Act 1974* (Tas), ss 9 and 17; *Community Welfare Act 1983* (NT) s 16.

Chapter 4

MATURITY: THE ABILITY TO UNDERSTAND

1. INTRODUCTION

4.1 The common law has never provided a fixed age at which, and only at which, a minor may consent to medical treatment, such as 16, though that age is commonly accepted as being significant. The age of 16 has no special legal magic; for example, though the age of consent for sexual matters in Western Australia is 16 years for girls[1] this age does not apply to boys.[2] This chapter looks at the various factors which may be relevant in deciding the appropriate criterion to be used in determining a minor's legal capacity to consent to medical treatment. The first part of the chapter deals with a maturity test, the second with a test based on age.

4.2 A "mature" person is defined as "fully developed in body and mind" and "maturity" as "fullness or perfection of development or growth . . . the state of being complete, perfect or ready."[3] These are not helpful definitions in this context because the physical or emotional development and social adjustment of minors is less than complete, and their bodily and mental powers may not develop fully until they are in their mid twenties, yet the law recognises their capacity to give consent to their own medical treatment in at least some cases.

4.3 If "maturity" is to be the test of capacity below the age of majority it is necessary to have some accepted means of measuring it, otherwise "maturity" may come to be measured solely in terms of the discretionary acceptance by an adult of a child's decision when the adult agrees with it.

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1 *Criminal Code* s 187 (the offence of unlawful carnal knowledge of a girl under the age of 16 years).

2 Though sexual dealing with boys aged less than 14 years is an offence (*Criminal Code* s 183), making that age a "de facto" age of "consent" for males, there is no such age specifically provided.

3 Shorter Oxford English Dictionary (3rd ed, reprinted 1966).

2. ABILITY TO UNDERSTAND

(a) Cognitive development

4.4 Psychological theories of cognitive development are of some help[4] in determining what children are actually able to understand. Jean Piaget[5] recognised four stages in human cognitive development which signal large qualitative changes in modes of thinking. These stages follow an unvarying sequence but happen at different times for different individuals. The stages are the sensorimotor stage, from birth to about age two; the preoperational stage, from approximately two to seven years of age; concrete operations, which lasts from about age seven to ten or twelve; and formal operations, which ends in late adolescence or early adulthood. In the earliest stage children think about what they can experience directly and barely understand the relationship between cause and effect. In the second a child starts to talk and to learn that words are symbols for objects. This lets children think of things simultaneously and get some concept of past, present and future events. From about the beginning of the third stage children start to understand more complex relations and may be able to consider a range of possible solutions to a problem and begin to use hypothetical or deductive thinking. There appears to be, around about the formal operations stage, little real difference between the cognitive ability of the child and the young adult. In other words, adolescents can think as logically about abstract relationships as adults.[6]

4.5 Since making decisions about medical treatment requires abstract thinking it would seem likely that the mature minor must have that ability. In Piagetian terms, the minor should have entered either the concrete or the formal operations stage, depending on the decision to be made. The formal operations stage will in many cases have been reached by the time the child is 11 or 12, though there will be individual differences in children's development. Some research indicates that decisions about medical treatment made by 14-year-olds are similar to those made by adults, judged by the "reasonableness" of the decision (for example, choosing insulin as an appropriate treatment for diabetes) though their understanding could vary depending on the way information is presented to them.[7]

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4 Though there is no unanimity of view: see Scottish Law Commission *Report on the legal capacity and responsibility of minors and pupils* (Scot Law Com No 110 1987) para 3.65 fn 2.

5 J Piaget *Judgment and reasoning in the child* (1968). See generally S R Goldberg and F Deutsch *Life-span individual and family development* (1977) 42-46.

6 See B Inhelder and J Piaget *The growth of logical thinking from childhood to adolescence* (1958).

7 See J Morgan *Controlling minors' fertility* (1986) 12 Monash U L Rev 161, 184 -195.

4.6 Furthermore, the amount of information minors have on which to base their decisions is very important in deciding their capacity. Minors in the concrete operations phase may have the capacity to consent, but if the information which is given to them is couched in technical or unfamiliar language they may not understand it. This places the burden of communicating the essential information in language and using available vocabulary on the medical practitioner.[8]

(b) Social indicators

4.7 We tend to define maturity, in lay terms, by recognition of the roles, tasks or responsibilities of adults in a particular society, which take into account the extent to which young people have begun to achieve social responsibilities, understanding their rights and duties, accepting themselves and others for what they are, ceasing to be dependent on others, and being open to new experiences.[9]

4.8 Looking at the social circumstances of a particular child, such as social independence or isolation, may provide some indication of maturity. Some conclusions can be drawn from a child's manner of living. Decisions about whether or not a child should be able to enter into his or her own arrangements about medical treatment might differ depending on whether or not parents have maintained some sort of authority over or responsibility for the child.

4.9 The maintenance of parental authority may be evidenced by the fact that a child lives at home or the parent otherwise accepts responsibility, such as by involvement in the child's education or work, or by provision of regular financial or social support - for example helping out when a child gets into trouble or needs accommodation.

4.10 Different considerations may apply if -

(1) the adolescent is unwilling to reveal or discuss particular sorts of problems with the parents, such as sexual behaviour or drug or other substance abuse;

(2) there is conflict between parent and child over the child's particular problem, whether it is a problem of the kind previously mentioned or one for which the

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8 See ch 8 below.

9 S R Goldberg and F Deutsch *Life-span individual and family development* (1977) 250.

parents are more directly responsible, such as sexual abuse by a family member;

(3) parents are not available to exercise authority by reason of absence, illness, incapacity or breakdown of the parent/child relationship;

(4) either the parent or the child perceives that the child is sufficiently mature or adult;[10] or

(5) children are in the care of a statutory welfare authority.

4.11 Maturity could be indicated by children living away from home, undertaking reasonable management of their own financial affairs or having attained the appearance of physical maturity. Seeking medical advice could in itself indicate a certain level of maturity; recognising a need and seeking to fulfil it in a socially acceptable way is an adult function. But social indicators may be ambivalent: if a child starts living apart from his or her parents this may only mean that the parents are unable to control the child or unable to support the child financially because of their own poverty.

(c) The nature of the choice

4.12 The nature or significance of the choice which the child is seeking to make is a factor in determining maturity. It may seem reasonable that an adolescent should be able to authorise medical treatment to remedy a simple physical problem such as toothache. Permitting the same young person to make decisions about treatments with permanent effects or illnesses with a particular social significance such as those related to sexuality causes a certain unease in adults.[11] This may be related less to children's capacity to understand and assess their own welfare requirements than to the social consequences of adults losing control over children's moral standards. Adolescence is a time in which young people begin to make "big" moral decisions in the abstract, struggling to apply them to choices affecting them

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10 Children living away from home may fall into either category (3) or (4). Some may be quite independent in all significant ways, providing their own accommodation, income and emotional stability, while others may have been abandoned by their parents, even though unable to assume full responsibility for their lives. Most would fall between those two extremes.

11 Particular treatments are discussed further in ch 6.

directly. Adults have similar difficulties, especially where decisions must be made about sensitive emotional issues.

3. A FIXED AGE?

(a) Introduction

4.13 Some preliminary submissions suggested the fixing of an age at which children might be said to be mature, or might safely be deemed to have attained capacity to consent to their own medical treatment. The Commission has considered whether it would be appropriate to fix such an age. The purpose of fixing an age is to avoid making a decision about a child's maturity in every case.

4.14 Common law recognises both the need for protection of children and their property and the fact that at some point the need for that protected status disappears. The age of majority, or at least the age of responsibility, varied depending on the times and the purposes for which capacity was relevant. For example in 1800 the age of consent to sexual intercourse for a girl was 13; in 1988 in most Australian States it is 16,[12] yet it is commonly recognised that the age of physical maturity (the onset of puberty) has advanced in recent decades. What has changed is the law's attitude towards the protection of children.

4.15 In recent years, the age at which capacity is acquired for a particular purpose has usually been fixed by statute. Children assume responsibilities and are treated differently under the law at varying ages for different purposes. For example -

(i) The *Criminal Code* acknowledges the incremental acquisition of legal responsibility as a child matures. Criminal responsibility presently begins at the age of seven,[13] subject to proof of the child's knowledge that what he or she

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12 The age of consent to sexual relations was originally imposed from a desire to protect young girls who had attained marriageable age from losing their capacity to contract a favourable marriage, or to prevent them or their families losing control over their property to a scoundrel by an unwise marriage. All Australian States still retain the offence of taking an unmarried girl under the age of 18 out of the possession of her parents without their consent: see eg *Criminal Code* s 193. But in *Stanton v R* [1981] WAR 185 (discussed at para 3.6 above) the court appeared to acknowledge that a child of 13 could by her actions choose to leave the custody of her parent. Her "abductor" was relieved of criminal liability on that basis.

13 The Minister for Community Services has announced plans to amend the age at which a child commences to acquire criminal responsibility to ten years: Media Statement from Minister for Community Services, 31 August 1987.

is doing is wrong. At the age of 14, children can be convicted as if they were adult without such proof though they may be tried in different courts and are subject to different sentencing policies.

(ii) The *Family Law Act 1975* requires a court in proceedings for guardianship, custody, access or welfare of a child to take into consideration the wishes of a child.[14] Before 1983 the Act required the court to give effect to the wishes of a child aged 14 or more, except in special circumstances. In practice it often gave effect to the wishes of children aged 12 and upwards. Now the court is required to consider any wishes expressed by a child in relation to custody, guardianship or access or in relation to any other relevant matter, and to "give those wishes such weight as the court considers appropriate in the circumstances of the case."[15]

(iii) An adoption of a child who is 12 years old or more cannot take place without the child's consent.[16]

(iv) Children under certain ages cannot enter into sexual relationships without their sexual partners committing offences. Sexual offences involving minors, especially female minors, carry severe penalties. Different ages are attached to different offences. Where the girl is under 13, unlawful carnal knowledge is an especially serious crime carrying a maximum penalty of 20 years' imprisonment.[17] Between 13 and 16, the same act carries a maximum penalty of five years' imprisonment.[18] When the girl is 16 but under 17 unlawful carnal knowledge is an offence only if the perpetrator is the girl's guardian, employer, teacher or schoolmaster.[19] There is a similar variable scale in relation to the offence of unlawful and indecent dealing. Unlawful and indecent dealing with a child (male or female) under 14 carries a penalty of

14 S 64(1)(b).

15 Ibid.

16 *Adoption of Children Act 1896* s 5(1) (unless ". . the Judge is satisfied that there are special reasons related to the welfare and interests of the child, why the order of adoption should be made notwithstanding that the child has not consented to the adoption, or his consent has not been sought").

17 *Criminal Code* s 185. The *Child Sexual Abuse Task Force Report* (1987) recommended that a person under the age of 13 years (male or female) should be deemed incapable of consenting to any activity which would be a sexual assault offence under s 324 of the *Criminal Code* and that the Code should be amended to that effect: paras 6.23-6.28 and recommendation 28.

18 *Criminal Code* s 187.

19 Id s 190.

seven years' imprisonment.[20] Such conduct involving girls (but not boys) under 16, or girls under 17 where the person concerned is the girl's guardian, employer, teacher or schoolmaster, involves a maximum sentence of four years' imprisonment.[21]

(v) Minors over the age of 16 are entitled to some Commonwealth social security benefits such as invalid pensions and supporting parent benefits in their own right, though some (such as the job search and Austudy allowances[22]) are income-tested in part on the income of the child's family. Such payments are a form of recognition by the State that a child under the age of 18 is no longer the parent's sole financial responsibility.

(b) Some possible ages

4.16 Pragmatic considerations are likely to play a large part in fixing an age at which a child gains capacity, or may be taken to be mature. Most of the recent discussion on medical treatment for young people has revolved around the sexual activities of young women, and the value society places on controlling such activities for the purposes of protecting parental rights, "family" rights, family property, and the children themselves. Such considerations may well be important in choosing a suitable age.

(i) Sixteen?

4.17 It might be appropriate to adopt the age of 16 - an age which has become in folklore an age of discretion for all purposes - as an age at which children acquire capacity to consent to their own medical treatment. There seems to be little controversy in practice that a child of 16 has the ability to give such consent. In England 16 has been selected as the age at which children can consent to medical treatment,[23] and a number of other jurisdictions have a similar

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20 Id s 183.

21 Id s 189.

22 *Social Security Act 1947* (Cth) s 117A (job search allowances); *Student Assistance Act 1973* (Cth) s 10 (education allowances under Austudy scheme).

23 *Family Law Reform Act 1969* (UK) s 8(1). This was the relevant legislation in *Gillick*. 16 is the age at which children in England can choose their own doctors and dentists under the National Health Scheme: *Report of the Committee on the age of majority* (Cmnd 3342, 1967) para 481.

rule.[24] The South Australian legislation allows children of 16 or over to consent to medical treatment,[25] while also permitting children under that age to consent to medical treatment if, in the opinion of a doctor, supported by the written opinion of another doctor, the child is capable of understanding the nature and consequences of the procedure and that it is in the best interests of the child's health and well-being. [26] Children of 16 or over may also consent to treatment for other persons to the same extent as persons of full age.[27]

(ii) Fourteen?

4.18 It might be thought appropriate to adopt the age groupings in the *Criminal Code* as relevant to consent to medical treatment - though there is no logical reason why, in 1988, a restriction on criminal responsibility need be the same as a test for maturity in an entirely different (civil) context. But the age groupings are not unreasonable; a child under the age of ten[28] might be presumed to be incompetent unless a court found that in exceptional circumstances the presumed incapacity should not apply to that individual child; up till the age of 14 a child might be presumed to be capable of exercising such choices subject to some simple test of maturity; from the age of 14 one might assume the child had the same capacity to consent to his or her own medical treatment as an adult.

4.19 14 is the age at which children are permitted to consent to treatment in New South Wales.[29] The *Minors (Property and Contracts) Act 1970* provides that where medical or dental treatment is carried out with the prior consent of a minor who is aged 14 years or more, the minor's consent has the same effect with respect to a claim by that minor for assault or battery as if he or she were of full age.[30] The New South Wales *Children (Care and Protection) Act 1987* requires the written consent to a "special medical examination" of a child from the parent (if the child is less than 14); of both the parent and the child if the child

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24 *Guardianship Act 1968* (NZ) s 25; *Age of Majority Act 1969* (NI) s 4; *Infants Act 1960* (BC) s 23; *Regulation 729* (Ont) s 49 made under *Public Hospitals Act 1970*.

25 *Consent to Medical and Dental Procedures Act 1985* (SA) s 6(1).

26 Id s 6(2). The Canadian *Uniform Medical Consent of Minors Act 1975* (adopted in New Brunswick in 1976) adopted similar principles, and the Scottish Law Reform Commission has recommended a similar scheme: *Report on the legal capacity and responsibility of minors and pupils* (Scot Law Com No 110 1987) paras 3.61-3.83.

27 *Consent to Medical and Dental Procedures Act 1985* (SA) s 6(1).

28 To be substituted for seven as the age at which a child commences to acquire criminal responsibility: see fn 13 above.

29 And also in Quebec: *Public Health Protection Act 1972* s 36.

30 S 49(2). The Act also provides that where medical or dental treatment of a child aged less than 16 is carried out with the prior consent of the minor's parent, the parent's substituted prior consent has the same effect as if it were the consent of the minor and the minor were of full age: s 49(1).

is 14 or 15 years old; and of the child alone if he or she is 16 or more.[31] Before the examination is carried out the parents (and children to whom this provision applies) must be counselled as to their rights by someone other than the doctor who will carry out the examination.[32] In the Commonwealth sphere the *Family Law Act* formerly required that the wishes of a child of 14 or more as to custody should be given effect, but in 1983 this requirement was repealed.[33]

(iii) Thirteen?

4.20 If capacity to consent to medical treatment is to be based on maturity, selecting 16 or 14 as the appropriate age may be too conservative a solution. Children of 13 are likely to be mature enough to make decisions about at least some classes of medical treatment. The age of 13 may be considered significant if maturity is seen as related to puberty, that is attaining the ability to procreate. This may be why the age of 13 is of such significance in the *Criminal Code* definitions of sexual offences committed against women.[34]

(c) Current practice of doctors

4.21 It appears that doctors are prepared to treat children under 16 without the consent of their parents. Some doctors feel that it would sometimes be irresponsible to refuse to treat children who had demonstrated their maturity by seeking medical advice independently. It is possible to bulk-bill Medicare for consultations with a child of 14 or over without advising the child's parents, and Medicare will issue a separate Card to a minor aged 15 or more. A Commonwealth agency seems to have recognised a child's likely autonomy at 14 or 15. Some doctors will treat children as young as 12 without the consent of their parents. Much depends on the nature of the treatment involved.[35]

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31 S 21. A "special medical examination" means a vaginal or anal examination or a penile examination involving the insertion of anything into the penis: s 21(12).

32 S 21(8).

33 *Family Law Amendment Act 1983* (Cth) s 29.

34 See para 4.15(iv) above.

35 As to which see ch 6 below.

Chapter 5

THE COMMISSION'S APPROACH

1. INTRODUCTION

5.1 The present ambiguities and uncertainties of the law should not be permitted to continue. It is undesirable that doctors should be left in a state of uncertainty as to what their obligations to a particular patient are, and unsure as to whether their treating or failing to treat a minor patient with or without the consent of the minor, parent, or another person or the leave of a court will result in liability. It is unacceptable that older children may fail to seek medical treatment to the detriment of their health and well-being because of the same uncertainty over their entitlement to treatment. There should be a rational legislative policy as to the age at which or the circumstances in which children should be able to act on their own behalf in relation to their own medical treatment. The age of 18 marks the end of childhood in a legal sense, but below that age a balance must be found between, on the one hand, the rights, privileges and responsibilities of parents which are exercised because, and only so long as, their children cannot look after themselves, and on the other hand, the rights and duties of children.

(a) Welfare or autonomy[1]

5.2 One possibility would be to adopt a test of capacity based on the "best interests" or welfare principle, but tests based on "best interests" do not really recognise any degree of patient autonomy. They give the adult who decides the question a great deal of power, and permit the invalidation of children's decisions on discretionary and subjective grounds. Opinions on what is "best" may justifiably vary. Parents and other adults may at times be unable to distinguish between their personal aims and the best interests of children, or may see the two as inextricably intermixed.

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1 See the earlier discussion in paras 3.8-3.11.

5.3 Another possible approach is to vest in decision-makers a discretion to assess a child's competence to make the decision by looking at the "reasonableness" of the child's wish, either in terms of the likely outcome, or of the reasons given for it. These tests would recognise children as competent if they either make the decision a "reasonable" person would make in the circumstances, or if the child expresses cogent reasons (that is, reasons acceptable to the adults involved) for his or her choice.

5.4 An attempt could be made to limit the discretion by providing a statutory code of matters to be taken into account in exercising it.[2] Such matters could combine an assessment of the child's maturity, particular social circumstances such as lack of parental involvement, the nature of the procedure, the parents' and children's wishes and the child's "welfare". But the balancing of such highly complex factors would require such a delicate judgment that a judicial determination would usually be necessary in all but obvious cases.

5.5 The Commission does not favour such approaches, since they appear to abrogate the present common law right of children to contribute to and ultimately make their own decisions about their manner of living.

(b) The nature of the treatment

5.6 There may be some medical procedures which have long-term social, emotional, psychological, physical or economic effects on children which children might not appreciate. Sometimes a child's own social and emotional environment may have a considerable effect on the desirability of a particular medical treatment (or withholding of treatment).

5.7 In some cases it may not be appropriate to provide quite routine medical treatment, for example if children making the decision are subject to severe emotional strain or other stress (whether as a result of the condition or not), or where they are unable to cope with the emotional consequences because they are homeless, living in unsanitary conditions, or without parental or other adult support, or even if they simply lack adequate financial resources.

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2 For example, s 64(1) of the *Family Law Act 1975* (Cth) sets out a series of factors to be taken into account in proceedings in relation to the custody or guardianship of, or access to, a child.

5.8 In chapter 6 below the Commission reviews some procedures where it might be thought that some special control should be imposed. The statutory scheme proposed in this chapter should be taken as being subject to any special exceptions or rules appropriate to such procedures.

2. A STATUTORY SCHEME

5.9 The Commission suggests that there should be a statutory scheme which -

(1) provides that children of 16 or over can consent to medical treatment to the same extent as if of full age;

(2) confirms the common law right of children below that age to consent to medical treatment if they are mature, and for the purpose of assessing their maturity divides them into two categories:

a) children between 13 and 16, who may be regarded as presumptively mature, and

(b) children under 13, who may be regarded as potentially mature but whose maturity must be established to the satisfaction of the doctor;

(3) provides defences for doctors who treat children who are not mature.

These principles are elaborated in more detail in the following paragraphs.

5.10 The Commission seeks to reinforce the rights of children of all ages to be consulted on health and medical decisions affecting their well-being. The Commission also seeks to encourage doctors to accept and act upon the wishes of mature children in the absence of parent consultation.

(a) An absolute right to consent at 16

5.11 There appears to be little controversy about the ability of children of 16 or over to consent to medical treatment on their own behalf. In a number of other jurisdictions, legislation has allowed children of this age to consent to medical treatment in all circumstances in exactly the same way as adults.[3] Though this reform standing alone would not be a complete answer to the problems of medical treatment for minors,[4] the Commission suggests that it should be incorporated as part of its proposed statutory scheme.

5.12 Accordingly, the Commission suggests that legislation should -

(1) enable children of 16 or over to give a valid and sufficient consent to medical treatment to the same extent as if they were of full age;

(2) preserve a parent's entitlement to consent on behalf of a child aged 16 or over in appropriate circumstances, if the child's consent cannot be given by reason of illness, unconsciousness, unsoundness of mind or other actual, rather than presumed, incapacity; but

(3) otherwise remove any parental right to override the consent to medical treatment, or refusal of consent to medical treatment, of a child of 16 or over.

There might be exceptions for particular kinds of treatment.[5]

5.13 As a consequence of these proposals, doctors will be absolved from criminal or civil liability for acting on the consent of a 16 year old to the same extent as they would be absolved from acting on the consent of an adult. As regards civil liability, this means that the child's parents will have no right of action against the doctor if the doctor carries out medical treatment with the child's consent but without their consent. Nor could an action brought by the child (with the parents as next friend) succeed in such circumstances. Rights to sue for damages not based on lack of capacity to consent, for example an action by the child for

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3 See para 4.17 above.

4 Legislation allowing children of 16 or over to consent to medical treatment often sets out the circumstances in which younger children can give such consent: ibid.

5 See ch 6 below.

negligent treatment or in cases where there is a lack of informed consent,[6] or an action by a parent for shock caused by negligent treatment of the child,[7] would of course not be affected.

(b) Children under 16: preserving common law rights

5.14 Merely to recognise 16 as an age at which children can consent to medical treatment, without dealing with the problem of medical treatment for children under that age, does not resolve the real problems of medical treatment for minors. Nor would it recognise the fact that the common law has already given minors under 16 the right to consent to medical treatment if they are mature.

5.15 The Commission suggests that the proposed statutory scheme should confirm the common law rule. In the same way as the suggested provision dealing with the rights of children of 16 or over, the legislation should -

(1) enable children under 16 to give a valid and sufficient consent to medical treatment to the same extent as if of full age if they are "mature", that is, if they are of sufficient intelligence and understanding to comprehend the nature and implications of the proposed treatment.[8] The implications include the consequences of having the treatment performed without parental consultation or agreement;

(2) preserve a parent's entitlement to consent on behalf of a mature child in appropriate circumstances, if the child's consent cannot be given by reason of illness, unconsciousness, unsoundness of mind or other actual, rather than presumed, incapacity; but

(3) otherwise remove any parental right to override the consent to medical treatment, or refusal of consent to medical treatment, of a mature child.

The legislation should make it clear that where children are not mature the parents have the responsibility of consenting to medical treatment.

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6 See paras 2.9-2.14 above and Appendix III paras 3-7.
7 See para 2.16 above.
8 See *Gillick* 189 per Lord Scarman.

5.16 This proposal would have the same effect on the doctor's criminal and civil liability as that relating to children over 16 made above.[9] The difference between this proposal and that relating to children over 16 is that children over 16 would always have the right to consent to medical treatment, whereas children under 16 would only have that right if they are mature. It would also be possible for the statutory scheme to provide that even mature children under 16 should not be able to consent to particular kinds of treatment.[10]

5.17 A rule allowing minors to consent to medical treatment if they are mature may not of itself provide clear guidance in all cases. For this reason the Commission suggests that the statutory scheme should provide that children of 13 or over are presumed to be sufficiently mature to consent to medical treatment. Doctors could treat such children without parental consent unless there was sufficient evidence to displace the presumption of maturity. Children under 13 might still be mature, and so able to consent to medical treatment, but the statutory presumption would not apply and a doctor would need to be affirmatively satisfied that they were mature. On every consultation a doctor would have to consider the question of maturity, and make a determination of maturity on the available evidence.

(c) A defence for doctors who treat minors who are not mature

5.18 The Commission's views will be frustrated if doctors are reluctant to treat minors in the absence of parental consent for fear of prosecution or civil action. The Commission wishes to encourage doctors to accept the directions and act upon the instructions of children whom they might previously have been disinclined to treat without parental control, interference or direction, without removing their liability for medical negligence or other forms of malpractice. It is desirable to remove the spectre of litigation while maintaining a proper legal sanction.

5.19 As the law presently stands, a doctor has difficulty if a child requests medical treatment and the doctor knows, either from the child or from the parent, that the parent will not authorise that treatment and would wish to prohibit it. Unless the doctor's assessment of the child's maturity is accurate, the doctor may fear being held liable to the parent for

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9 Para 5.13.

10 See ch 6 below.

damages,[11] or being prosecuted for a criminal offence.[12] On the other hand, if a child is mature and the doctor fails to treat and damage ensues, the child might sue for negligence. The doctor might seek to avoid the problem by refusing to treat the patient or referring the case on elsewhere, but there may be a case, sooner or later, in which a court may find that refusal to treat the patient would amount to professional negligence in that the patient's interests would be harmed by that refusal.

5.20 There may also be problems where the child's maturity is in doubt, but treatment (to which the child consents) is urgently required in the child's interest. The common law provides the doctor with an immunity from liability where the doctor treats in an emergency, but this is limited to the preservation of life or the avoidance of serious long term injury, and there is a clear sense of crisis decision-making.[13] With adolescent patients there may be situations which are not covered by common law emergency powers but in which treatment is urgently needed, for example drug or alcohol abuse or health risks incurred as a result of sexual behaviour. In such cases it may be inexpedient for the doctor to inform the parents. Any such requirement may simply result in the minor refusing to have treatment.

5.21 The Commission suggests that these problems should be dealt with by giving the doctor a defence to criminal or civil liability.[14] The proposed statutory scheme should provide that where a doctor treats a child who is not mature with the consent of the child but without the consent of the parents, the doctor does not commit any offence, and will not be liable in any civil action based on the child's lack of capacity to consent, if -

(a) the doctor reasonably believed that the child was mature; or

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11 See paras 2.8-2.16 above. Under the present law a mistaken belief that the plaintiff was capable of consenting is probably not a defence to an action in trespass: see J G Fleming *Law of Torts* (7th ed 1988) 71; F A Trindade and P Cane *Law of Torts in Australia* (1985) 208.

12 See paras 2.17-2.23 above.

13 There are also statutory provisions to this effect, eg s 49B of the *Medical Practitioners Act 1938* (NSW), which provides statutory protection for a medical practitioner for treatment performed upon a child where two medical practitioners are of the opinion that the child is in imminent danger of dying and the carrying out of the treatment is necessary for the preservation of its life. P W Young *Law of Consent* (1986) 104 states that this provision is not often used because medical practitioners prefer to have the child made a ward of court and to require a judge to make the decision.

14 Cf *Consent to Medical and Dental Procedures Act 1985* (SA) s 8.

(b) the treatment was necessary to deal with a serious threat to the life or health of the child.[15]

5.22 If either of these circumstances is made out, the doctor's civil liability will be limited to the same extent as if the child were over 16,[16] or under 16 but mature.[17] The doctor will not be liable in any action alleging that the child did not have the capacity to consent, but other rights of action would not be affected.

(d) Other requirements unnecessary

5.23 The Commission does not at this stage propose that a doctor should be obliged to make a reasonable effort to persuade a child to seek parental consent as a pre-condition to treating a mature child. The Commission does not read the *Gillick* decision as requiring this. A doctor's failure to encourage the child to seek parental involvement might affect a court's determination as to whether or not he or she was acting in good faith in believing that the child was mature, or that the child fully understood the implications of the decision. There are social implications of many medical decisions, including decisions not to tell parents, which the mature child will have thought about. The Commission believes that it would be exceptional for a doctor to fail to enquire as to the involvement of the parents whenever a minor sought medical treatment other than treatment of a truly trivial nature without parental involvement. This, however, is not a ground on which immunities should be based, but is a part of the doctor's general duty of care to his or her patient.

5.24 The Commission has considered, and at this stage does not propose, an additional requirement that the doctor seek a second opinion from another doctor.[18] On balance the Commission considers that the requirement of a second opinion becomes, all too easily, a mechanical and irritating ritual which could be counterproductive to the well-being of the patient and of little real safeguard to the patient's rights. It would also be a disincentive to doctors, and to adolescent patients who might otherwise seek advice and treatment.

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15 In such cases it would still be necessary for the doctor to have the child's consent to treatment. The Commission does not contemplate extending the scope for involuntary treatment by giving the doctor a defence where he or she reasonably believes that a particular procedure is necessary to deal with a serious threat to the life or health of the child.

16 See para 5.13 above.

17 See para 5.16 above.

18 The Scottish Law Commission decided not to recommend such a requirement: *Report on the legal capacity and responsibility of minors and pupils* (Scot Law Com No 110 1987) paras 3.75-3.77.

Chapter 6

PARTICULAR CONDITIONS AND MEDICAL PROCEDURES

1. INTRODUCTION

6.1 The Commission discusses in this chapter whether different considerations should apply to the law and practice concerning medical treatment for children depending on the type of treatment sought.[1] For example it might be thought that a child's capacity to consent fluctuates depending on the severity or duration of the consequences of the decision to be made. A child might well understand the nature and consequences of a decision to treat an infection with antibiotics but be less able to comprehend the sequelae of cosmetic surgery or chemotherapy. A doctor might think that a child is in such need of care or protection that the need to obtain parental consent should, in light of that need, be modified. This might apply to a minor who seeks psychiatric treatment as a result of abuse or treatment for a sexually transmitted disease arising out of incest or sexual assault.

2. GENERAL CONSIDERATIONS

6.2 Young people, in order to become mature and adult, need to distance themselves emotionally from their parents, becoming less dependent and eventually independent of them. This is often disclosed in disruptive behaviour and disrupted relations between parent and child, and in experimentation and risk-taking by the adolescent.

6.3 In some circumstances the Commission believes it is appropriate that minors should have direct access to medical care on a confidential basis. Some circumstances are personal to the patient, such as the adolescent who is no longer under parental control either because the parent has voluntarily relinquished it or because the adolescent has asserted substantial independence.[2] Other circumstances relate to the nature of the illness, disease, condition or conduct for which advice or other treatment may be sought. Some conditions or manners of

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1 See paras 5.8, 5.12 and 5.16 above, where it is suggested that the proposed statutory scheme should be subject to special rules of this kind.

2 See paras 4.7-4.11 above.

living in themselves constitute a health risk, or there may be moral dilemmas about them, whether or not the children are living at home or otherwise under parental control. For example, major concern is expressed about alcohol and drug use and abuse and the promiscuous or deviant expression of sexual needs. A third set of circumstances relate to the nature of the treatment proposed.

3. THE CONTROL OF SEXUAL ACTIVITY AND ITS CONSEQUENCES

(a) Introduction

6.4 A commonly expressed parental concern to control behaviour and to monitor information and access to medical treatment is where female children seek treatment and advice for problems which are related to their sexuality, especially contraceptive advice and treatment.[3]

6.5 Some children start having sexual intercourse at ages as early as 12 and a significant number have serious sexual involvements by ages 15-17: overall approximately 50 per cent of young people have had sexual intercourse by the time they are 17 or 18.[4] This can lead to a number of harmful effects including emotional and social difficulties for the young people themselves, increases in the incidence of sexually transmitted diseases, and unwanted pregnancies.

6.6 The Family Planning Association of Western Australia told the Commission that in its experience an adolescent's decision to seek medical advice, especially about contraception, was usually made *after* the primary decision to have sexual intercourse. Half of teenagers' first visits to their clinic were made by sexually active young women who were seeking to prevent a first pregnancy, but 84 per cent of those first attended more than three months after having intercourse for the first time. 36 per cent were prompted by suspicion of pregnancy, and only 14 per cent of visits were made in anticipation of having full sexual intercourse for the first time. The major reason for their delay was the teenagers' fear that their parents might find out.

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3 Cf the *Gillick* case, discussed in paras 3.12-3.23 above. See Royal Commission on Human Relationships *Final Report, Vol 3 Part IV: Sexuality and fertility* (1977).

4 Adolescent Health Services Review Position Paper *Future Health* (1987) para 4.2.3. In this chapter, whenever statistics are cited they have been extracted from this Position Paper, unless otherwise attributed.

6.7 Children are having children: in Western Australia in 1983 21 births were registered where the mother was under 15, and 56 15 year old girls, 147 16 year old girls and 307 17 year old girls had children.

6.8 There is evidence that the youngest mothers (under 16) had three times the rate of low birthweight babies than mothers aged 25 to 29 and their babies were more likely to die after 28 days of life. In 1987, the Health Department cited increasing evidence that low birthweight and perinatal mortality associated with teenage pregnancy are related to socio-economic circumstances and poor support and lack of antenatal care rather than maternal age. It proposed that efforts be made to improve the situation, including somehow taking steps to delay the onset of sexual activity, and improved access to effective contraception, improved antenatal care and socio-economic support.[5]

6.9 It is probably reasonable to assume that if teenagers were obliged to involve parents in decisions which have to be made because of their sexual behaviour, a significant number of teenagers would not seek contraceptive or other preventive services, but would continue their sexual activities. There is a major dilemma to be faced. Many young adolescents still either resident at home or legally under parental control or supervision engage in behaviour which exposes them to health risks. Most try to avoid parental involvement in the conduct which places them most at risk. Their values and those of their parents may very well conflict. This potentially places supportive, counselling and other preventive services in conflict too, because at times parental views will be seen to be in direct conflict with a counsellor's view. This is particularly so in the area of sexual expression. Adolescents deeply resent the intrusion of parents or any adult authority into their privacy on these matters. The need to prevent sexually transmitted disease, or pregnancy, and feelings about the activities which lead to these needs, can result in serious confrontations over conflicting moral values. Emotions can run high between parent and child.

(b) Contraception

6.10 Contraceptive advice or treatment to young women is sometimes a major cause of disagreement between parent and child, as parents rarely accept their daughter's expression of

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5 Ibid.

sexuality without emotional anguish and disapprobation. The Commission suggests that the evidence detailed in the preceding paragraphs leads to the conclusion that minors have a great need for contraceptive advice and treatment.

6.11 This could be dealt with either by having special rules dealing with the provision of contraceptive advice and treatment, or by ensuring that the general rules governing a minor's ability to consent to medical treatment are suitable to cover contraceptive advice and treatment. The Commission prefers the latter alternative, and believes that its proposed statutory scheme[6] meets this need. Special rules for contraceptive advice and treatment would in practice only apply to women, and in the Commission's view it is undesirable to suggest anything which is inconsistent with the principle that responsibility for sexual behaviour and its consequences is, or ought to be, shared by both male and female.

(c) Termination of pregnancy

6.12 In Western Australia 22 per cent of all terminations of pregnancy were carried out on 15 to 19 year old women. Between 1978 and 1984 there was a 75 per cent increase in the number of terminations of pregnancy of young women in this age group. In 1984 49 terminations were reported where the mother was aged between 12 and 14. 1,855 were reported for women between the ages of 15 and 19.

6.13 The Commission has indicated[7] that it does not propose to deal with the termination of pregnancy in any sense other than on the basis that some terminations of pregnancy may be lawful. In *R v Davidson*[8] Menhennit J held that a doctor does not act unlawfully if he or she honestly and reasonably believes that the termination of pregnancy is necessary to preserve the mother from a serious danger to her life or physical or mental health which the continuance of the pregnancy would entail, and the need to preserve her life in this manner is not disproportionate to the danger to be averted. It has been suggested that this test would also be appropriate for the interpretation of *Criminal Code* provisions concerning termination of pregnancy.[9]

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6 See paras 5.9-5.22 above.
7 See para 1.15 above.
8 [1969] VR 667.
9 See M J Murray *The Criminal Code: A general review* (1983) 127.

6.14 It appears that doctors are prepared to carry out lawful abortions on girls under the age of 16 without the consent of their parents, if they are satisfied of the girl's maturity. In the English case of *Re P (A Minor)*[10] Butler-Sloss J agreed that a 15 year old schoolgirl should be allowed to have an abortion against the wishes of her parents. The judge was satisfied that the girl wanted the abortion and understood the implications of it.

6.15 Australian courts take a similar attitude. In *K v Minister for Youth and Community Services*[11] the Chief Justice in Equity, Helsham J, authorised the performance of an abortion on a 15 year old ward of the State because it was in her best interests so to do. The court's approval was required since the Minister, who had the power to grant consent, had refused to do so. It is significant that the court treated the girl's expressed wishes as of fundamental importance. This would appear to suggest that the minor could and should be able to consent to the termination of her pregnancy in her own right, but the judge would not accede to an argument, based on an interpretation of section 49(2) of the New South Wales *Minors (Property and Contracts) Act 1970*,[12] that her consent made the guardian's consent irrelevant.[13]

6.16 In the Commission's view, the suggested general rules as to the ability of minors to consent to medical treatment[14] are adequate to cover lawful abortions. If a mature minor wished to have an abortion, then provided it was otherwise lawful, her parents could not prohibit it. Nor could an adult with guardianship rights force a mature child to undergo an abortion. The Commission suggests in chapter 7 below a means of resolving disputes as to a child's maturity.[15]

(d) Sexually transmitted diseases

6.17 In 1985 there were 678 reported cases of venereal disease among the 15 to 19 year old age group, being 33.2 per cent of all reported cases in that year. Females aged 15-19 exceeded 20 to 24 year olds in contracting "classical venereal disease" (gonorrhoea and

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10 (1982) 80 LGR 301.

11 [1982] 1 NSWLR 311.

12 As to which see para 4.19 above.

13 He said: "I do not think this can be elevated into a conferring of power or right of a minor aged between fourteen and sixteen to give consents to medical and dental treatment in a way that really displaces or erodes or sets at nought a guardian's powers in this area. . . . It does not take away any power of a guardian to withhold consent or to refuse.": [1982] 1 NSWLR 311, 321.

14 See paras 5.9-5.22 above.

15 See paras 7.2-7.8 below.

syphilis). The sexually active teenager is at particular risk of all forms of sexually transmitted diseases including chlamydia, trachomatis, papilloma and AIDS. Venereal disease is notifiable,[16] but it is not known whether minors and other young people avoid treatment because they are afraid that their sexual activities will become known.

6.18 In the Commission's view its suggested general rule governing the consent of minors to medical treatment is adequate to cover treatment for sexually transmitted diseases. A minor who is mature should be able to consent to such treatment on his or her own behalf.[17] Doctors who treat minors who are not mature for sexually transmitted diseases without obtaining the consent of their parents would have a defence to any action based on the child's lack of capacity to consent if the treatment was necessary to deal with a serious threat to the child's life or health.[18]

4. OTHER ADOLESCENT HEALTH ISSUES

6.19 Adolescence is often a time of great stress to parents as well as children. Emotional and behavioural problems are not uncommon and can become entrenched and manifest themselves as severe psychiatric disorder. A significant number of teenagers suffer from depression or suicidal thoughts. Some minors kill themselves. Others suffer from conditions such as eating disorders which may lead to death or permanent ill-health. Some manifest their distress in other self-destructive behaviour such as drug or other substance abuse.

6.20 Just as it is desirable to encourage adolescents to accept responsibility for their sexual behaviour, and appropriate both to inform them about and to treat the consequences of risk-taking, in the Commission's view it is desirable to encourage the voluntary seeking of advice and treatment in the use and abuse of alcohol and legal and illegal substances. To that end it is important that young patients should feel assured of confidentiality and not be refused treatment simply because they are minors.

6.21 Adolescents who seek professional advice and counselling on life-problems or mental or emotional distress or disturbance may decline to do so if parents or guardians must be informed of their problems.

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16 *Health Act 1911* s 300.
17 See para 5.15 above.
18 See para 5.21 above.

6.22 Under the Commission's suggested general rule, doctors would be able to treat mature minors in such circumstances.[19] Where the minor is not mature, the minor's behaviour or condition may be such that to refuse to treat him or her without parental consent may result in the minor not seeking treatment and a continuing risk of damage to the minor's health. Under the Commission's proposals, a doctor would have a defence to any action based on the child's lack of capacity to consent if the treatment was necessary to deal with a serious threat to the child's life or health.[20]

5. STERILISATION AND LONG-TERM PREGNANCY PREVENTION

6.23 Procedures intended to prevent pregnancy on a long-term basis include surgical means such as tubal ligation or cauterisation, mechanical means such as intrauterine devices, and the administration of long-acting drugs such as Depo Provera.[21] These are not normally administered to children, even sexually active minors, unless there are special reasons. Hysterectomies and other procedures with a sterilising effect have been performed on intellectually handicapped women, both minors and adults, for a variety of reasons over the years, including "hygienic" reasons associated with the minor's social incapacity to cope with the cleanliness requirements of menstrual bleeding.[22]

6.24 Sterilisation is a process whereby the capacity to reproduce is permanently removed. Though in some cases the process can be reversed, it is not intended as a temporary measure. Sterilisation was the subject of a significant decision of the House of Lords in 1987, *Re B (A Minor) (Wardship: Sterilisation*),[23] which concerned an application in the wardship jurisdiction for authority to perform a sterilisation procedure on a 17 year old intellectually handicapped ward of court.

6.25 Eleven years previously Heilbron J had refused permission to sterilise an 11 year old intellectually handicapped girl on the ground, primarily, that to do so was not in the child's interests as it would deprive her of the basic right of reproduction.[24] In that case leave was

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19 See para 5.15 above.

20 See para 5.21 above.

21 A long-acting contraceptive preparation administered by injection.

22 Some other procedures may have the effect of removing the ability to procreate but are performed for other, therapeutic reasons, eg the performance of an orchidectomy for the relief of torsion in males.

23 [1988] AC 199.

24 *Re D (A Minor) (Wardship:_Sterilisation*) [1976] Fam 185.

sought to perform a hysterectomy on a minor for whom there was a relatively favourable prognosis but whose guardian was under great stress. The court said that the child was "as yet" unable to appreciate the implications of the procedure and could not consent on her own behalf. In *Re B* the House of Lords was told that the girl was seriously intellectually handicapped, showed very clear signs of being sexually aware and was desirous of being, if she was not already, sexually active, but would be quite unable to comprehend the state of pregnancy and the event of childbirth and indeed would be likely to injure herself and the foetus and any child once born.

6.26 The two cases differed on their facts and both were decided on the basis of the best interests of the minor. Both related solely to intellectually handicapped young women who could not possibly make the decision about the proposed procedure on their own behalf because of the intellectual and cognitive disability they suffered, not because of their minority.

6.27 Intellectually impaired women have been sterilised to prevent pregnancy because mechanical or chemical means are not suitable for people who cannot be relied on to use them or whose living environment makes it difficult to ensure they will use them. It is no longer argued that the children of handicapped women are likely, on genetic grounds, to be handicapped themselves. It is said that such women may be incapable of going through the birth process or raising their children. In *Re B* it was also argued that the young woman was vulnerable to sexual abuse by unscrupulous men.

6.28 Sterilisation, in itself, is not usually "therapeutic" in the sense of being carried out to prevent or ameliorate disease, but the prevention of pregnancy may be therapeutic for those who are likely to become involved in sexual activity but are not capable of understanding the responsibilities associated with it or the consequences of undesired parenthood. A permanent form of pregnancy prevention may be the only appropriate method of contraception in such cases. For example in a Canadian case,[25] sterilisation was authorised on the ground that the young woman could not undertake any other form of contraception and that to prevent

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25 *Re Eve* (1981) 115 DLR (3d) 283.

pregnancy by supervision would have placed unreasonable restrictions on her freedom. On those facts, it was the least restrictive alternative.[26]

6.29 The loss of the capacity to procreate may have significant psychological or emotional implications for the person concerned. Special rules might be appropriate for any medical treatment which will have the effect of permanently removing the capacity to procreate of any person, particularly a person who is intellectually handicapped or psychiatrically disturbed, whether an adult or a minor.[27]

6.30 The Commission suggests that removal of the capacity to procreate is of such significance that it is desirable that intellectually handicapped or psychiatrically disturbed children, male or female, should be afforded the same protection as intellectually handicapped or psychiatrically disturbed adults, and that the leave of a court exercising an appropriate guardianship jurisdiction should be required before sterilisation is performed. This proposal would in effect remove any right which a parent may otherwise have to give a valid consent to the sterilisation of such children.

6. CHILD SEXUAL OR OTHER PHYSICAL ASSAULT

6.31 The Western Australian Child Sexual Abuse Task Force was established in June 1986. Its terms of reference included:

> "The adequacy of laws relevant to the protection of children from sexual abuses and, in particular:
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> (i) the reporting of child sexual abuse;
>
> (ii) the investigative procedures following upon the reporting of child sexual abuse;

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26 For discussion of the case, and recommendations for reform of the law, see Alberta Institute of Law Research and Reform *Sterilization decisions: Minors and mentally incompetent adults* (Report for Discussion No 6 1988).

27 On 5 March 1988 the Melbourne Age reported that Victoria's Guardianship and Administration Board had "taken a tough stand" on the sterilisation of young women with intellectual disabilities, noting that it had been a common practice, even a condition of entry, to some government institutions. Decisions of the Board had indicated that all less severe alternatives must be first explored.

(iii) the substantive and procedural law relating to prosecution, trial and disposition of cases of child sexual assault and, in particular, whether such cases should be disposed of in the Children's Court or superior courts."

The report of the Task Force was submitted in December 1987.

6.32 The Commission does not propose to deal with the special problems of the victims of child sexual assault because this was within the brief of the Task Force. However there are presently certain statutory powers to require the medical examination or treatment of a child who is suspected of having been assaulted or otherwise abused.[28] Recommendation 39 of the Report proposed a further means by which a medical practitioner in a public hospital could ensure that a child was treated as a result of suspected child abuse, but the Task Force expressly acknowledged the right to privacy and self-determination of children consistent with their growing maturity and autonomy.[29]

7. SCIENTIFIC TESTS OF PARENTAGE

6.33 The guardian of a young child is able to consent on that child's behalf to blood tests. [30] Blood tests are used in an attempt to determine the parentage of a child. In addition a form of "genetic fingerprinting" is now available which can prove, to a very high degree of probability, both maternity and paternity of a particular child. In contrast to the position 20 years ago it is now possible to rely on a scientific test as proof of paternity.

6.34 The Commonwealth *Family Law Act 1975* has been amended to permit a court to require persons to submit to a "parentage testing procedure" for the purposes of establishing paternity of a child.[31] The Western Australian *Family Court Act 1975* also provides for a "prescribed medical procedure" to establish paternity.[32] Neither a "parentage testing procedure" nor a "prescribed medical procedure" may be performed unless a guardian of the

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28 Under s 29(3a) of the *Child Welfare Act 1947* a hospital may detain and treat a child under the age of six where there are reasonable grounds to suspect that the child is in need of care and protection. Under s 308 of the *Health Act 1911* a Children's Court may order medical examination of a child believed to suffer from venereal disease. Under s 5 of the *Child Welfare Act 1947*, the Director-General of the Department for Community Services may give his or her consent to medical treatment of a ward.

29 See *Child Sexual Abuse Task Force Report* (1987) paras 6.87, 6.89.

30 *S v McC* [1972] AC 24, 43 per Lord Reid.

31 S 66W.

32 S 82E.

child consents.[33] There is no provision for the obtaining of the consent of a child, though a child may institute his or her own proceedings for custody, guardianship, access and other matters relating to the child's welfare in the Family Court of Western Australia.[34] It is paradoxical that a child who has the right to be a party to proceedings might conceivably be subjected to scientific tests of parentage against his or her will, in contrast to the position at common law, under which a mature child could not be subjected to such tests against his or her will. This might be inconsistent with a general principle which recognises a child's right to consent to or refuse medical treatment.

6.35 Though courts will not order an adult to undergo scientific tests of parentage without consent,[35] the decision to order a minor to undergo such tests has not in the past been based on any concept of consent, but the "best interests" of the minor.[36] In light of the provisions of Australian family law legislation referred to in the previous paragraph, and since *Gillick*, it would seem proper to review that attitude and require an assessment of the child's capacity to consent to scientific tests of parentage.

8. UNORTHODOX MEDICAL TREATMENT

6.36 Particular problems arise where parents wish their children to be subjected to unorthodox medical treatments of which traditional doctors disapprove. This might include rejection of traditional treatment (such as the use of medication or chemotherapy for malignancies), reliance on a restricted diet to "purify the system" when organic disease has been diagnosed, or physical manipulations, massage, constriction or exercise which are seen as less traumatic to the patient and offering some hope of cure or alleviation of symptoms. Established medical opinion might well not recognise the validity of such regimes or might believe that they would damage the child. In severe cases parental persistence or juvenile intransigence might involve the State in guardianship proceedings to protect the child's interests, but that will not resolve a difficulty which could arise if a child understood the implications of the decision and elected to refuse "traditional" remedies in favour of alternative treatments. There seems to be little justification for treating a mature minor any differently when the choice he or she makes is in favour of a procedure which doctors consider therapeutically useless or outside the bounds of their professional practice, or when

33 S 66W; s 82E.
34 *Family Court Act 1975* s 36(aa).
35 *W v W* [1964] P 67.
36 See Lord Denning MR in *B (BR) v B(J)* [1968] P 466, 473-474.

the minor merely refuses a particular procedure which is generally acceptable amongst doctors. The Commission's suggested general principles[37] should apply in such cases.

9. OTHER SPECIAL MEDICAL PROCEDURES

6.37 There are certain types of medical procedures with serious and long-term effects, such as tissue donation,[38] in vitro fertilisation and experimental procedures, and drastic, "heroic" or "aggressive" treatments or procedures with radical effects (for example, a bone marrow transplant) to which special considerations might apply. There are others which are controversial within some groups of the community because they are thought to be destructive to the integrity of the individual, such as ECT (or "shock therapy"), psychosurgery and some sorts of medication or drug regimes, or thought likely to cause complex emotional and social reactions ("sex-change" surgical procedures), or are culturally unpopular (surgery during initiation into adulthood in some cultural groups). It might be desirable to adopt special rules or safeguards in cases such as these.

10. CONCLUSION

6.38 Though the circumstances discussed in this chapter do raise special problems, and it might be appropriate to make special rules to cover them, overall the Commission sounds a note of caution. The law governing the medical treatment of minors should be as simple and as easy to apply in practice as possible. A multiplicity of special rules would make the law unworkable.

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37 See paras 5.19-5.22 above.

38 See paras 1.16-1.22 above.

Chapter 7

RESOLVING CONFLICTS

1. INTRODUCTION

7.1 In a number of situations there may be doubt or conflict about who has the responsibility of giving or withholding consent to medical treatment of a child. In such cases there needs to be a means of resolution which is capable of being set in motion quickly to meet emergency situations.

2. PARENT AND CHILD CONFLICTS

7.2 Under the present law there may be conflicts between parents and children about medical treatment. It has been suggested in chapter 3 that at common law mature minors are able to make their own decisions about medical treatment whatever the wishes of their parents. There may be doubts as to whether a particular minor is mature and this may lead to a dispute. Another possible source of dispute arises even where there is no doubt that the minor is mature, since it may be possible to interpret *Gillick* as giving parents some rights in this situation.[1]

7.3 The statutory scheme proposed by the Commission in chapter 5 seeks to minimise the possibility of disputes between parents and children about medical treatment, by providing that minors over 16 have the same rights as adults to consent to medical treatment; that "mature" children under 16 have similar rights, with possible exceptions relating to certain kinds of treatment; and that children aged 13 or over are to be presumed to be mature.[2] Nonetheless, there may be disputes between parents and children as to whether the child is mature, or whether a mature child can consent to particular kinds of treatment.

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1 See para 3.23(ii) above.

2 See paras 5.9-5.17 above.

7.4 These disputes could be resolved either by a court, or by some third person such as a doctor, or an officer such as the Health Commissioner or the Director-General of the Department for Community Services or their delegates.

7.5 The Commission provisionally suggests that such disputes should be resolved by a court exercising an appropriate guardianship jurisdiction. A person who wished to permit, require or prohibit the performance of a particular medical treatment on a child under 16 irrespective of that child's consent should be able to make an application to the court. In line with the presumption of maturity suggested by the Commission,[3] where the child is 13 or over the burden of proving that the child was not mature, or that the treatment was exceptional in nature, would be on the applicant. The standard of proof would be the ordinary civil standard, that is proof on the balance of probabilities. In the case of a child under 13, the burden would be reversed.

7.6 The Commission has considered which court is the proper court to which to make an application. Several courts already exercise guardianship powers which could be used to resolve such disputes.[4] The Family Court, acting under the *Family Law Act 1975*, can make guardianship orders, and could make an order granting guardianship for a limited period of time or for a particular purpose to a parent or a third party.[5] The passing of the *Family Law Act* did not deprive the Supreme Court of its parens patriae jurisdiction:[6] under the *Supreme Court Act 1935*, the Supreme Court can appoint guardians and committees of persons and estates of infants.[7] Children's Courts can place a child in need of care and protection in the guardianship of the Director-General of the Department for Community Services, who has statutory power to give or withhold consent to treatment of such children.[8]

7.7 The Commission is provisionally of the opinion that a determination concerning consent to medical treatment of minors should remain within the province of the Supreme Court and would best be initiated by an application in chambers.

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3 See para 5.17 above.

4 See para 3.4 above.

5 The Family Court of Western Australia exercises both federal jurisdiction and non-federal jurisdiction under the provisions of the *Family Court Act 1975*. It can therefore exercise jurisdiction concerning the custody or guardianship of, access to, or maintenance of any child, including an ex-nuptial child.

6 See *Carseldine v Director of the Department of Children's Services* (1974) 133 CLR 345; *Johnson v Director-General of Social Welfare (Vic)* (1976) 135 CLR 92.

7 S 16. The section also gives power to appoint guardians and committees of the persons and estates of lunatics and persons of unsound mind.

8 See para 3.33 above.

7.8 The Commission's proposals would not remove the discretionary power of the court exercising family jurisdiction or a Children's Court to make orders in the best interests of the child. The Commission would not expect such orders to be made in either jurisdiction purely for the purposes of medical treatment if a child were mature.

3. OTHER POSSIBLE CONFLICTS

(a) Disputes between parents

7.9 At common law, parents or other guardians have the responsibility of making decisions about the medical treatment of children who are not mature, and parents would retain this responsibility under the statutory scheme suggested by the Commission in chapter 5. Where parents have this responsibility, there could be a dispute between parents who disagree about whether treatment should be given.

7.10 If parents or other guardians have joint responsibilities to children then the Family Court, the Supreme Court exercising a wardship jurisdiction or a Children's Court (at the instance of the Department for Community Services[9]) could vest guardianship in one person and thereby resolve the issue. Another option might be to vest decision-making power in the case of conflict in the person who has day to day custody or care and control, or in a State official as suggested above.[10]

(b) Doctors' dilemmas

7.11 There may be cases in which there is no dispute between parent and child, or between parents, but the doctor is unhappy about carrying out the proposed treatment. For example, the doctor may have doubts about the child's maturity or the appropriateness of the proposed treatment. Under the statutory scheme suggested by the Commission in chapter 5, the doctor would not commit any offence, and would not be liable in any civil action based on the child's lack of capacity to consent, if he or she reasonably believed that the child was mature, or the

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9 See para 7.6 above.

10 Ibid.

treatment was necessary to deal with a serious threat to the child's life or health.[11] The doctor might wish to confirm that he or she would not be liable in the circumstances in question.

7.12 Another situation of difficulty for doctors might be where there is a dispute between the wishes of the patient and the wishes of others, for example when a minor of uncertain maturity requests the doctor to perform a termination of pregnancy but an interest group opposed to such terminations threatens to intervene to protect the foetus, claiming that the child's consent was invalid.

7.13 These disputes could again be resolved by vesting the power to make a decision in a court or a State official. Another option might be to leave the decision to the doctor's discretion, subject perhaps to statutory criteria or guidelines.

(c) State intervention

7.14 Where a child is a ward (that is, someone whom a Children's Court has ordered to be placed under the care and control of the Director-General of the Department for Community Services) the Director-General may give consent to any required medical treatment.[12] Most other States have similar provisions.[13] There is no statutory provision for the recognition of a mature minor's capacity to give or withhold consent on his or her own behalf. Though the *Child Welfare Act* specifically prohibits certain interferences with wards, the Commission considers that the common law rights of wards are not necessarily thereby curtailed. If this is so, the Director-General's power to consent to medical treatment would be no more extensive than that of a natural parent, and the scheme proposed by the Commission in chapter 5 would apply to wards in the same way as other minors. There would be the same need for a dispute resolving process.

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11 See para 5.21 above.

12 *Child Welfare Act 1947* s 50.

13 *Children's Services Ordinance 1986* (ACT) s 158; *Children (Care and Protection) Act 1987* (NSW) s 20; *Children's Services Act 1965* (Qld) s 143; *Community Welfare Act 1972* (SA) s 85; *Community Welfare Services Act 1970* (Vic) s 199. The South Australian provision and (in effect) the Victorian provision require reasonable inquiries to be made as to the whereabouts of the guardians of the child before the Director-General (the statutory "guardian") gives his or her consent.

(d) The Commission's proposals

7.15 Consistently with its earlier suggestion for resolving disputes between parents and children concerning medical treatment, the Commission provisionally suggests that disputes about the medical treatment of minors involving parents, doctors or wards of the State should be dealt with by the Supreme Court by means of an application in chambers. Applications could be made by persons with guardianship rights (at common law or by order of a competent authority or court) or persons (doctors or others) who persuaded the court that they had a legitimate concern with the welfare of the child.

Chapter 8

PROVING CONSENT

1. INTRODUCTION

8.1 Paragraph (b) of the terms of reference requires the Commission to examine the means by which minors should give or refuse consent to medical treatment. In the following paragraphs the Commission describes the current position and makes some provisional proposals.[1]

2. THE GENERAL PRINCIPLES

8.2 It is not necessary to give consent to medical treatment in any particular way. Consent may be evidenced -

* *By a written document*

  Before any hospital procedure begins the patient is usually required to sign a document containing contractual terms. The most significant terms are waivers of patients' rights by which the patient absolves the hospital from certain liabilities (for example, for failing to provide the services of a particular doctor), and consents to the procedure being carried out. It is often a "blanket" consent. Rarely does a patient vary the terms of the document presented to him or her prior to that procedure.

* *Orally*

  Oral consent is usually all that a doctor requires before prescribing medication or for a routine medical examination.

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1 The Commission would welcome further information about current practice, especially if it deviates from the Commission's understanding of the current position.

* *By implication from the patient's behaviour*

Consent may be evidenced by implication from the patient's behaviour, such as the patient's holding out his or her hand to enable a doctor to remove a wart. Attendance at a hospital for a routine medical procedure of a minor nature on the recommendation of a doctor would amount to consent in those circumstances.

8.3 No matter what documents are signed, or what advice is given, or what words or actions are used, if the treatment which is subsequently performed is so different from that to which the patient has given consent that there is no reasonable relation between the two, or f the patient has been coerced or pressured sufficiently by the circumstances or persons involved, then there is no true consent. Where the patient is a child there is a real probability that the minor patient may simply have acquiesced, rather than consented, to medical treatment performed at the wish of significant and powerful adults, even if the circumstances would not readily be interpreted as coercion or duress by a court.

8.4 In ordinary circumstances the issue of the reality of consent simply does not arise because there is no dispute either at the time or afterwards. The appearance of consent will be sufficient. So far as hospital treatment is concerned, usually forms are signed. If forms are used problems may arise in the following areas -

(a) When the doctor or the hospital in which the patient is to be treated has delegated the task of obtaining the patient's consent to junior clerical or medical officers, consent forms may be given to the patient and executed without any actual or contemporaneous explanation of the proposed medical procedures and their potential effects.

(b) In some circumstances the consent forms may be inadequate because they are insufficiently specific. A doctor cannot and does not assume that he or she has a totally free hand in the course of any treatment, but some consents may be so vague or all-encompassing that they cannot be construed with certainty.

(c) The timing of the giving of any consent is crucial. The nature of the medical treatment proposed may change dramatically in the light of later events or changed circumstances. For example, where a patient had signed a consent form believing at the time that her condition was a minor one requiring perhaps a day's hospitalisation, it would be inappropriate for a doctor to proceed on the basis of that consent to carry out a hysterectomy. Signing a consent form after the event or once treatment has begun would be useless if there were no consent in actuality at the beginning, though it could be a ratification. The execution of a written consent by a person at a stage at which he or she is physically incapable of giving consent (for example through pain, the effects of disease or the effects of medication or anaesthesia) would also be useless.

3. PROVING CONSENT BY CHILDREN

8.5 Though it is comparatively easy to imply consent on behalf of an adult patient, the problems involved in proving consent when that consent has been given by a child are quite substantial. Because the comprehension or maturity of a child is so significant, it is necessary to establish that the child had capacity to comprehend and that the consent was real. This may not be at all easy to prove, and it might be most unsafe to rely on behaviour, such as attendance at a hospital on the recommendation of a doctor, which in an adult might amount to implied consent but in a child may indicate mere passive acquiescence in an adult decision. Forms are only evidence of a communication between doctor and patient. In the case of a minor that evidence may be rebutted with singular ease. The Commission understands that hospitals generally seek the signature of a person who holds himself or herself out to be the parent or guardian of the child and will not act on the signature of a child, even a child on the verge of adulthood.

8.6 In cases of comparatively minor medical treatment a written form of consent is not required. Where the potential effects of the proposed procedure are deleterious, permanent or long-term, there is likely to be a higher degree of formality, but the mere fact of writing will not affect subsequent evidence that a child was unable to give consent by virtue of his or her circumstances, immaturity or general condition.

4. THE COMMISSION'S PROPOSALS

8.7 The Commission suggests that there should be guidelines, preferably uniform guidelines, by which individual doctors and hospitals should regulate their own conduct when a child's consent is required to medical treatment.[2] The Commission suggests that the guidelines might require that the following information must be communicated to a child who is mature,[3] or in other cases to the child's guardian -

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

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

(c) an indication of alternative treatment;

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

(e) a description of any benefits which might be expected;

(f) an offer to answer any questions about the proposed procedure; and

(g) that the child is free to withhold or withdraw consent at any time.

8.8 The Commission's terms of reference are limited to the medical treatment of minors, but it would be appropriate to adopt the same guidelines for the treatment of adult patients. The Commission emphasises that in a case involving a child's consent to medical treatment the major issues are whether the child is mature, or whether in the circumstances the treating

2 Doctors in private practice do not have the same sort of administrative support as do hospitals and would appear to apply their own standards, some of them on an ad hoc basis.

3 See para 5.15 above.

doctor has a defence. In each case the child must freely choose to proceed with medical treatment.

Chapter 9

CONFIDENTIALITY

1. INTRODUCTION

9.1 Paragraph (c) of the terms of reference requires the Commission to consider the extent to which, and the circumstances in which, the parents, guardians or other persons or institutions responsible for the care or control of minors should be informed of any consent, or refusal of consent, to treatment given by a minor.

2. THE GENERAL PRINCIPLE

9.2 The heart of the relationship between a doctor and a patient is trust. It is normally a breach of a doctor's professional ethics to disclose particulars relating to a patient to any person without that patient's authority. A breach of confidence may also render the doctor liable to pay damages, either for breach of the contractual relationship between doctor and patient or possibly for breach of a non-contractual duty of confidence. It may also be possible to obtain an injunction to restrain a breach of confidence. The confidentiality of the doctor/patient relationship applies to information obtained from the patient by the doctor and any other information he or she obtains from any other source acting in that capacity, even if the relationship has ceased.[1]

3. CONFIDENTIALITY IN RELATION TO A CHILD PATIENT

9.3 There are special considerations and practical problems where the patient is a child. If, for example, a doctor is consulted by a teenager of 14 or 15 years of age about contraception and discovers that the child is in fact pregnant, ill (with a non-notifiable disease) and intent on refusing all forms of conventional treatment, the doctor may consider notifying the parents. If the patient were an adult such action would not normally be professionally open to the doctor.

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1 *Furniss v Fitchett* [1958] NZLR 396.

9.4 Where the patient is a child there are several different approaches to confidentiality which could be taken -

(a) The same rules could apply to a minor as to any other patient, namely that the patient's confidences must generally be respected whether or not the doctor agrees with the patient's decision, or the patient's assessment of his or her own best interests. Whether or not the minor has involved his or her parents in the medical decision-making would be irrelevant.

(b) The maintenance of the patient's confidence could be regarded as a matter for the doctor's professional discretion, which must be exercised with appropriate care and skill, taking into account the child's maturity and the nature and consequences of the proposed treatment.

(i) If the child is mature, then if *Gillick* is authority that the rights of the parent to control the child are extinguished when the child attains maturity, the duty to maintain a confidence would prevail over any assessment of the child's best interests. If on the other hand the rights of the parent are merely suspended, parental rights might be revived in special circumstances when the child's best interests require it.[2] In such a case there may be circumstances in which the doctor may be justified in breaching the confidence in the child's best interests.

(ii) If the child is not mature, there may be circumstances in which the doctor's assessment of the child's best interests would justify his or her breaching the duty of confidentiality and informing the parents.

(c) Finally, a doctor might be placed under a duty to seek out and inform parents in circumstances where this was in the best interests of the child, whether the child was mature or not.

9.5 After the *Gillick* case the General Medical Council in England issued revised guidelines to doctors. The previous guidelines had provided:

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[2] On the question whether parental rights are extinguished or merely suspended when a child becomes mature, see para 3.23 above.

> "Where a child below the age of 16 requests treatment concerning a pregnancy or contraceptive advice, the doctor must particularly have in mind the need to avoid impairing parental responsibility or family stability. The doctor should seek to persuade the patient to involve the parents (or guardian or other person in loco parentis) from the earliest stage of consultation. If the patient refuses to allow a parent's consent to be sought, the doctor should withhold advice or treatment except in an emergency or with the leave of a competent court; but in any event he should observe the rules of professional secrecy."

9.6 The new guidelines appear to confuse the "best interests" principle with principles of patient autonomy.[3] They provide as follows:

> "Where a child below the age of 16 consults a doctor for advice or treatment, and is not accompanied at the consultation by a parent or a person in loco parentis, the doctor must particularly have in mind the need to foster and maintain parental responsibility and family stability. Before offering advice or treatment the doctor should satisfy himself, after careful assessment, that the child has sufficient maturity and understanding to appreciate what is involved. For example, if the request is for treatment for a pregnancy, or contraceptive advice, the doctor should satisfy himself that the child has sufficient appreciation of what is involved in relation to his or her emotional development, family relationships, problems associated with the impact of pregnancy and/or its termination and the potential risks to health of sexual intercourse and certain forms of contraception at an early age.
>
> If the doctor is satisfied of the child's maturity and ability to understand, as set out above, he must nonetheless seek to persuade the child to involve a parent, or another person in bco parentis, in the consultation. If the child nevertheless refuses to allow a parent or such other person to be told, the doctor must decide, in the patient's best medical interest, whether or not to offer advice or treatment. He should, however, respect the rules of professional confidentiality set out above in the foregoing paragraphs of this section.

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3 See paras 3.8-3.11 above.

> If the doctor is not so satisfied, he may decide to disclose the information learned from the consultation; but if he does so he should inform the patient accordingly, and his judgment concerning disclosure must always reflect both the patient's best medical interest and the trust the patient places in the doctor."

9.7 These guidelines appear to give a doctor a discretion based on the best interests of the child to breach the confidence of a patient whom the doctor considers to be insufficiently mature - in effect the second approach outlined above.[4]

9.8 The guidelines direct a doctor what to do when the child is immature. They also recognise that in the relationship between the doctor and the mature child the obligation of confidentiality applies to the full extent. But they justify what would otherwise be a breach of confidence on the basis of a subjective determination of maturity by the doctor and are open to discretionary interpretation and possible abuse.

9.9 Accepting that a doctor should normally try to persuade a child patient to seek the consent of the parent, there seems to be a strong argument for requiring a doctor to observe the same secrecy and confidentiality as he or she would for an adult patient. This is obviously so in the case of a child who, under the common law rule endorsed by the Commission, is "mature",[5] but may equally be so where the doctor treats a child who is not mature in circumstances where, under the statutory scheme suggested by the Commission, the doctor would have a defence to criminal liability or a civil action based on the child's lack of capacity to consent.[6]

9.10 An important practical argument against relaxing the general rule about confidentiality is that the lack of assured confidential treatment may deter the child from seeking any advice or treatment where the child's medical condition or manner of living exposes him or her to a high risk of disease or injury. For example, young people who are sexually active or involved in drug or alcohol abuse are especially vulnerable. One situation in which the defence proposed by the Commission would be available to a doctor who treated a child without

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4 Para 9.5.
5 See para 5.15 above.
6 See para 5.21 above.

parental consent, even where the child was not mature, is where the treatment was necessary to deal with a serious threat to the child's life or health.[7]

9.11 There are arguments in favour of the contrary view. Many doctors would be deeply concerned if they were unable to advise or treat a child who was not mature, where the nature of the treatment sought or the condition precipitating the request suggests that it would be in the interests of the child to inform a responsible adult of the risks to health of the child's present condition or manner of living. This may be seen as both a professional responsibility and a social one.

4. THE COMMISSION'S PROPOSALS

9.12 The Commission proposes that the principles which should apply to the duty to maintain a confidence should be similar to those which apply in determining whether or not a child has the right to choose whether he or she receives medical treatment.

9.13 There is no suggestion in *Gillick* or in the guidelines issued either prior to or following the decision that a doctor should breach the duty of secrecy imposed on him or her by a mature child.[8] If a child is sufficiently mature to give consent, and to comprehend the advice which is necessary before that consent can be real, then the duty to maintain a confidence should not be broken in circumstances other than those presently permitted by the law with respect to an adult patient. If the child seems mature but the doctor were to choose not to treat for some other reason, such as his or her assessment of the child's best interests, or the doctor's belief that the child should involve the parents in the decision-making, then there seems to be no valid reason why the child's right to have confidences respected should thereby be removed. In the absence of specific legislation a parent would not then have the right to require a doctor to disclose particulars of advice, counselling or treatment given to a mature child.

9.14 If the child is not, in the doctor's opinion, mature the doctor may decline to treat without the consent of the parent or guardian or, if the Commission's suggestions are adopted, may treat where treatment is necessary to deal with a serious threat to the child's life or health.

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7 Ibid.

8 Although the guidelines do say that if a child refuses to allow the doctor to involve the parents the doctor has a discretion as to whether to treat.

9.15 The doctor's obligation or right to inform other responsible adults of the child's approaches and to disclose confidences given by the child to him or her in those circumstances may well depend on a professional assessment of the child's best interests. The Commission is mindful of the importance of respecting any patient's confidences, including those of a child. An assessment of "maturity" is usually, sometimes unconsciously, a subjective one. On one view a doctor should respect a child's confidences except where the child's life would be endangered by non-disclosure. On another view, ordinary professional standards might justify a breach of confidence in a wider range of situations, for example, where a doctor informs parents that a child has sought advice or treatment for a drug or other substance abuse problem. There is no easy answer to these dilemmas, which arise in the context of an adolescent's intense wish for privacy. The Commission seeks comment. Apart from certain public health matters,[9] a doctor at present has no legal obligation beyond that of an ordinary citizen to disclose matters concerning the welfare of children.

9 See ch 3 fn 48 above.

Chapter 10

HANDICAPPED CHILDREN

1. INTRODUCTION

10.1 The previous chapters of this discussion paper have concentrated on the question of when minors are mature enough to be able to consent to medical treatment on their own behalf, and what role, if any, parents then have in such decisions. This chapter is concerned with a very different problem: cases where minors are suffering from a mental or physical impairment. In such cases there is no question of minors making decisions on their own behalf.

10.2 In some cases, such children are suffering from a condition which is terminal or from which recovery is unlikely. If that is so they fall within the ambit of the Commission's discussion paper on **Medical treatment for the dying**.[1] But in many cases handicapped children are not suffering from terminal conditions - though they may frequently require life saving treatment. This chapter discusses the question who should give consent to treatment in such cases, and what factors should be taken into account.

10.3 Impaired or handicapped children require medical treatment for many different purposes. Treatment may be intended to remove a handicap, such as a cleft palate, or a club foot, with every chance of complete recovery. Treatment may be intended to remove a condition naturally associated with a non-correctable handicap.[2] The treatment may be intended to cure a condition not caused by, but perhaps aggravated by, the impairment. The treatment may require merely a holding operation to allow normal growth.[3] In many cases

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1 Project No 84 1988.

2 Down's syndrome (trisomy 21) children often have gastrointestinal blockage or congenital heart defect. Down's syndrome is a congenital malformation caused by faulty chromosome distribution, characterised by mental deficiency, physical abnormalities, and a higher than normal susceptibility to infection: see *Re B (A Minor) (Wardship: Medical Treatment*) [1981] 1 WLR 1421.

3 Infants of low birth weight may require mechanical ventilation because of immature lung development.

there is an urgent need for medical intervention.[4] Given the variety of possible cases, the Commission is mindful of the risks of generalisation.

2. DECISION-MAKING

10.4 Where an impaired child is not capable of consenting to treatment, parents have a primary role. Parents have a right to be consulted and a right to consent on the child's behalf. Of course, the child's doctor is not bound to follow parental wishes slavishly. Independent judgment is called for. In relation to immature children parents and doctors share responsibility for treatment decisions, which must be taken within the scope of the law.

10.5 Few would dispute the special interest which parents have in decisions about their children. Parents must be fully informed regarding the medical situation. This might require a prognostic written statement from the child's doctor or the hospital. Any humane procedure must also take account of the possibility of emotional or post-traumatic shock to parents when first told of a major birth defect.[5] At this time the parents and the child are especially vulnerable.

10.6 Where a doctor is concerned that a parent has not made a decision in the best interests of an impaired child, the case might be referred to a hospital review committee,[6] and if necessary, various courses of action could be followed to protect the child. The child (if under six) could be detained in the hospital for a short period for the purpose of observation, assessment or treatment.[7] An application could be made to have the child placed in the care of the Department for Community Services,[8] or the parens patriae power of the Supreme Court might be called upon.[9]

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4 Spina bifida children may suffer severe and possibly fatal complications if surgery is withheld or postponed: see generally H Kuhse and P Singer *Should the baby live?* (1985) 48-60.

5 "In most instances, parents must make treatment decisions in the first few hours of birth, a period during which, typically, they are still reeling from the shock, fear, and disappointment of learning that their child is seriously deformed or defective. Parents during this period are unusually vulnerable to the suggestions of physicians, friends, and family, and may make decisions they later regret. By any standards, this is not the optimum time for parents to make life and death decisions with respect to the newborn": T S Ellis *Letting defective babies die - Who decides?* (1982) 7 American Journal of Law and Medicine 393, 414.

6 See the Commission's discussion paper on *Medical treatment for the dying* (Project No 84 1988) paras 3.38-3.40.

7 *Child Welfare Act 1947* s29 (3a).

8 Id s 30.

9 See para 7.6 above.

10.7 In cases where parental guidance is lacking, and the child's doctor is unwilling to act unilaterally (perhaps for ethical reasons or for concern about personal liability) the matter might be referred to a court exercising a welfare or wardship jurisdiction, an ethics committee established in a hospital for that purpose, or a statutory officer such as the Director-General of the Department for Community Services.

10.8 Where a parent refuses to consent to life-sustaining treatment, and in the considered opinion of health or welfare authorities, such refusal is unreasonable, steps may be taken to have the child made a ward of court, or for the appointment of a guardian.[10] The former course of action was taken in the English case of *Re B (A Minor) (Wardship: Medical Treatment)*.[11] B was born with Down's syndrome and an intestinal blockage which required surgery. Her parents refused to consent to the operation. The local authority instituted wardship proceedings and sought an order for the operation to be performed. Templeman LJ stated:[12]

> "It is a decision which of course must be made in the light of the evidence and views expressed by the parents and the doctors, but at the end of the day it devolves on this court in this particular instance to decide whether the life of this child is demonstrably going to be so awful that in effect the child must be condemned to die, or whether the life of this child is still so imponderable that it would be wrong for her to be condemned to die. There may be cases, I know not, of severe proved damage where the future is so certain and where the life of the child is so bound to be full of pain and suffering that the court might be driven to a different conclusion, but in the present case the choice which lies before the court is this: whether to allow an operation to take place which may result in the child living for 20 or 30 years as a mongoloid or whether (and I think this must be brutally the result) to terminate the life of a mongoloid child because she also has an intestinal complaint. Faced with that choice I have no doubt that it is the duty of this court to decide that the child must live. . . . The evidence in this case only goes to show that if the operation takes place and is successful then the child may live the normal span of a mongoloid child with the

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10 Under the provisions of the *Child Welfare Act 1947* s 30, the *Supreme Court Act 1935* s 16(1)(d)(ii); the *Family Law Act 1975* (Cth) Part VII Division 5 or the *Family Court Act 1975* s 36.

11 [1981] 1 WLR 1421.

12 Id 1424.

handicaps and defects and life of a mongol child, and it is not for this court to say that life of that description ought to be extinguished."[13]

10.9 It is the provisional view of the Commission that the general rule should be that the responsibility for making decisions with regard to a critically ill child's treatment should remain with the parents, subject to the possibility of court intervention in exceptional cases.

3. RELEVANT FACTORS

(a) Legal constraints and moral considerations

10.10 The law in Western Australia is based on the view that the preservation of human life is of paramount importance. It does not appear that the provision of less than full care, or the withholding of care, can be justified or excused under any of the usual defences available in the criminal law. This applies with special force to decisions aimed at accelerating death.

10.11 The question whether life-sustaining medical treatment should be given to seriously defective or ill children raises difficult moral issues and conflicting considerations. In some cases a decision to withhold or stop a particular treatment may be considered to be in the best interests of the child because it is thought to be more humane. This might be so where the proposed treatment could not lead to or restore consciousness, or where the life so preserved must inevitably involve such great physical and psychological torment that it should not be inflicted on any person. This last category would include those who suffer incessant unmanageable pain where continued life is itself a torture.[14] In such circumstances it may be recognised as morally justified to stop or withhold treatment for a seriously ill child, even though failing to give treatment could shorten the patient's life.

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13 In Victoria a judge made a 10 day old spina bifida baby a ward of the court and ordered a hospital to take all necessary steps to preserve the life of the baby: *Give baby a chance - judge* The West Australian, 3 July 1986, 3; *Grandfather fights mother for care of deformed baby* The Australian, 3 July 1986, 1. The judge is reported as holding that no decision could be made to determine the life of a child and, in particular, that no decision could be made on the basis of the child's quality of life.

14 For example a child with Lesch-Nyham syndrome. This is an X-linked recessive condition that involves a process of neurological and physiological deterioration from approximately the sixth month of life. The condition also involves compulsive self-mutilation. There is no curative treatment and no effective relief for the pain brought on by the condition: R F Weir *Selective nontreatment of handicapped newborns* (1984) 149-150.

10.12 Is it ever proper to decide against using all available means to keep a child alive? In a recent survey of nearly 200 obstetricians and paediatricians all but two agreed that in some circumstances it was proper not to use all available means to keep an infant alive.[15] The same survey revealed that:

> "90 percent of obstetricians, and 83 per cent of paediatricians had, on at least one occasion, directed that less than maximum efforts should be made to preserve the life of a handicapped infant. Thirty per cent of the obstetricians, and 48 per cent of the paediatricians, said that they had given such directions on several occasions. With the exception of one or two doctors who thought parents should be spared the burden of these agonizing decisions, the doctors said that they consulted with the parents."[16]

10.13 It might be argued that a child with Lesch-Nyham syndrome[17] should not be given life-prolonging treatment if the child contracted a passing virus, on the ground that there is no hope that such a child will have an acceptable standard of living. There may be cases where the treatment may be so painful or distressing to a child, and the prospects of a recovery so poor, that it would not be in the child's best interest to embark on the treatment. On the other hand, the case of *Re B*[18] provides an example in which the mere existence of a handicap would not necessarily result in an unacceptable quality of life.

10.14 It is arguable that the existing criminal law does not allow decisions about treatment (including for example the withdrawal of life support equipment) to be made by reference to an assessment as to the child's welfare, understood in a broad[19] sense. Whether a decision to withhold viable treatment for an incidental condition based upon an assessment of the value of the infant's life is unlawful has not been fully tested.[20]

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15 H Kuhse and P Singer *Should the baby live*? (1985) 77.

16 Ibid 176-177. The Kuhse-Singer survey was conducted in Victoria. Surveys in the USA have shown a similar approach to the selective nontreatment of newborn with serious medical conditions or deformities: R F Weir *Selective nontreatment of handicapped newborns* (1984) 60-61.

17 See fn 14 above.

18 [1981] 1 WLR 1421, discussed at para 10.8 above.

19 That is, a sense in which an acceleration of death may be treated as in the best interests of the patient.

20 Some guidance may be had from the English case of John Pearson, a Down's syndrome child rejected by his parents at birth and marked by his doctor for "nursing care only". The child died (the cause of death was stated by the doctor as broncho-pneumonia) and the Crown alleged poisoning by dyhydrocodeine(DF118). The doctor was charged with murder. The charge was reduced at the trial to attempted murder on the ground that the child was suffering from certain defects from birth, which may have caused death. He was acquitted. See M J Gunn and J C Smith *Arthur's case and the right to life of a Down's syndrome child* [1985] Crim L R 705. There is reason to believe that a case of this kind could give rise to a charge of unlawful killing under the Criminal Code.

(b) The family interest

10.15 The emotional and financial burden on the family is an important consideration. Families caring for defective children may experience considerable domestic tension. The divorce rate of such families is above average. Some families may disintegrate under the strain. Even if the family survives, there may be some deterioration in the marital relationship and an increased likelihood that siblings will suffer emotional or behavioural problems.[21] On the other hand, some families find the experience rewarding and strengthening.[22]

10.16 Is it possible to balance the interests of an impaired child against those of "the rest of the family"? This is a natural question, but there does not seem to be any coherent way of measuring and comparing such interests.[23] How can the loss of one life be weighed against the strain inflicted on another? Is it ever possible to weigh the "value" of a handicapped child's life against the benefit to other members of the family by being spared the continuing drain on family resources? How is the quality of a particular life to be measured?

(c) The community cost

10.17 Considerations of community cost cannot be avoided. The community must bear some of the cost of caring for and supporting defective children, particularly if institutional care is necessary. Despite efforts made to provide normal homes, including adoption or fostering arrangements, many institutionalised children will require ongoing institutional care. In many cases children will be too severely disabled to be cared for outside an institution. Some may question whether the financial burden is worth it unless the child can look forward to an acceptable quality of life. Nevertheless, the Commission considers that wherever possible community resources should be made available to assist families who assume the responsibility of caring for a handicapped child.

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21 H Kuhse and P Singer *Should the baby live?* (1985) 146-153.

22 Id 152.

23 J A Robertson *Involuntary euthanasia of defective newborns: A legal analysis* (1975) 27 Stanford LRev 213, 256.

4. CIVIL AND CRIMINAL REMEDIES

10.18 The legal protection afforded to children does not vary according to the child's state of health or bodily integrity. The various civil remedies available to minors in relation to improper medical treatment are discussed earlier in this discussion paper.[24] As to the criminal law, the *Criminal Code* sets out in Chapter XXVII several duties in relation to the preservation of human life. Section 262 imposes a duty on persons having charge of another to provide the necessaries of life.[25] Section 265 imposes a duty to exercise reasonable skill in relation to the provision of surgical or medical treatment. In each case, the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to perform that duty. The duty provisions referred to do not create offences but lay the foundation for charges of, say, failing to perform a duty resulting in bodily harm[26] or manslaughter.[27] The question of criminal sanctions is further explored in the discussion paper on *Medical treatment for the dying*.[28]

5. CONCLUSIONS

10.19 It is desirable to clarify existing procedures to ensure that in relation to the provision of medical services the rights of severely impaired or defective minors are respected and protected. No member of society, however disadvantaged, should be discriminated against in the vital area of health care. In the context of treatment decisions for seriously ill impaired children, where inactivity may lead to a loss of life, the Commission recognises that there is a presumption in favour of steps aimed at preserving life. The Commission recognises that reasonable persons may have strong and passionate but divergent views on this topic. The Commission welcomes views.

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24 Paras 2.17-2.23. Note that no action will lie for wrongful life. A severely handicapped child cannot recover damages on the basis that the abnormality should have been detected prior to birth and the pregnancy terminated: see *McKay v Essex Area Health Authority* [1982] QB 1166. However, an action may lie at the suit of a parent: damages have been awarded against a physician for failing to warn a patient that there was a possibility of post-vasectomy pregnancy: see *Thake v Maurice* [1986] QB 644; see also *F v R* (1983) 33 SASR 189.

25 This might apply to a doctor who is caring for a child in a clinic in the absence of the parents.

26 S 306.

27 Ss 268, 270, 277 and 280. Where death results from a failure to act, ie, an omission, then a charge of unlawful killing under either s 278 (wilful murder), s 279 (murder) or s 280 (manslaughter) will not lie unless (i) the case falls under one of the duties specified in Chapter XXVII, or (ii) the case falls under s 273, which provides that a person who does any act or makes any omission which hastens the death of another person who was "labouring under some disorder or disease arising from another cause" is deemed to have killed that person.

28 Paras 2.3-2.14.

Chapter 11

QUESTIONS AT ISSUE

The Commission welcomes comment, with reasons where appropriate, on any matters arising out of this discussion paper and in particular on the questions set out below. It will be noted that although the Commission has made provisional suggestions for a statutory scheme the questions below are not limited to the appropriateness or otherwise of the Commission's suggested scheme but cover all the issues dealt with in this paper.

A statutory age for consent to medical treatment

1. Should there be a fixed age under the age of majority (18) at which a minor may consent to medical treatment?
2. If so,
   (i) Should that age be 16 or some other age?
   (ii) What reason do you have for selecting a particular age?
3. What, if any, restrictions would you consider desirable, if such an age were fixed?

Chapter 5 paragraphs 5.11-5.13

A maturity test

4. If a fixed age under the age of majority at which a minor may consent to medical treatment were set, should a minor under that age still be able to consent to medical treatment on his or her own behalf on some demonstration that he or she is mature, ie is of sufficient intelligence and understanding to comprehend the nature and implications of the proposed treatment?
5. If you do not think that there should be a fixed age at which a minor may consent to his or her own medical treatment, should a minor's capacity to consent to medical treatment on his or her own behalf be determined on a case-by-case basis on some demonstration that he or she is mature, ie is of sufficient intelligence and understanding to comprehend the nature and implications of the proposed treatment?
6. If, in either Question 4 or Question 5 above, you are of the opinion that maturity should not be determined on the basis that the minor is of sufficient intelligence and understanding to comprehend the nature and implications of the proposed treatment -
   (i) What reasons do you have for this view?

(ii) Is there an alternative definition of maturity you would wish to see adopted?

Chapters 3 and 4

Chapter 5 paragraphs 5.14-5.16

A presumption of maturity at a fixed age

7. Should there be a statutory age at which it is reasonable to accept that, prima facie, a minor is sufficiently mature to consent to medical treatment on his or her own behalf?

8. If so, should that age be 13 or some other age? What reason do you have for selecting that age?

9. If so, should mature minors under that age be able to consent to their own medical treatment?

Chapter 5 paragraph 5.17

A defence for doctors who treat minors who are not mature

10. Should the law provide that a doctor does not commit any offence and will not be liable to any civil action based on the minor's lack of capacity to consent if

(i) the doctor reasonably believed that the minor was mature; or

(ii) the treatment was necessary to deal with a serious threat to the life or health of the minor?

Chapter 5 paragraphs 5.18-5.22

Particular conditions and medical procedures

11. Should a minor who is either mature or of a statutory age to consent to his or her own medical treatment be able to consent to medical treatment for specified disorders or in specified circumstances only?

12. If so, would such disorders or circumstances include or exclude -

Sexually transmitted diseases?

Contraceptive advice, counselling and treatment?

Drug and alcohol problems?

Pregnancy and determination of pregnancy?

Any communicable disease?

Emotional disturbance?

Alleged sexual or other abuse in the family?

Alleged mental illness?

Psychosurgery, shock therapy, sterilisation, or other treatment?

13. If so, why should these cases be singled out?

Chapter 6

Overriding minors' statutory rights to consent

14. If a minor is given by statute a power to consent to his or her own medical treatment, should any other person be able, in general, to give an alternate consent on the child's behalf? If so, who -
    (i) both parents?
    (ii) one parent?
    (iii) a relative?
    (iv) Director-General, Department for Community Services?
    (v) the Family Court?
    (vi) the Children's Court?
    (vii) some other person or body?
15. If so, should any of the disorders or treatments referred to in the previous paragraph be excepted? If so, which ones, and what reason do you have for making a special rule?
16. On what grounds should a minor's statutory right to consent be overridden by another person?
17. Alternatively, should a minor's consent alone be sufficient?

Chapters 5 and 6, particularly paragraphs 5.12, 5.15, 5.21

Resolving conflicts

18. In the case of a parent or guardian and the minor having conflicting views over the giving or withholding of consent, in what manner should this be resolved?
    If by a court, which court? A Children's Court, the Supreme Court, or the Family Court? If by another agency, which agency?
19. Who should have standing to make applications?
20. To whom should notice be given of such an application -
    (i) a parent?
    (ii) a guardian?
    (iii) a spouse?
    (iv) the Director-General for the Department of Community Services?
    (v) any other person or body?

21. In the case of other conflicts about the medical treatment of minors, for example disputes between parents or involving doctors or wards of the State -

Should conflicts be resolved in the same manner as conflicts between parent and child?

If not, in what way should they be resolved?

Chapter 7

Proving consent

22. What should be the appropriate means of establishing that a valid consent has been given to medical treatment of a minor -

(i) A written form? If so, executed by whom, in what circumstances, and what should the form contain?

(ii) An administrative order from a person or government agency? If so, which person or agency?

(iii) Some other manner?

Chapter 8

Confidentiality

23. Should the usual rules as to the confidentiality of the doctor-patient relationship apply to the provision of health care sought by a minor, whether or not that minor is sufficiently mature or has otherwise acquired the capacity to consent to medical treatment?

24. Should a doctor be entitled to breach such confidentiality? If so, when and on what grounds? What protections would you think desirable?

Chapter 9

Handicapped children

25. (a) Should anyone other than the parent or parents have the right to decide what medical treatment their handicapped child should receive?

(b) If so, who: a doctor, a committee, a social worker, a court, a government official, some other person?

What reason do you have for selecting this person?

(c) If so, on what grounds should someone else make that decision?

26. Should there be special rules for decisions about particular forms of medical treatment, for example treatment which may fail to prolong or actually shorten the child's life? If

so, what criteria would you adopt, and what reason would you give for making special rules?

Chapter 10

Appendix I

ORIGINAL TERMS OF REFERENCE[1]

The Commission was required -

"To inquire into and report upon the existing law in Australia as it concerns minors in relation to -

(i) the provision of surgical, medical, contraceptive, psychiatric, dental and other health and related counselling services;

(ii) participation in experiments and other procedures related to the provision of surgical, medical, contraceptive, psychiatric, dental and other health and related counselling services;

(iii) the provision to other persons of body organs and tissues;

with the object of recommending uniform legislation suitable for enactment in Australia.

In considering the foregoing and without limiting the generality thereof particular regard should be paid to -

(a) the special needs of minors, if any, in respect of counselling, treatment and services concerning drug, tobacco and alcohol dependence and abuse, emergency treatment, sexually transmitted diseases, examination for suspected sexual assault, emotional and psychiatric services and the control and termination of pregnancy;

(b) the age, if any, at which minors should be able to consent or refuse to consent and the means by which such consent, or the refusal of consent, should be given;

(c) the extent to which, and the circumstances in which, the parents, guardians or other persons and institutions responsible for the care and control of minors should be informed, and be able to consent, refuse consent, or overrule consent;

(d) the need to provide legal protection for medical practitioners and other health professionals in respect of the provision of the services referred to above;

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1 Referred 24 June 1981, withdrawn 22 March 1984.

(e) all aspects of the supply to minors of the goods and services which are a necessary adjunct to the provision of surgical, medical, contraceptive, psychiatric, dental and other health and related counselling services;

(f) the extent to which the claims of minors for privacy and confidentiality should be given legal protection;

(g) the position in regard to providing the services referred to above if consent is unreasonably withheld or cannot reasonably be obtained;

(h) the special responsibilities medical practitioners and other health professionals should be expected to exercise in relation to providing the services referred to above to minors."

Appendix II

PRELIMINARY SUBMISSIONS

Abortion Law Repeal Association of WA (Western Australia) (Mrs M Sassi)

Alcohol and Drug Addicts Treatment Board (South Australia) (Mr R G Pols, Director of Treatment Services)

Capital Territory Health Commission (Canberra) (S J Gisz)

Australian Medical Association (Western Australian Branch) (R G Hayward)

Australian Medical Association (Sydney) (John Best)

Catholic Family Welfare Bureau (South Australia) (Mr J O'Neil)

Christian Science Committee (Mr W A Carran)

Daniel, Rev W (Jesuit Theological College)

Deal (C J Borthwick)

Director-General of Health Services (Tasmania) (G Mackay-Smith)

Doctors' Reform Society of New South Wales (Dr A Refshauge)

Education Department (Committee of Guidance Officer)

Family Planning Association of New South Wales (Professor D Llewellyn-Jones)

Family Planning Association of Western Australia (Mr R Hamilton)

General Practitioners' Society in Australia (Western Australia Branch) (Dr J Wearing-Smith)

Guhl, Ms Jenny

Hayes, Dr S C, Senior Lecturer, Department of Behavioural Sciences in Medicine (The University of Sydney)

Health Commission of Victoria (P R Wilkinson, Secretary) (G Lipton, Director)

Hoffman, T D

Kyme, Rev BR (Assistant Bishop of Perth)

Mental Health Services Commission (Tasmania) (Peter Eisen, Chairman and Medical Commissioner)

National Health and Medical Research Council (Canberra) (D de Souza)

O'Bryan, Justice Norman M (Supreme Court of Victoria)

Peters, B

Princess Margaret Hospital for Children (Ms J M Pilgrim, Chief Social Worker)

Public Health Department (Western Australia) (J C McNulty, Commissioner)

Reynolds, Mr G

Right to Life Association (Western Australian Branch) (Mrs Maureen MacKay, Honorary Secretary)

Royal Australian College of Obstetricians and Gynaecologists (Victoria) (Gytha Betheras, Chairman)

Sexual Assault Referral Centre, Sir Charles Gairdner Hospital (Carol D Deller, Clinical Co-ordinator)

South Australian Health Commission (Mr J W Joel, Director)

Appendix III

CONSENT AND MEDICAL TREATMENT: THE PRINCIPLE OF PATIENT AUTONOMY

1. PATIENT AUTONOMY

1. The principle of patient autonomy states that in the absence of special circumstances medical treatment should not be undertaken against the will or without the consent of a patient.[1] This principle is supported by the common law doctrine of consent.[2] There is however no general rule that medical treatment is unlawful in the absence of consent. The proper rule is that medical treatment which involves bodily touching or the deprivation of liberty is unlawful in the absence of consent. Some treatment may be lawful in the absence of consent,[3] and conversely, some may be unlawful despite consent.[4] Therefore, as a statement of positive law, the principle of patient autonomy cannot be based solely on the doctrine of consent.[5]

2. The modern tendency is to base medical malpractice claims in negligence[6] (where the issue of consent is not paramount) and not in trespass[7] (where the issue of consent is crucial).

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1 "Every human being of adult years and sound mind has a right to determine what shall be done with his own body": *Canterbury v Spence* (1972) 464 F 2d 772, 780, quoting Cardozo J in *Schloendorff v Society of New York Hospital* (1914) 105 NE 92, 93.

2 The absence of consent is part of some civil wrongs concerned with the violation of personal integrity: see para 2.4 above. This is equally true of the crime of assault.

3 For example, treatment to save life in an emergency.

4 The absence of consent is neither necessary nor sufficient for liability in negligence: see para 2.8 above.

5 Much medical practice lies in the area of diagnosis, counselling, and the prescription of drugs for self-administration. Negligence is the appropriate remedy for harm from such improper treatment. A doctor who gives careless advice may be liable to a patient for personal injuries and for pure economic loss. Where counselling gives rise to damage, it will in most cases be of a physical or psychological nature, and an action in negligence will lie and there is no need to invoke the specialised and more modern rules relating to negligent misstatement causing pure economic loss: *Mutual Life & Citizens Assurance Co Ltd v Evatt* (1968) 122 CLR 556, reversed [1971] AC 793; *L Shaddock & Associates Pty Ltd v Parramatta City Council* (1981) 150 CLR 225; *San Sebastian Pty Ltd v Minister administering the Environmental Planning and Assessment Act 1979* (1986) 162 CLR 340.

6 See *Sidaway v Bethlem Royal Hospital* [1985] AC 871; *Reibl v Hughes* (1980) 114 DLR (3d) 1.

7 According to Lord Diplock in *Sidaway v Bethlem Royal Hospital* [1985] AC 871, 894, it is wrong to say that trespass will not lie for medical malpractice. This does not seem to be correct. Trespass may lie against a doctor for the performance of medical treatment: see *Cull v Royal Surrey County Hospital* [1932] 1 Br Med J 1195, [1932] 1 Lancet 1377 (consented to abortion by curettage, doctor performed a hysterectomy); *Chatterton v Gerson* [1981] QB 432; *D v S* (1981) 93 LS (SA) JS 405 (liability in trespass for negligently performed mammoplasty); *Hart v Herron* [1984] Aust Torts Reports 80-201. The cases

The most common legal remedy over the entire spectrum of medical treatment is the tort of negligence[8] rather than trespass.[9]

2. THE DOCTRINE OF "INFORMED CONSENT"

3. In some recent cases patients have sued for damages in negligence for non-disclosure of risks associated with medical treatment. The doctrine of informed consent on which they rely claims that a patient has a right to personal medical information, sometimes called the patient's "right to know".[10]

4. This doctrine has been the subject of vigorous judicial and academic debate throughout the common law world.[11] If a doctor fails to disclose information relevant to a treatment decision or to warn of associated risks the patient loses the opportunity to choose whether or not to have the treatment in light of the known risks and the available alternatives.[12] The patient is denied an equal role in the "therapeutic alliance".[13] In a practical sense, the patient is also deprived of the opportunity to take post-operative precautions.[14] Opponents of the informed consent doctrine are concerned at the possibility of

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suggest that negligence rather than trespass is the appropriate remedy except where the treatment consists of a touching substantially different in nature and character from that to which the patient consented: *Cornfeldt v Tongen* (1977) 262 NW 2d 684, 699.

8 As to the doctor's contractual liability, see *Morris v Winsbury-White* [1937] 4 All ER 494. Actions by children for breach of contract for improper medical treatment are dealt with in ch 2 fn 4 above.

9 In Australia there are few reported decisions in which a patient has successfully sued a medical practitioner in trespass, but such actions are not unknown: see fn 7 above. Over fifty years ago Winfield and Goodhart noted that the tort of negligence "had driven the action of trespass for personal injuries into the shade": P H Winfield and A L Goodhart *Trespass and negligence* (1933) 49 LQR 359.

10 Lord Scarman *The Right to Know* 1984 Granada Guildhall Lecture.

11 The leading judicial discussions are: *Sidaway v Bethlem Royal Hospital* [1985] AC 871 (discussed at para 2.10 above); *F v R* (1983) 33 SASR 189 (discussed at para 2.11 above); *Reibl v Hughes* (1980) 114 DLR (3d) 1; *Smith v Auckland Hospital Board* [1965] NZLR 191; *Canterbury v Spence* (1972) 464 F 2d 772.
For academic discussions, see P D G Skegg *Informed consent to medical procedures* (1975) 15(2) Med Sci Law 124; A Meisel *The expansion of liability for medical accidents: From negligence to strict liability by way of informed consent* (1977) 56 Neb L Rev S1; M Brazier *Informed consent to Surgery* (1979) 19 Med Sci Law 49; G Robertson *Informed consent to medical treatment* (1981) 97 LQR 102; H Teff *Consent to medical procedures: Paternalism, self-determination or therapeutic alliance?* (1985) 101 LQR 432 (hereafter cited as Teff); D Manders *Following doctors' orders: Informed consent in Australia* (1988) 62 ALJ 430.
See also Victorian Law Reform Commission *Informed Consent: Symposia* (1986); Victorian Law Reform Commission *Informed consent to medical treatment* (Discussion Paper No 7 1987).

12 The problems facing a litigant in recovering damages on this basis are illustrated by the recent case of *Gold v Haringey Health Authority* [1987] 2 All ER 888. The plaintiff became pregnant after undergoing a sterilisation operation. She complained that the doctor had not advised her of the advantages of her husband undergoing a vasectomy. The action failed. See also *F v R* (1983) 33 SASR 189.

13 See Teff passim. The concept of a "therapeutic alliance" is based on the idea that it is sensible and sound medical practice to share decision-making wherever possible. A "therapeutic alliance" can only work if there is an open exchange of information relating to the patient's condition.

14 *Thake v Maurice* [1986] QB 644.

increased health costs resulting from expanded liability in tort,[15] question the assumption that medical judgments should be subject to patient, let alone judicial, review, and argue that there are many cases where it is good medical practice to withhold information from a patient.[16]

5. A doctor and a fully informed patient may well disagree about whether to have or continue with a particular treatment. Only in exceptional circumstances does a doctor have a right to treat a non-consenting patient. In general, the patient has a right to refuse[17] medical treatment, which presupposes a right to be informed as to its nature and likely risks.[18] This right is not eclipsed by the doctor's responsibility to exercise medical judgment.

6. The informed consent doctrine has little relevance to an action in trespass; consent based upon a full appreciation of the nature and purpose of the proposed treatment does not cease to be effective merely because the doctor failed to disclose all relevant risks.[19] The question is whether the patient understood the specific nature of the bodily touching and assented to it.

7. In relation to negligence, the attempt to derive a duty to warn from the doctrine of informed consent has met with only limited success.[20] A failure to disclose known medical risks may constitute a breach of a duty of care owed by a doctor to his patient but although according to the orthodox view the basis for determining the relevant standard of care is

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15 Even in the United States the informed consent doctrine has not led to significant payouts in medical malpractice cases: Teff 434 fn 20.

16 This is not inconsistent with the doctrine of informed consent. Under the doctrine of "therapeutic privilege" a doctor may withhold information which is reasonably considered to be harmful; for example, knowledge of possible pain might so affect the patient's courage that essential treatment would be declined. For the high water mark of this doctrine see *Hatcher v Black* The Times, 2 July 1954 (see also Lord Denning *The Discipline of Law* (1979) 242. According to the US President's Commission for the Study of Ethical Problems in Medicine "…. there is much to suggest that therapeutic privilege has been vastly overused as an excuse for not informing patients of facts they are entitled to know", quoted, Teff 441.

17 The patient does not usually have any right to demand a particular treatment which the consulting doctor opposes. A patient may seek alternative advice, if it is available.

18 The duty of disclosure is qualified by a duty to withhold information which may be harmful to the patient. A doctor may rely upon the doctrine of "therapeutic privilege" to justify non-disclosure: see also A Meisel *The "exceptions" to the informed consent doctrine: Striking a balance between competing values in medical decisionmaking* [1979] Wis L Rev 413, 460-470.

19 *Chatterton v Gerson* [1981] QB 432, 442-3*; Hatcher v Black* The Times, 2 July 1954. However, in the American case of *Canterbury v Spence* (1972) 464 F 2d 772 it was suggested that trespass was an appropriate cause of action where the defendant doctor failed to provide full information about the nature of the treatment and the risks involved.

20 The doctrine was rebuffed by the House of Lords in *Sidaway v Bethlem Royal Hospital* [1985] AC 871; but it was more favourably received in South Australia: see *F v R* (1983) 33 SASR 189; *Battersby v Tottman* (1985) 37 SASR 524, 537 per Zelling J; *Gover v State of South Australia* (1985) 39 SASR 543, 551-553.

whether the doctor acted in accordance with a responsible body of medical opinion,[21] the wisdom of this has not gone unquestioned.[22]

3. EXCEPTIONS TO PATIENT AUTONOMY

8. As a statement of positive law, the principle that medical treatment should not be undertaken against the will or without the consent of the patient is qualified by a host of exceptions dealing with public health[23] and child protection. There are special cases where a patient's capacity to contribute to decision-making is diminished or lacking.[24] Sometimes public health or safety may justify treatment without consent, and, in extreme cases, against the patient's will.[25]

9. Different considerations apply according to whether treatment was given without consent, or was against the will of the patient. It may be possible to justify treatment by reference to an "implied" consent where consent is merely absent but impossible to do so where consent is actively withheld.[26]

10. Courts would almost certainly protect any person who acted in order to save life, even against the will of the patient, provided that the intervention did not aggravate the patient's condition.[27] Whether forcible treatment (ie, treatment against the patient's will) could be justified by something less than the immediate need to preserve life is another matter. Where the consequence of non-intervention is likely to be death or serious injury, the intervener is unlikely to incur liability. Where a patient has severely limited intellectual powers there may be a case for permitting treatment without consent.[28] In some cases it is an offence to refuse

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21 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, 122 per McNair J. *In Sidaway v Bethlem Royal Hospital* [1985] AC 871, a majority favoured this approach.

22 *F v R* (1983) 33 SASR 189, 193-194 per King CJ.

23 For examples, see the statutory provisions cited in ch 3 fn 45, and *Health Act 1911* s 263 (infectious diseases); ss 293-294 (tuberculosis); ss 298-299, 307 (venereal disease); *Mental Health Act 1962* ss 29-32, 36.

24 For example, intellectually impaired persons and minors may, in some cases, lack sufficient powers of understanding to participate in treatment decisions other than as passive subjects.

25 See P D G Skegg *A justification for medical procedures performed without consent* (1974) 90 LQR 512; *Criminal Code* s 259.

26 The resuscitation of a patient who has given express, cogent, and lucid instructions against revival in specific circumstances (such as after a stroke) might well be wrongful.

27 See *Criminal Code* s 25 and R S O'Regan *The defence of sudden or extraordinary emergency in the Griffith Code* (1985) 9 Crim LJ 347; *Marshall v Curry* [1933] 3 DLR 260.

28 For example, compulsory treatment in an approved (psychiatric) hospital under the provisions of the *Mental Health Act 1962*.

treatment.[29] Most jurisdictions have, for example, in one form or another, legislated to authorise compulsory inoculation against infectious diseases.[30] Conversely, certain procedures may be outlawed by legislation despite patient consent.[31]

4. TREATMENT OF MINORS

11. What particular features of a therapeutic relationship between doctor and patient are qualified when the patient is a minor? Any relationship between doctor and patient is characterised by a degree of reliance and dependence; factors which promote paternalism.[32] This tendency is magnified in dealings with minors.[33] Children, especially young children, are vulnerable to exploitation. This may call for supervision or intervention by health or welfare authorities, even against the will of children and parents.[34] Young children are usually deferential to, and easily pressured by, authority figures. They often have active imaginations and limited language skills. They are suggestible and easily frightened. Adults act instinctively to protect children, especially young children, from pain and from the fear of pain. Adults tend to comfort children in distress by understating danger and downplaying the

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29 Eg, s 251(5) of the *Health Act 1911*, which avoids the problems which confronted American authorities in 1938. Mary Mallon, an Irish cook, was found to be a typhoid carrier and responsible for a series of epidemics of that disease, which were caused by her involvement in and the nature of her employment. She declined voluntarily to restrict her working activities to limit the chances of such outbreaks and was eventually detained involuntarily for quarantine purposes to preserve community health. Her soubriquet, "Typhoid Mary", has since become a synonym for a person who is by force of circumstances a source from which something thoroughly undesirable spreads.

30 Eg *Health Act 1911*.

31 For example, the *Mental Health Act 1983* (NSW) s 180 (not yet in force) outlaws prolonged deep sleep therapy and insulin coma therapy.

32 Buchanan *Medical paternalism* (1978) 7 Philosophy and Public Affairs 370.

33 Recent writings on medical law reveal a tension between the paternalistic tendencies of the medical profession and the rights philosophy of those who emphasise patient autonomy and self-determination. Paternalism emphasises professional medical judgment and shields doctors from supposedly irksome duties of explanation and disclosure. It assumes that doctors have exclusive responsibility for determining the best interests of the patient. Those who emphasise patient autonomy and self-determination seek to maximise patient participation in the healing process. The patient is viewed as an active participant and not as a passive subject: see A Meisel *The "exceptions" to the informed consent doctrine: Striking a balance between competing values in medical decision-making* [1979] Wis L Rev 413.

34 However, as evidence presented at the recent Cleveland Inquiry into alleged sexual abuse in Middlesbrough, England strikingly illustrates, in some cases it may be necessary to protect children and parents from health workers and doctors. This may require some re-evaluation of the rights of children. "It seems incredible that a desire to protect children can be transmuted into a more sophisticated form of actual cruelty because we have lost sight of the essential right of the child, especially one who has been abused in any way, to exercise some degree of autonomy": M E Rayner *The right to remain silent: The interrogation of children*, paper delivered at the Australian Institute of Criminology Seminar *Children as Witnesses*, 3-5 May 1988.

risk of harm.[35] These are ploys which may cease to be appropriate at a certain stage, perhaps the point at which the child says: "Stop treating me like a child!".

12. As a general principle a person (whether adult or child) who is capable of thinking rationally about the factors which persons of mature and healthy mind would ordinarily contemplate in reaching a decision about an important matter, is naturally capable of participating in a therapeutic alliance as an equal partner.[36] Any child, regardless of age, who fully understands the nature and consequences of specific treatment could be an equal partner in the treatment process. Experience suggests that few children under twelve or thirteen would have this capacity, but some might. This requires a doctor to explain the treatment proposed very carefully, taking into account the patient's state of intellectual and linguistic development.

5. THE ELEMENTS OF CONSENT

13. Assuming that the treatment is one for which consent must be obtained, what are the requirements of a valid consent?[37] A valid consent requires (a) legal capacity,[38] (b) freedom of choice, (c) proper timing,[39] and (d) relevance.[40]

14. The first of these requirements is discussed at length in chapters 3 to 5 of this paper. As to the second requirement, children have a natural tendency to acquiesce in decisions made by adults (who are usually in a position of authority over the child) even if they do not in fact understand or agree with the proposed treatment. Acquiescence obtained through fraud or as a result of a mistake or misrepresentation is not consent, and non-disclosure of material information may in some circumstances amount to a misrepresentation.

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35 In the United States it is recognised that the disclosure of frightening information may be tortious in some circumstances. See W L Prosser and P Keeton *Law of Torts* (5th ed 1983) ch 2 s 12; P R Handford *Intentional infliction of mental distress: Analysis of the growth of a tort* (1979) 8 Anglo-Am LR 1.

36 A decision to undertake medical treatment might include consideration of factors such as: likely pain, economic costs and benefits, capacity for future enjoyment of life, aesthetic considerations, the implications for family members and for future development, and so on.

37 See generally P W Young *Law of Consent* (1986) chs 1-7.

38 The person consenting must have legal capacity to consent, whether that person is the patient or a representative of the patient.

39 The consent must have been given at the time at or within a reasonable time before the relevant act took place.

40 The thing done must relate to the consent given. An act substantially different from that to which consent was given may well incur liability.

15. Similarly, an apparent consent obtained by the overpowering of a person's will is not a real one. Duress, undue influence or coercion vitiate consent by actually depriving a person of the opportunity of making a choice about whether or not to submit to or acquiesce in a course of action.[41] Whether in any given case moral, social or emotional pressure is such as to amount to duress is a matter of degree. Some special relationships, of which the doctor/patient relationship is one, may be such that pressure which would not affect an adult could amount to undue influence over a child and negate any apparent consent.

16. Furthermore, special considerations apply to the relationship between a doctor and a child patient, bearing in mind the comparative powerlessness of a child in any adult/child relationship, as well as the actual limitations placed on any patient's power to make choices when the patient does not possess the professional knowledge and experience on which a professional opinion is based (something which might be termed the natural disadvantage of laity).

17. Where there are alternative treatments, then clearly the parent should be advised as to their respective merits and demerits. The choice must be based on sufficient information about the nature and likely effects of the proposed treatment to enable the patient to make a reasoned decision. A doctor who fails to inform a patient as to the existence of an alternative treatment may be liable in negligence.[42]

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41 The law relating to the protection of children under pressure is discussed by the Commission in its report *Minors' contracts* (Project No 25 Part II).

42 *F v R* (1983) 33 SASR 189.

Appendix IV

1. FAMILY PLANNING ASSOCIATION OF WESTERN AUSTRALIA POLICY ON MEDICAL ADVICE TO AND TREATMENT OF MINORS

A clinician is justified in counselling or treating a minor without parental knowledge or consent, providing that the clinician is satisfied that:

1. the minor has sufficient maturity to understand the advice and treatment and its implications, and so to give informed consent;

2. the clinician cannot persuade her to inform her parents or to allow them to be informed that she is seeking contraceptive or other medical advice;

3. the minor is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment;

4. unless the minor receives appropriate advice or treatment her physical or mental health or both are likely to suffer;

5. the minor's best interests require her to be given medical treatment, advice, or both, without parental consent.

This policy is based on the judgment of the House of Lords in the *Gillick* case in the United Kingdom. The policy has been amplified in the document Medical Advice to and Treatment of Minors, which is printed in the Clinicians' Handbook, and staff should follow the guidelines set out there.

February 1986

2. FAMILY PLANNING ASSOCIATION OF WESTERN AUSTRALIA DOCUMENT "MEDICAL ADVICE TO AND TREATMENT OF MINORS"

Preamble

In considering guidelines for medical advice to and treatment of minors, it is important to consider what is in the best interests of the adolescent. There is always tension between the rights of parents to be involved in decisions about their children, and the rights of children to privacy and access to appropriate services. In the face of a vague legal situation, this will inevitably involve uncertainties for clinicians. Some comments from Paxman (1984)[1] are pertinent here.

> "Ready access to fertility regulation services should be a basic requirement [for adolescents] . . . Any program involving services to adolescents should strive to ensure two things (i) that those adolescents who need care are provided with it and are fully informed of all the foreseeable consequences; and (ii) that the doubts doctors and other health personnel have about the legality of treating minors are minimized by appropriate legal and educational processes.
>
> . . . When faced with unclear laws and policies, health care personnel will interpret them in ways which minimize or eliminate the risk of legal controversy to themselves: this may not, however, serve the best interests of the adolescent."

It is generally agreed that at some stage a person under the age of 18 does have the capacity to consent to the giving of medical advice or the provision of medical treatment. However it is not clear at what stage the minor has this capacity.

In the Law Lords' judgment in the *Gillick* case in the United Kingdom (October 1985) the Lords supported the UK Department of Health and Social Security Memorandum of Guidance on family planning services for young people.

The Law Lords' judgment provides support for the premise that young people under 16 have the legal capacity to consent to advice and treatment. In the majority judgment, Lord Fraser

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[1] Paxman J M *Law, policy and adolescent fertility: An international overview* (London: International Planned Parenthood Federation 1984).

said he was not disposed to hold that a girl less than 16 lacked the power to give valid consent to contraceptive advice and treatment, merely on account of her age. He argued that a girl under the age of 16 has the legal capacity to consent to contraceptive advice, examination and treatment, provided that she has sufficient intelligence and understanding to know what they involve.

FPA Policy

Based on the majority opinion in the *Gillick* case, the Family Planning Association policy on advice and treatment of minors states that:

A clinician is justified in counselling or treating a minor without parental knowledge or consent, providing that the clinician is satisfied that:

1. the minor has sufficient maturity to understand the advice and treatment and its implications, and so give informed consent;

2. the clinician cannot persuade her to inform her parents or to allow them to be informed that she is seeking contraceptive or other medical advice;

3. the minor is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment;

4. unless the minor receives appropriate advice or treatment her physical or mental health or both are likely to suffer;

5. the minor's best interests require her to be given medical treatment, advice, or both, without the parental consent.

Informed Consent

Informed consent is a most important requirement. As Paxman (1984) has pointed out, a minor cannot give informed consent unless he/she is mature enough to understand the explanation. Furthermore, 'the ability to consent may be affected by the nature and

seriousness of the treatment'. If the minor is not able to understand the explanation, then the informed consent of the parent or guardian must be obtained unless there is an emergency or Court permission is obtained. An extract from Contraceptive Technology 1984-1985 (attached)[2] details seven basic components which need to be considered in obtaining informed consent.

Guidelines for staff

1. Where medical diagnosis, advice, treatment, prescription, or surgical intervention is sought by a person who appears to be under the age of 18 years, staff should be aware of the need not to undermine parental responsibility and family stability.

2. The treating professional should tactfully enquire into the circumstances of the minor, and where appropriate, e.g. in the case of a minor living at home, should seek to persuade the minor to involve her parent or guardian. For girls under 16, parental consent should be obtained wherever possible.

3. In making a decision about the provision of contraceptive advice and/or treatment to clients under 18 years, the doctor must consider the maturity of the client, taking into account her age, intelligence, life circumstances, and her understanding of the advice or treatment and its implications.

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[2] The attached extract from R A Hatcher et al *Contraceptive Technology 1984-85* (1984) reads as follows -
"The importance of informed consent in family planning has three bases: 1) pragmatic, 2) ethical, and 3) legal. Pragmatically, a person who thoroughly understands her/his contraceptive method will be more likely to use it safely and effectively. Ethically, every person has a right to complete information about her/his method. Legally, the clinician must provide adequate information to help the person reach a reasonable and informed decision about family planning medications and procedures.
The issue of informed consent is particularly crucial in the field of contraception because of the 'non-therapeutic' nature of these services. That is, family planning methods and medications are usually initiated at the request of a healthy person and in the absence of 'traditional' medical indications for treatment.
Informed consent comprises seven basic elements. A simple mnemonic (BRAIDED) may prove useful in remembering the seven basic components:

Benefits of the method
Risks of the method (both major and common minor ones)
Alternatives to the method (including abstinence and no method)
Inquiries about the method are the patient's right and responsibility
Decisions to withdraw from using the method are the patient's right
Explanation of the method (what to expect and what to do) is owed the patient
Documentation of the above

The importance of a voluntary decision - free of any coercion - is self evident. Documentation is essential. Legally the documentation of discussion and patient understanding is of primary importance.

4. Regardless of the age of the patient, informed consent to treatment must be obtained. If it appears that the client is not capable of understanding the advice or explanation given, the doctor cannot proceed without the informed consent of the parent or guardian. The treatment of any person without fully explaining that treatment, or advice to any person which is less than total and complete and capable of being understood by that person would be negligent.

5. Consultations between doctor and patient are confidential and the confidence should not be broken in the case of a minor, unless for the most exceptional reasons.

6. For legal reasons it is not advisable to see or counsel the sexual partners of girls under 16 years of age (the legal age of consent).

   This is for the protection of the girl, the practitioner and the Association, because it is an offence for a person to have sexual relations with a girl under the age of consent (usually 16 years). To counsel a sexual partner of that girl, knowing that the relationship was ongoing, or would take place in the future, would be seen by the police, upon complaint, as an offence by the counselling practitioner. If the name of the partner was known, the medical practitioner could then be forced to give evidence in court to identify that person.

3. STATEMENT USED IN KING EDWARD MEMORIAL HOSPITAL

This statement originates from the Western Australia Health Department, and has been published in the King Edward Memorial Hospital Bulletin - presumably as a guide to clinical practice in the hospital.

1. Minor's consent to treatment

2. Obligation to notify parents

There is no statute or case law in Western Australia on the ability of minors to consent to or refuse medical treatment. However the definitive statement of the principles involved may be

taken as stated in *Gillick v West Norfolk Health Area Authority* [1985] 3 All ER 402. The UK House of Lords regarded the applicable law to be as follows:-

1. A parent's right to determine whether or not his or her child will have medical treatment ceases when the minor achieves sufficient capacity to understand the nature and consequences of the proposed treatment. There is no fixed age as to when a minor gains this capacity and it will always be a question of fact as to whether a minor has that capacity.

2. Until a minor achieves the capacity to consent the parental right to decide continues except in exceptional circumstances (emergency, neglect, abandonment or inability to find the parent) where treatment without parental consent can be justified.

Whether the minor has the capacity to consent (or refuse) medical treatment or procedures depends on the minor and the nature of the treatment or procedures proposed. The Medical Practitioner using his clinical judgment and general discretion is entrusted with the responsibility of establishing whether a patient who is a minor is capable (or otherwise) of giving competent care.

If a minor is considered to be capable of giving or refusing consent to medical treatment or procedures then there is no legal requirement to take into account the wishes of the parents or any other person, although in many circumstances it may be desirable to consult with their parents or guardians.

If the medical practitioner in direct charge of the patient is not satisfied that the patient has the capacity to consent, he or she may decide whether it is in the patient's best medical interest to disclose the information learned from the consultation, but if this is to be done, the patient ought to be informed. Trust placed in the medical practitioner by a patient should also influence the judgment as to whether or not to disclose the information.

In summary - each situation is unique and should be dealt with after careful assessment of all the available facts.

Appendix V

UNITED KINGDOM DEPARTMENT OF HEALTH AND SOCIAL SECURITY GUIDELINES

1. ORIGINAL GUIDELINES

The guidelines issued by the DHSS provided:

> "Clinic sessions should be available for people of all ages, but it may be helpful to make separate, less formal arrangements for young people. The staff should be experienced in dealing with young people and their problems.
>
> There is widespread concern about counselling and treatment for children under 16. Special care is needed not to undermine parental responsibility and family stability. The Department would therefore hope that in any case where a doctor or other professional worker is approached by a person under the age of 16 for advice on these matters, the doctor, or other professional, will always seek to persuade the child to involve the parent or guardian (or other person in loco parentis) at the earliest stage of consultation, and will proceed from the assumption that it would be most unusual to provide advice about contraception without parental consent.
>
> It is, however, widely accepted that consultations between doctors and patients are confidential, and the Department recognises the importance which doctors and patients attach to this principle. It is a principle which applies also to the other professions concerned. To abandon this principle for children under 16 might cause some not to seek professional advice at all. They could then be exposed to the immediate risks of pregnancy and of sexually transmitted disease, as well as other long-term physical, psychological and emotional consequences which are equally a threat to stable family life. This would apply particularly to young people whose parents are, for example, unconcerned, entirely unresponsive, or grossly disturbed. Some of these young people are away from their parents and in the care of local authorities or voluntary organisations standing in loco parentis.

The Department realises that in such exceptional cases the nature of any counselling must be a matter for the doctor or other professional worker concerned and that the decision whether or not to prescribe contraception must be for the clinical judgment of a doctor."

2. AMENDED GUIDELINES

The DHSS amended its guidelines after *Gillick* to provide -

"1. In considering the provision of advice or treatment on contraception, doctors and other professional staff need to take special care not to undermine parental responsibility and family stability. The doctor or other professional should therefore always seek to persuade the young person to tell the parents or guardian (or other person in loco parentis), or to let him inform them, that contraceptive advice is being sought and the nature of any advice or treatment that is given. It should be most unusual for a doctor or other professional to provide advice or treatment in relation to contraception to a young person under 16 without parental knowledge or consent.

2. Exceptionally, there will be cases where it is not possible to persuade the young person either to inform the parents or to allow the doctor or other professional to do so. This may be, for example, where family relationships have broken down. In such cases, a doctor or other professional would be justified in giving advice and treatment without parental knowledge or consent, provided he is satisfied -

(a) that the young person could understand this advice and had sufficient maturity to understand what was involved in terms of the moral, social and emotional implications;

(b) that he could neither persuade the young person to inform the parents, nor to allow him to inform them, that contraceptive advice was being sought;

(c) that the young person would be very likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment;

(d) that, without contraceptive advice or treatment, the young person's physical or mental health, or both, would be likely to suffer;

(e) that the young person's best interest required him to give contraceptive advice, treatment or both without parental consent.

3. Decisions about whether to prescribe contraception in such cases are for a doctor's clinical judgment. If a doctor who is not the young person's general practitioner has formed the view, after due consideration of the points made above, that it is in the best interests of the young person to prescribe contraception without parental knowledge or consent, it may be advisable and helpful for him, with the young person's agreement, to discuss the matter in confidence with her own general practitioner before making his decision.

4. In organising contraceptive services for young people, health authorities may find it helpful to make separate, less formal arrangements than those for older age groups. The staff should be experienced in dealing with young people and their problems."