REFUSAL OF MEDICAL TREATMENT – A CHILD'S PREROGATIVE?

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I INTRODUCTION

Society has a need for children to be able to make health care decisions.[1] Homeless children need access to health care. Parents may not be accessible or competent to consent to their child's health care. The familial relationship may have broken down. Children may not want their parents to know about drug, alcohol or pregnancy related issues. There is legal and academic support for the right of children to make autonomous decisions with respect to their health care.[2] However, what these decisions cover and who can make them is not clear.

Whether or not a minor has capacity and is therefore competent to consent to medical treatment is a question of law. Some states of Australia have enacted legislation, while others rely on the common law to determine this issue.[3] At common law a minor is capable of giving consent to medical treatment when he or she achieves a sufficient understanding and intelligence to be able to understand fully what is proposed.[4] Known as 'Gillick competence'[5] this is a well known principle of law. The question posed by this paper is whether the decision of a 'Gillick competent' child can and should be overridden by the court?[6]

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1 A reference to the words 'child', 'children' and 'minor' in this article are synonymous and refer to a person who has not reached the age of majority which, in Australia, is 18 years of age; *Age of Majority Act 1974* (Qld) s 5.

2 J Potter, 'Rewriting the Competency Rules for Children: Full Recognition of the Young Person as Rights Bearer' (2006) 14 *Journal of Law and Medicine* 64, 69.

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

4 *Secretary, Department of Health and Community Services v JWB ('Marion's Case')* (1992) 106 ALR 385, 395.

5 See *Gillick v West Norfolk AHA* [1986] AC 112, 189.

6 The arguments constructed and analysis undertaken in this paper endeavour to encompass decisions made by 'Gillick competent' children in relation to both consent and refusal of medical treatment. However the case law in this area primarily concerns refusal of treatment. The court will override a 'Gillick competent' child's refusal of medical treatment where such refusal poses a risk to the child's health and survival. Generally this occurs where a child has refused life-saving treatment. However if a child consented to treatment which posed such a risk, it is likely a court could override the decision if the decision is not in the child's best interests. Case law does not illustrate this point because it is

Can a 'Gillick competent' child refuse health care, particularly when to do so may result in serious injury, illness or death? This is an important area of law due to the practical implications. For example, in the United Kingdom, the only chance of survival for a 14 year old girl, who suffered cardiomyopathy, was to undergo a heart transplant. The child, named Hannah, refused to consent to the operation and this decision was supported by her parents. Following an interview with child protection officers, it was determined that the child was mature enough to make the decision for herself.[7] She had spent much of her life in hospital having been diagnosed with acute myeloid leukaemia at 4 years of age. Hannah had undergone over 20 major operations and had been close to death on many occasions. She wanted to die with dignity at home with family and friends at her side.[8] Should this child's decision be respected or should all attempts be made to protect her life?[9]

This is a difficult emotive question which is not dealt with consistently by legislation or legal precedent. Once it is established that a child is 'Gillick competent' and, therefore, has capacity to make decisions relating to the proposed medical treatment, there is academic argument which suggests the child should be treated as a competent adult and entitled to make all medical decisions for which he or she has capacity, even if they involve high risk and complicated procedures.[10] However, case law in both the United Kingdom and Australia does not reflect this.

A court can override decisions made by minors relating to medical treatment where it is in the child's best interests to do so. The inherent powers of the *parens patriae* jurisdiction allow this. *Parens patriae* is a discretionary jurisdiction developed to protect the vulnerable and those who cannot look after themselves.[11] This paper analyses the *parens patriae*, in light of its historical development, and reaches two conclusions. The first is that the jurisdiction extends to all children including those found to be 'Gillick competent'. This conclusion is reached after an extensive examination of the history and application of the jurisdiction and an analysis of relevant case law. The second conclusion is that it is not an appropriate exercise of the court's discretion to invoke the jurisdiction to override the decision of a 'Gillick competent' child. A thorough and critical examination of factors taken into account by the court in its determination of whether or not to invoke the *parens patriae* jurisdiction is undertaken.

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unlikely such treatment would be offered. However the writer can see no reason why, if the court applies the *parens patriae* jurisdiction to refusal of treatment, it would not do the same for consent. On this basis, the conclusions reached in this paper apply to both consent and refusal of medical treatment by 'Gillick competent' children.

7 J Percival and P Lewis, 'Teenager Who Won Right to Die: I Have Had Too Much Trauma', *Guardian* (online), 11 November 2008 <http://www.guardian.co.uk/society/2008/nov/11/child-protection-health-hannah-jones>.

8 <http://sixtyminutes.ninemsn.com.au/stories/lizhayes/799741/hannahs-choice>. Whilst court proceedings had been instigated by the Health Authority, these were subsequently abandoned. As a result, Hannah's decision to refuse treatment was not challenged in a court of law.

9 Hannah subsequently changed her mind while in hospital for kidney treatment and consented to a heart transplant. Richard Smith, 'I'm Feeling Brilliant Says Hannah Jones, The Girl Who Wanted To Die, Then Got a New Heart', *Mirror* (online), 17 August 2009 <http://www.mirror.co.uk/news/top-stories/2009/08/17/i-m-feeling-brilliant-115875-21602215/>.

10 L Bunny, 'The Capacity of Competent Minors to Consent and Refuse Medical Treatment' (1997) 5 *Journal of Law and Medicine* 53, 78.

11 *Re X (a Minor)* [1975] 1 All ER 697, 700 refers to *Wellesley v Wellesley* [1824-34] All ER 189, 194.

Current legislation is explored to provide insight to the context in which some Australian jurisdictions allow children to consent to medical treatment. The need to obtain consent and elements of capacity are briefly addressed. However, the main focus of this paper involves an exploration and analysis of the *parens patriae* jurisdiction and the extent of its application to medical decisions made by 'Gillick competent' children.

II WHY IS CONSENT NECESSARY?

Prima facie, it is illegal to make or threaten to make physical contact with a person without their consent.[12] A person can be found to be criminally liable for assault or liable for the civil tort of trespass to the person.[13] Consent has the effect of transforming what would otherwise be unlawful into acceptable contact.[14] Generally consent from a patient is required in order to lawfully administer medical treatment.[15] It must be given voluntarily[16] and relate to the treatment being provided.[17] In addition, the patient must have the requisite capacity to consent to treatment. There is a rebuttable presumption that an adult has capacity to consent to medical treatment.[18] However, this presumption does not apply to children. A child is presumed incompetent unless he or she satisfies the test of 'Gillick competence'.

III WHAT IS THE CURRENT LAW REGARDING THE CAPACITY OF MINORS TO CONSENT TO MEDICAL TREATMENT?

Not all jurisdictions rely on the common law test of 'Gillick competence.' Some jurisdictions have passed legislation facilitating the ability of children to consent to medical treatment.

A *Legislation*

The *Consent to Medical Treatment and Palliative Care Act 1995* (SA) treats decisions about medical treatment made by children 16 years and over as if they were an adult.[19] The object of the South Australian Act is to allow such persons to decide whether *or not* to undergo medical treatment.[20] The Act refers to refusal of treatment as well as consent.

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12 *Criminal Code 1899* (Qld) s 245, 246. A person who strikes, touches or moves or otherwise applies force of any kind to the person of another, either directly or indirectly, without the person's consent ... is said to assault that other person and the act is called an 'assault'. Assault is an offence unless justified or excused by law.

13 *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's Case)* (1992) 106 ALR 385, 391.

14 Ibid 391.

15 There are exceptions such as emergency medical treatment. *Criminal Code 1899* (Qld) s 286 provides that it is the duty of every person who has care of a child under 16 years to take the precautions that are reasonable in all the circumstances to avoid danger to the child's life, health or safety. *Transplantation and Anatomy Act 1979* (Qld) s 20 allows a medical practitioner to administer a blood transfusion to a child without parental consent if it is necessary to preserve the child's life.

16 *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95.

17 Bunney, above n 10, 54, refers to *Murray v McMurchy* [1949] 2 DLR 442.

18 *Hunter and New England Area Health Service v A* [2009] NSWSC 761 [23] refers to *Re MB* [1997] 2 FCR 514, 553. See also *In re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782, 796.

19 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 6.

20 *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 3. This section states the objects of the Act. The object of s 3(a)(i) is to allow persons of or over the age of 16 years to decide freely for themselves on an informed basis whether or not to undergo medical treatment.

It also allows a medical practitioner to administer medical treatment to a consenting child under 16 years of age without the consent of the child's parent or guardian, provided the child understands the nature, consequences and risks of the treatment, the treatment is in the child's best interests and the medical practitioner has the written support of at least one other medical practitioner who has examined the child.[21] Although the South Australian legislation allows for children to consent to and refuse medical treatment, where a child is under 16 years court intervention may still be required to make a determination of whether or not the treatment is in the child's 'best interests', or whether the child has the requisite understanding of the nature, consequence and risks involved in the treatment.

New South Wales legislation provides protection to a medical practitioner against a claim for assault or battery, where a minor aged 14 years and over provides consent to medical treatment.[22] However, the legislation does not confer a general capacity on children to consent to or refuse medical treatment and does not prevent a court overriding the child's decision if the decision is not in the child's best interests.

There is also legislation precluding children from undergoing certain procedures until they reach the age of majority. For example the *Health Legislation (Restriction on Use of Cosmetic Surgery for Children and Another Measure) Amendment Act 2008* (Qld) prohibits certain cosmetic surgery being carried out on a minor.[23] It is an offence to administer a tattoo to a minor.[24] In each case it is irrelevant whether the child consents to such treatment. Parliament has overruled the possibility of children consenting to certain medical treatment by placing an age limit on the person wishing to have the procedure undertaken.[25]

In summary, there are aspects of medical treatment to which children are unable to consent. Other circumstances exist where legislation allows children to consent to treatment; however, in most cases these decisions can be overruled by a court if the decision is not in the child's best interests. An exception to this is in South Australia where a child of 16 years is treated as if he or she were an adult.

B *Common Law*

In jurisdictions where there is no legislation prescribing whether or not a child can consent to medical treatment, the common law applies. The test of 'Gillick competence' has been adopted into Australian common law so that a minor is capable of consenting to medical treatment when he or she 'achieves a sufficient understanding and

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21 Ibid ss 12(b)(i)-(ii). In terms of the ability of the child, this is, essentially restating the test of 'Gillick competence'.

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

23 Section 5 of this Act inserted a chapter in the *Public Health Act 2005* (Qld). *Public Health Act 2005* (Qld) s 213B, makes it an offence to perform cosmetic surgery on a child. Prohibited procedures are outlined in *Public Health Act 2005* (Qld) s 213A.

24 *Summary Offences Act 2005* (Qld) s 19; *Summary Offences Act 1953* (SA) s 21A; *Children and Young People Act (2008)* ACT s 877(1) makes it an offence to administer a tattoo to a child or young person without agreement in writing from a person who has the daily care or long term responsibility for the child or young person. See also *Children and Community Services Act 2004* (WA) s 103.

25 It should be noted that there are procedures to which an adult is unable to consent in Queensland such as female genital mutilation, other than for genuine therapeutic purposes. *Criminal Code 1899* (Qld) s 323A.

intelligence to enable him or her to understand fully what is proposed.'[26] No fixed age attaches to this legal principle and, as a consequence, the test for capacity imposes a significant onus and discretion upon the treating professional's assessment of the minor.[27]

Where a child lacks capacity, consent to medical treatment will usually be provided by the child's parents or guardian, save for exceptional circumstances where a doctor can proceed without consent such as emergency, parental neglect, abandonment of the child or an inability to find the parent(s).[28] Added to these are certain procedures where parental consent is insufficient at law and court authorisation in required. These include, for example, non-therapeutic sterilisation,[29] gender reassignment,[30] removal of organs for transplant[31] and bone marrow transplant.[32]

Parental power to consent to medical treatment on a child's behalf diminishes gradually as the child matures and his or her capacities grow. This rate of development depends upon each individual child.[33] At common law, the decision making process in an adult comprises of comprehension and retention of information material to the treatment decision including the likely consequences of having the treatment (or not), believing the information and the ability to use and weigh the information to arrive at a decision.[34] This also applies to children.[35] If the patient suffers from a compulsive disorder or phobia which distorts the information presented then this may also affect competency.[36] In addition, temporary factors such as confusion, shock, fatigue, pain or drugs may erode capacity to the extent that the patient is no longer competent to make a decision.[37]

Capacity varies according to the nature of the treatment. A person may be competent to make a decision in respect of one treatment but incompetent to consent to another. The more serious the decision, the greater the capacity required.[38] Whether or not a child has capacity to consent to a particular type of treatment will be influenced by the child's life experience.[39] It has been stated the graver the consequences of the decision, the commensurately greater the level of competence required to make the decision.[40] This has been described as the 'risk related standard' theory.[41]

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26 *Gillick v West Norfolk AHA* [1986] AC 112, 189 adopted into Australian law in *Secretary, Department of Health and Community Services v JWB* (1992) 106 ALR 385.

27 *Re Alex (Hormonal Treatment for Gender Dysphoria)* (2004) 31 Fam LR 503, 529.

28 *Gillick v West Norfolk AHA* [1986] AC 112, 189.

29 *Secretary, Department of Health and Community Services v JWB* (1992) 106 ALR 385.

30 *Re Alex (Hormonal Treatment for Gender Dysphoria)* (2004) 31 Fam LR 503.

31 I Freckelton and K Petersen (Eds), *Disputes and Dilemmas in Health Law* (Federation Press, 2006) 66.

32 *In the Marriage of GWW and CMW* (1997) 21 Fam LR 612.

33 *Secretary, Department of Health and Community Services v JWB* (1992) 106 ALR 385, 394.

34 *In Re C (Refusal of Treatment)* [1994] 1 FLR 31, 33E.

35 *Re C (Detention: Medical Treatment)* [1997] 2 FLR 180, 195.

36 *Re C (Adult: Refusal of Treatment)* [1994] 1 FCR 31, 33.

37 *In Re T (Adult: Refusal of Treatment)* [1992] 3 WLR 782, 796.

38 *NHS Trust v T (Adult Patient: Refusal of Medical Treatment)* [2005] 1 All ER 387, 403.

39 *Re L* [1998] 2 FLR 810.

40 *NHS Trust v T (Adult: Refusal of Medical Treatment*) [2004] 3 FCR 297 [53] refers to *Re MB (An Adult: Medical Treatment)* [1997] 2 FCR 541, 553-4.

41 M Parker, 'Judging Capacity: Paternalism and the Risk-Related Standard' (2004) 11 *Journal of Law and Medicine* 482, 484. Parker notes that, based on the 'risk related standards' theory, a person could be found to be competent to consent to life-saving treatment, but incompetent to refuse treatment for the same condition, as there is a greater risk to the health of the patient in refusing life-saving

Equally, it has been argued once a child is found to have capacity to consent to medical treatment he or she should be treated as competent, regardless of the risk or benefit to the patient.[42] In other words, once the determination of 'Gillick competence' has been made, the child's decision should be respected, regardless of the consequences, and not overridden by the court. This is not the approach indicated by some case law. Judicial findings in the UK and Australia have resulted in decisions of 'Gillick competent' children being overridden. The *parens patriae* jurisdiction has been invoked to justify these decisions where the court has found it is in the child's best interests to do so.[43] This paper explores the *parens patriae* jurisdiction, from an historical perspective, in an attempt to explain how and why the jurisdiction applies to all children, regardless of competence. Examples where the court has indicated that it has power to override the decision of a 'Gillick competent' child are detailed.

IV PARENS PATRIAE

Parens patriae is a protective jurisdiction which stems from the concept that the Crown has an inherent jurisdiction to do what is for the benefit of the incompetent.[44] Originally it protected the rights of guardians rather than those of the minor and was administered by the Court of Wards and Liveries.[45] However, over time, the jurisdiction extended to the protection and education of minors[46] and the Court of Chancery became the guardian of infants, whom it made wards.[47]

A *Application Today*

Today a child need not be made a ward for the court to exercise its inherent power under *parens patriae*.[48] The court may make ad hoc orders which do not affect the guardianship or custody of the child concerned.[49] *Parens patriae* is a discretionary power invoked by the court to protect persons who, because of their legal disability, stand in need of protection.[50]

Whilst the *parens patriae* jurisdiction has been described as unlimited,[51] this protective jurisdiction does not apply to everyone. The court will not exercise the jurisdiction if it would interfere with the statutory machinery set up by Parliament.[52] It does not extend to an unborn foetus[53] or to deceased persons.[54] It is not applicable to competent adults.

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treatment. However fully understanding the nature of effect of refusing treatment may actually be less complicated than a decision to consent to the treatment, although the ramifications of refusal may be greater in that it could result in serious injury or death.

42 Potter, above n 2.

43 *Re R (A Minor) (Wardship: Consent to Treatment)* [1991] 3 WLR 592; *Docs v Y* [1999] NSWSC 644.

44 *Secretary, Department of Health and Community Services v JWB* (1992) 106 ALR 385, 395.

45 *Re Eve* [1986] 2 SCR 388, 408.

46 *Wellesley v Wellesley* [1824-34] All ER 189.

47 *Re Eve* [1986] 2 SCR 388, 408 refers to *Beal v Smith* (1873) LR 9 chs 85, 92.

48 *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311.

49 *Secretary, Department of Health and Community Services v JWB* (1992) 106 ALR 385, 428.

50 *Docs v Y* [1999] NSWSC 644 [88].

51 *Re X (A Minor) (Wardship: Restriction on Publication)* [1975] 1 All ER 697, 699.

52 *Hanif v The Secretary of State for Home Affairs* [1968] 2 All ER 145.

53 *State of Queensland v B* [2008] QSC 231.

54 *In the Matter of Gray* [2000] QSC 390.

However, the category of cases over which the jurisdiction has been invoked is broad and includes, but is not limited to, protection of property, custody, care and control of persons, health problems, religious upbringing and protection against harmful associations.[55] The Crown has a duty to protect its subjects. The court must act as the supreme parent of the child concerned and 'exercise its jurisdiction in the manner in which a wise, affectionate and careful parent would act for the welfare of the child.'[56] It will prevent damage occurring to a child rather than risk the child incurring damage it cannot repair.[57]

There is no doubt the *parens patriae* jurisdiction applies to decisions relating to the health of a child. The jurisdiction has been applied to separate conjoined twins,[58] authorise a blood transfusion for an infant,[59] the termination of a pregnancy in a 12 year old girl,[60] and to authorise consent to medical treatment where it has been refused by a child and her parents.[61]

It is clear the courts have assumed the *parens patriae* jurisdiction extends to protecting 'Gillick competent' children where the child has made a decision which will seriously jeopardise the child's health and survival. Examples of decisions in support of this proposition are detailed below.

In the United Kingdom, the Court of Appeal in *Re W (A Minor)*[62] did not disturb the trial judge's finding that a 16 year old girl suffering anorexia nervosa was 'Gillick competent.' Nonetheless, relying on its *parens patriae* jurisdiction, the court overrode the child's wishes and ordered that she undergo a particular form of treatment to which she objected. The court accepted that it cannot lightly override the wishes of a 'Gillick competent' child with respect to medical treatment unless it is in the child's best interests to do so. Lord Donaldson noted it would generally be in the child's best interests to follow his or her wishes, except where the child refuses medical treatment in circumstances which would probably result in death or severe permanent injury to the child.[63] Similarly in *Re R (A Minor) (Wardship: Consent to Treatment)*[64] the court stated it can override the decisions of 'Gillick competent' children in appropriate cases.

The inherent power of the court under its *parens patriae* jurisdiction has also been invoked to override the decision of a 15 year old girl who refused to provide consent for a heart transplant.[65] The child in that case was found not to be 'Gillick competent. Despite the child's lack of competence, the court adopting statements made by Lord

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55 *Re X (A Minor) (Wardship: Restriction on Publication)* [1975] 1 All ER 697, 700 refers to *Wellesley v Duke of Beaufort* (1827) 2 Russ 18.

56 *Secretary, Department of Health and Community Services v JWB* (1992) 106 ALR 385, 429 referred to *R v Gyngall* [1893] 2 QB 232, 241.

57 *Re X (A Minor) (Wardship: Restriction on Publication)* [1975] 1 All ER 697, 700 refers to *Wellesley v Duke of Beaufort* (1827) 2 Russ 18.

58 *State of Queensland v Nolan* [2002] 1 Qd R 454.

59 *Re R* [2000] 2 Qd R 328.

60 *State of Queensland v B* [2008] QSC 231.

61 *Docs v Y* [1999] NSWSC 644.

62 [1992] 4 All ER 627. English legislation relevant to the facts of the case deemed the consent of a minor who has attained the age of 16 years to be effective as it would be if she were of full age. The court doubted the section applied to the refusal of treatment.

63 Ibid 643.

64 [1991] WLR 592, 602.

65 *Re M (Child: Refusal of Medical Treatment)* [2000] 52 BMLR 124.

Donaldson[66] and Lord Justice Balcombe[67] in *Re W (A Minor)*,[68] was in no doubt that, at law, it had power to override the decision of a child, *whether or not* that child was 'Gillick competent'. The child's welfare was the paramount consideration. 'Whatever that risk may be [in overriding the child's decision], it has to be matched against ... the certainty of death [if she did not receive the transplant]'.[69]

Australian courts have also indicated a preparedness to override medical decisions made by 'Gillick competent' children. In *Department of Community Services v Y*[70] the Supreme Court of New South Wales made an order requiring a 15 year old female (X) suffering anorexia nervosa be returned and, if necessary, detained at a particular hospital for treatment. This was against the child's wishes and those of her parents who were being obstructive, thwarting the treatment regime and encouraging X to refuse the recommended treatment. The court noted the exercise of its inherent jurisdiction to override the wishes of the child must be exercised sparingly. In this case it was required because her long term health and survival were seriously at risk unless steps were taken to give her the medical treatment required.[71] No specific ruling was made in that case with respect to X's competence although the court noted her wishes were affected by her illness which prevented her from understanding the seriousness of her medical condition and from taking proper account of the expert medical advice which was available to her.[72] Nonetheless, the court referred to statements made in *Re R*[73] and *Re W*[74] to infer that, exercising its *parens patriae* jurisdiction, it could override the decision of a 'Gillick competent' child.[75]

Blood transfusions have been the subject of court orders pursuant the *parens patriae* jurisdiction. In *Minister for Health v AS*[76] the court invoked its inherent jurisdiction to authorise a blood transfusion for a 'Gillick competent' child who had refused treatment. The court found that the best interests of the child required it. The guiding principle upon which the exercise of the *parens patriae* jurisdiction was based, was that the welfare of the child is paramount and protection of the child should be elevated above all other interests. The justification for overriding the child's wishes and those of his parents was that the child's health and survival were put seriously at risk if the transfusion was not implemented.[77] These decisions leave little doubt that there is an assumption that the decision of a 'Gillick competent' child can be overridden by a court of law.

B *Case Law Analysis*

However, although the court readily states it has the power to override the decision of a 'Gillick competent' child, it has rarely done so, and certainly not on the basis of the

66 *Re W (a Minor)* [1992] 2 FCR 785, 804, 806.
67 Ibid 810.
68 Ibid 785.
69 *Re M (Child: Refusal of Medical Treatment)* [2000] 52 BMLR 124, 128.
70 [1999] NSWSC 644.
71 Ibid [103].
72 Ibid.
73 [1991] 3 WLR 592.
74 [1992] 3 WLR 758.
75 *Department of Community Services v Y* [1999] NSWSC 644 [100], [101].
76 [2004] WASC 286 [20].
77 Ibid [23].

parens patriae jurisdiction alone. In most cases, doubt has been expressed in relation to the child's competence to make the decision. In other cases, where the court has found the child is 'Gillick competent,' legislation exists to support the court's decision.

In many of the cases where the court has **stated** that it has power to override the decision of a 'Gillick competent' child, the competence of the child concerned was either lacking or questionable. In *Re R*[78] the court authorised the administration of anti-psychotic drugs against the will of a child. In *Re M*[79] a heart transplant was authorised. In both cases, although the child had refused treatment, the child was not competent, yet the court made note of its inherent power to override the child's decision even if 'Gillick competent'. In *Re W* although the child was found to be 'Gillick competent', it was noted by Lord Donaldson that one of the symptoms of anorexia nervosa is a desire by the sufferer to be in control and refusal of medical treatment is an obvious way of demonstrating this.[80] Whilst the finding of 'Gillick competence' was not overruled, these words place some doubt on W's ability to honestly evaluate her situation. In the Australian case of *Department of Community Services v Y*[81] the court did not make a specific finding with respect to the child's competence. However, it was noted the child's wishes were affected by her illness which was 'preventing her from understanding the seriousness of her medical condition and from taking proper account of the expert medical advice which is available to her.'[82] In all of these cases the court found it could override the wishes of a child in respect of medical treatment where it was in the child's best interests to do so. In each case the court made statements confirming it had power to override the decisions whether or not the child was Gillick competent. However, in each case the court also indicated there was a limit to or lack of competence in the child. *Re W* is the only case where the court actually overrode the decision of a child found by the court to be 'Gillick competent' but even in that case, the court indicated her refusal of treatment could have been based on something other than an ability to understand fully the proposed treatment.

In another case, the court stated it could override the decision of a 'Gillick competent' child; however legislation existed which allowed the treatment without the child's consent in any case.

In *Minister for Health v AS*[83] the Minister for Health sought an order authorising medical staff in an oncology ward to administer a blood transfusion to a 15 year old Jehova's Witness. The child was found to be 'Gillick competent.' His belief in not accepting blood products had been with him all his life and was an integral part of his persona. He felt he could not agree to a blood transfusion even though, under the circumstances, his chances of dying would be significantly increased. The court made the order sought by the Minister on the basis that the child's health and survival would be seriously placed at risk unless steps were taken to give the child a transfusion should the need arise.[84]

78 [1991] WLR 592, 603.
79 52 BMLR 124.
80 [1992] 4 All ER 627, 631. Note also *Re C (Detention Medical Treatment)* [1997] 2 FLR 180.
81 [1999] NSWSC 644.
82 Ibid [103].
83 [2004] WASC 286.
84 Ibid [23].

However, the *Human Tissue and Transplant Act 1982* (WA)[85] provided that a medical practitioner could perform a blood transfusion on a child without consent if the child is likely to die without the transfusion. The hospital sought clarification of the words 'likely to die' because it wanted to be able to administer the transfusion as a preventative measure rather than having to wait until a haemorrhage occurred. The court found that the wording of the statute covered administration of a blood transfusion for preventative purposes. The statute therefore allowed administration of the blood transfusion without the child's consent, thereby overriding the decision of the child. The statute supported the authorisation of a blood transfusion regardless of whether the court had such power under its *parens patriae* jurisdiction.

The courts have been very clear with words about an apparent power to override the decision of a 'Gillick competent child.' However, an examination of the case law reveals it has rarely done so. Are the courts correct to assume the *parens patriae* jurisdiction extends to a 'Gillick competent' child? One can argue that a 'Gillick competent' child is no longer in need of protection, is not incompetent and, therefore, not within the category of subjects intended to attract the protective jurisdiction of the Crown known as parens patriae. On the other hand, a 'Gillick competent' child is not an adult and, as such, should be entitled to the same protection afforded, by *parens patriae*, to those who are not 'Gillick competent'.

V EXTENSION OF THE *PARENS PATRIAE* JURISDICTION TO A 'GILLICK COMPETENT' CHILD.

The *parens patriae* jurisdiction applies to children because of their age and the environment in which they find themselves – that is, an environment in which they need the court's protection. A child's intelligence, maturity and ability to understand does not disentitle them to the benefit of the *parens patriae* jurisdiction. *Parens patriae* does not discriminate. The jurisdiction can apply to **all** children regardless of intelligence and maturity.

Support for this argument is found by looking at how the jurisdiction developed over time. The *parens patriae* jurisdiction applies to the mentally incompetent and children, but these two aspects have separate origins. From the 17th century, the Crown exercised its jurisdiction over the mentally incompetent by Letters Patent under the Sign Manual granting power to the Lord Chancellor which included the care and custody of persons who had been found, *by inquisition*, to be of unsound mind.[86] By the 19th century, the work was assigned to the Chancery Court and jurisdiction in respect of 'custody of persons and estates of persons *found* idiot, lunatic or of unsound mind' could be exercised by those justices entrusted with such power.[87]

Historically, incompetence had to be established before the court's *parens patriae* jurisdiction could be invoked to protect an adult. However, there was no need to test for incompetence in children because it was presumed. The parens patriae jurisdiction automatically applied to children because of the legal presumption that they were incompetent and, therefore needed protection.

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85 *Human Tissue and Transplant Act 1982* (WA) s 21. See also *Royal Alexandra Hospital for Children Trading as Children's Hospital at Westmead v J* [2005] NSWSC 465.

86 *Re Eve* [1986] 2 SCR 388, 407.

87 Ibid.

Factors which determine whether or not a child is 'Gillick competent' are not influenced by the same circumstances which bring the *parens patriae* jurisdiction into play. 'Gillick competence' concerns the developmental progress of the child including the child's maturity and intelligence, and whether or not the child has reached a sufficient stage in his or her development and understanding to make a medical decision independent of, and preferential to, that child's parents. Capacity to make a decision in relation to particular medical treatment does not disentitle a child to the protective inherent *parens patriae* jurisdiction of the Supreme Court.

Elements of vulnerability and a need for protection attach to children by virtue of their youth. They have not had the experiences nor formed the defences which adults have[88] and need protection against injury of whatever kind from whatever source.[89] Despite their achievement of a sufficient understanding and intelligence to fully understand the proposed medical treatment, a 'Gillick competent' child is, nonetheless, a child. The jurisdiction extends to children because they are minors, regardless of their intellectual milestones and maturation. It can be used in relation to the custody, guardianship and welfare of children and the protection of property which is subject to a charitable trust.[90] It is not limited by the developmental progress of certain minors in particular or limited circumstances.

However, it is also arguable that the lack of requirement to prove incompetence in children historically existed because there was no concept of a competent child, so nothing existed which had to be countermanded. To this extent the *parens patriae* jurisdiction should develop alongside the notion the 'Gillick competent' child, thereby respecting the child's ability to take care of themselves. This is reflected in the Canadian case of *Region 2 Hospital Corp v Walker*[91] where the court specifically stated that its *parens patriae* jurisdiction did not extend to a mature minor.[92] In that case, the court noted that the *parens patriae* jurisdiction cannot be invoked to deprive competent mentally-ill patients of their treatment decisions, therefore it cannot apply to competent children. Likewise, *parens patriae* cannot be used to override the decision of an incompetent person who gave instructions about his or her treatment when competent.[93] The decision indicates that the status of competence at the time the decision is made deflects application of *parens patriae*. Logical as they sound, little support for these arguments can be found in Australian caselaw, which declares repeatedly that the *parens patriae* extends to all children, 'Gillick competent' or otherwise.

A *Overview*

'Gillick competence' is earned by achieving a certain level of development and maturity and is not determined by reference to a particular age.[94] On the other hand, a child attracts the *parens patriae* jurisdiction by virtue of age and circumstance. The *parens patriae* jurisdiction applies to 'Gillick competent' children because they have not

88 *Re X (A Minor) (Wardship: Restriction of Publication)* [1975] 1 All ER 697, 700.
89 Ibid.
90 *In the Matter of Gray* [2000] QSC 390 [10].
91 1994 NBR (2d) LEXIS 1127 [29].
92 A 'mature minor' under Canadian law is one who is capable of understanding the nature and consequences of the proposed treatment; ibid [25].
93 Ibid [27].
94 *Gillick v West Norfolk AHA* [1986] 1 AC 112, 188.

reached the age of majority, regardless of how mature, intelligent or knowledgeable they are. However, there is argument to suggest competence, from whatever source, shields a person from the *parens patriae* jurisdiction. The basis for this argument is that a competent person can take care of themselves and is, therefore, not in need of a protective jurisdiction. However attractive the argument may be, it is not supported by Australian case law. The court has on a number of occasions stated it has power pursuant to its *parens patriae* jurisdiction, to override the decision of a 'Gillick competent' child.

However the exercise of the *parens patriae* jurisdiction is discretionary. Even if the jurisdiction can apply to all children, including those who have achieved 'Gillick competence', invoking the jurisdiction in all cases may not necessarily be appropriate. As noted by Lately J, it is one thing that the powers exist; it is another thing whether they should be exercised.[95] There must be some clear justification for a court's intervention to override the decision of a 'Gillick competent' child: 'if these powers are called on in a novel category of case the court should walk warily and circumspectly before exercising them.'[96]

VI IT IS AN APPROPRIATE USE OF THE *PARENS PATRIAE* JURISDICTION TO OVERRIDE THE DECISION OF A 'GILLICK COMPETENT' CHILD?

Whilst this discretionary power has been activated in many cases to override the medical decision of an **incompetent** child, it is inappropriate to use the power to override the decision of a 'Gillick competent' child with respect to that child's medical treatment. An analysis of the case law indicates that the court has rarely relied solely on its *parens patriae* jurisdiction to override the decision of a child found to be 'Gillick competent'. In many cases the child referred to had either been found to lack competence, or no finding as to competence was made. In other cases, legislation guided the court's decision. In addition, the case law suggests there are certain factors which require consideration when the court is determining whether to override the decision of a 'Gillick competent' child. An analysis of these factors strongly suggests it is inappropriate to override the decision of a 'Gillick competent' child.

A *Factors for Consideration*

Relevant factors for consideration are - balancing the interests of the child with those of society; the level of understanding possessed by a 'Gillick competent' child and ascertaining the best interests of a 'Gillick competent' child. Each of these is examined below.

1 *Balance*

There must be a balance between the child's interests and that of society. Factors which benefit a child and factors from which society gains a benefit are not necessarily the same. In fact, the interests of the individual and that of society can compete.[97] The court

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95 *Re X (A Minor)* [1975] 1 All ER 697, 701.

96 Ibid.

97 The common law recognises two interests which can conflict – a competent adult's right of autonomy or self-determination being the right to control his or her own body; and the interest of the

must therefore weigh up competing interests and make a determination as to whose interests require protection in each particular case.

In *Re X (A Minor)*,[98] the court had to determine whether it should issue an injunction preventing the publication of material which, if read by the child, would have been detrimental to her mental health and well-being. The court declined to impose restrictions on the publication because it found the public interest of freedom of speech outweighed the interests of the child. Freedom of speech is a fundamental democratic right. The court looked at the effect the publication would have on the child concerned. There was no doubt the effects would be detrimental. However, after performing what the court described as a difficult balancing act looking at both sides of the case before it, the court found the scales tipped in favour of freedom of speech. The following statement was made by Sir John Pennycuick in considering whether or not the *parens patriae* jurisdiction should be exercised in this case:

> the jurisdiction must be exercised with due regard to the rights of outside parties. ... By 'outside parties' I mean those not in a family or personal relationship to the ward. The court must hold a proper balance between the protection of the ward and the rights of outside parties.[99]

While the court found that the *parens patriae* jurisdiction extended to the particularly novel situation, it did not exercise its discretion to invoke the jurisdiction in this case. The need to allow freedom of publication outweighed any potential detriment such publication might have on the child concerned.

The court must carry out a balancing act when determining whether or not to override the decision of a 'Gillick competent' child. The autonomous interests of the child, that is, the right to control what happens to his or her body, must be balanced against the public interest in protecting a minor against harm. Autonomy means the competent person has responsibility and authority over his or her body and respect must be given to that person's wishes no matter how unreasonable or unwise the decision may appear to others.[100] On the other hand, society seeks to protect the welfare of the child. This is achieved by investing the court with the *parens patriae* jurisdiction on the basis that the welfare of the child is paramount and elevated above all other interests.[101] The question is whether a 'Gillick competent' child should be given complete autonomy. The two cases in which the court has overridden the decision of a child found 'Gillick competent' would suggest not. In *Re W (A Minor)*[102] the interests of the child were best served, according to the court, by her undergoing a particular form of treatment to which she had refused to consent. In *Minister for Health v AS*[103] the autonomous interests of the child in refusing medical treatment based on his strong religious beliefs, were outweighted by the need to preserve his life.

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state in protecting and preserving the lives and health of its citizens. See *Hunter and New England Area Health Service v A* [2009] NSWSC 761 [5].

98 [1975] 1 All ER 697.

99 Ibid 706.

100 *Airdale NHS Trust v Bland* [1993] AC 789, 864.

101 *Minister for Health v AS* [2004] WASC 286 [21].

102 [1992] 4 All ER 627, 643.

103 [2004] WASC 286.

The level of autonomy afforded to a 'Gillick competent' child rests largely with the interpretation of the term itself. A narrow interpretation of 'Gillick competence' simply removes those with parental responsibility, such as parents or guardians, from the decision making process. Where a child is found not to be 'Gillick competent,' those with parental responsibility can consent or refuse medical treatment for the child, provided the decision is in the child's best interests. If the decision is not in the child's best interests, the court can intervene and make a decision based on the child's best interests. So, according to this narrow interpretation 'Gillick competence' simply defers parental consent or refusal to that of the child, thereby affording the child the same powers to consent as his or her parents had. This was the view held by the court in *Re W*.[104] However, it places an uncomfortable caveat on competence by implying, the child is competent, provided he or she makes the 'right' decision, that is, one that is in his or her 'best interests' from an objective perspective.

It is accepted that competency in children can be limited by the nature of the decision being made. In other words, a child can be 'Gillick competent' to make a decision about one form of treatment but not for a more complicated treatment.[105] However, it is a mockery to suggest a child's competence or otherwise depends on the answer given in relation to the proposed medical treatment, rather than an understanding of the treatment itself.

A broad interpretation of 'Gillick competence' is that it affords the child the decision-making competence of an adult. This interpretation removes any paternalistic attitudes which could otherwise be conferred on the child. Having established that the decision of a 'Gillick competent' child should be respected, the question arises as to whether this means autonomy outweighs the principle of sanctity of life. It does in an adult. The decision of a competent adult with respect to medical treatment must be respected regardless of the opinion, belief or judgment of those treating the adult.[106] It cannot be overridden in a court of law. If 'Gillick competence' does not afford adult competence on a child, it raises the implication that there are two levels of competence – 'adult' competence and 'Gillick competence' – the latter being a lesser level of competence.

However, if 'Gillick competence' was truly a lesser form of competence, there would be no need to assess the competence of the child at all. The only relevant question for the court would be whether or not the decision is in the child's 'best interests'. If it is, then it can stand; if not, the court can override the decision utilising the powers of its inherent jurisdiction. However, an analysis of the case law above indicates the court does consider the child's competence and continues to make comment on it, indicating it is relevant in the decision making process. Further, despite commenting regularly that it has power to override the decision of a 'Gillick competent' child, the court on many occasions, has found that, in fact, the child lacked competence.[107]

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104 [1992] 4 All ER 627.

105 *NHS Trust v T (Adult Patient: Refusal of Medical Treatment)* [2005] 1 All ER 387, 403. See part 3(b) above.

106 *Re T* [1993] Fam 95, 112 referred to in *Hunter and New England Area Health Service v A* [2009] NSWSC 761 [9], [10].

107 *Re R (A Minor) (Wardship: Consent to Treatment*) [1991] 3 WLR 592; *Re M (Child: Refusal of Medical Treatment)* [2000] 52 BMLR 124; *Re L (Medical Treatment: Gillick Competence)* [1998] 2 FLR 810; *Department of Community Services v Y* [1999] NSWSC 644, *Royal Alexandra Hospital for Children Trading as Children's Hospital at Westmead v J* [2005] NSWSC 465.

The New South Wales Law Reform Commission[108] has outlined the aims of law reform in young people consenting to medical treatment. These include ensuring young people have access to medical treatment, recognising and protecting young people's rights in decisions affecting them, protecting young people from detrimental decisions that may harm them, and providing the medical profession with a workable framework for treating young people. Working within the framework of these goals, the following points are noted.

The decision made by a 'Gillick competent' child deserves respect. To force a competent person to undergo treatment, to which they strenuously object, would surely have negative consequences. A 'Gillick competent' child has the ability and maturity to weigh up the consequences of the decision. To disallow that decision on the basis of another person's views is to violate the bodily integrity and autonomy of the 'Gillick competent' child. It would also have a negative impact on medical staff who may, for example, be required to apply force in order for the treatment to be administered.

Similarly, the medical profession needs assurance they are acting legally and professionally if they accept the decision of a child patient they have assessed as 'Gillick competent'. If a doctor administers treatment, which a 'Gillick competent' child has refused, because the doctor believes it is in the child's best interests to provide such treatment, issues of assault and trespass can arise.

If a child is not 'Gillick competent', then the child needs to be protected from detrimental decisions that may cause harm, as indicated by the New South Wales Law Reform Commission.[109] Parents or guardians should ensure this occurs. In this context the court provides a safety net should the child's best interests not be met.

2 *Understanding*

A 'Gillick competent' child has an onerous obligation to fulfil. The common law requires that the child demonstrate sufficient maturity and intelligence to *fully understand* the proposed treatment.[110] This is, in fact, a higher level of ability to understand than that which is required from an adult under the same circumstances. In order to consent to treatment an adult need only be informed in broad terms of the nature of the treatment.[111]

In addition, it is vital that those making the determination of 'Gillick competence' are sure their determination is correct. Consequently, the physical process which a child must go through to prove competency is rigorous. The ramifications of a wrong decision, such as exposure to civil claims of trespass or negligence, and criminal allegations of assault and grievous bodily harm, cause the person making the determination of 'Gillick competence' to ensure the child is very well informed and knowledgeable in terms of the treatment proposed. These issues are explored further below.

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108 New South Wales Law Reform Commission, *Minors' Consent to Medical Treatment*, Issues paper No 24 (2004) 1.19.

109 Ibid.

110 *Gillick v West Norfolk AHA* [1986] AC 112, 189.

111 *Rogers v Whitaker* (1992) 175 CLR 479, 489.

(a) Legal Requirements

Consent from a patient is required for the clinical purpose of ensuring patient co-operation during treatment, and for the legal purpose of avoiding a criminal charge of assault or a civil claim in damages for trespass to the person.[112] While there is a duty upon doctors to give adult patients full information as to the nature of the proposed treatment and the risks involved, a failure to provide such detail will found an action in negligence, but will not vitiate consent to medical treatment.[113] An adult is presumed to be competent to consent to medical treatment. To provide a valid consent, a doctor need only ensure the adult knew *'in broad terms' the nature and effect of the procedure* for which consent is given.[114] For a child to be 'Gillick competent' he or she is required to be mature and intelligent enough to be able to '*understand fully' the proposed treatment*. An ability to understand the nature and effect of the procedure in broad terms will not satisfy the 'Gillick competence' test. A higher standard of ability is required and, it is submitted, a much higher standard is sought for the reasons outlined below.

(b) Factual Proof of Competency

A child is presumed not to be competent to consent to medical treatment. In order be found competent, the child must have the *intelligence and maturity to fully understand the proposed treatment.* This ability is not achieved by age, but by the stage of development towards adulthood the child had reached. Because a presumption against competence must be rebutted, in order to satisfy the medical professional or court, as the case may be, the child must demonstrate his or her ability to understand. Questions will be asked and discussions had with the child in order to establish whether or not the child's level of understanding is sufficient to satisfy the test of 'Gillick competence'. An ability to understand the actual treatment alone is not sufficient.

As noted by Lord Scarman in *Gillick*:

> there is much that has to be understood by a girl under the age of 16 if she is to have legal capacity to consent to such [contraceptive] treatment. It is not enough that she should understand the nature of the advice which is being given; she must also have a sufficient maturity to understand what is involved. There are moral and family questions especially the relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate ... [A] doctor will have to satisfy himself that she is able to appraise these factors before he can safely proceed on the basis that she has, at law, capacity to consent to contraceptive treatment.[115]

Essentially, the child must be able to understand the problems which may be experienced as a result of treatment including any associated risks. This extends beyond an ability to understand physical aspects of the proposed treatment. It extends to other related circumstances surrounding the treatment. An ability to understand social, emotional and psychological issues must be demonstrated. In addition to the nature of the treatment itself, the relatively straight forward issue of contraceptive advice requires

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112 *Re W (A Minor)* [1992] 4 All ER 627.
113 *Re T (Adult: Refusal of Treatment)* [1993] Fam 95.
114 *Rogers v Whitaker* (1992) 175 CLR 479, 489.
115 *Gillick v West Norfolk AHA* [1986] AC 112, 189.

extensive scrutiny of the child's ability to understand moral, familial and emotional consequences; short-term, long-term and associated risks of accepting the treatment; and dangers of not accepting the treatment. It follows that treatment of a more complicated nature would involve a series of highly comprehensive discussions, almost to the point of interrogation, in order to establish whether or not the child can satisfy the test of 'Gillick competence'. In order to establish the child's ability to understand, it is likely that, in the course of these extensive discussions, the child actually becomes highly apprised of the treatment, its effects on the child and on others close to the child. Through this physical process, the child's ability to understand becomes an actual understanding – how else can ability be measured?

A determination of competence depends upon the abilities of the particular child. These must be tested. Not only does a 'Gillick competent' child have to attain a higher threshold of understanding than a competent adult by virtue of the common law tests, but the 'Gillick competent' child's intelligence and maturity must be tested, checked and approved to ensure the common law requirements are satisfied. The child is very well apprised of the situation because it is so important that the necessary professionals are satisfied of his or her competence. Through maturity and intelligence, a 'Gillick competent' child not only has the *ability* to fully understand what is proposed, but *actually* fully understands due to discussions, questions and the information which must be provided to the child to properly establish whether or not the child is 'Gillick competent'.

> [T]he requirement for a young person to understand not just the nature of the proposed treatment but also its consequences, appears to place a greater burden on the extent of the young person's understanding in order to be deemed competent to give valid consent, and on the amount of information disclosed by the medical practitioner in order to obtain a valid consent to avoid liability in trespass, than ordinarily applies in the case of treating adult patients.[116]

This requirement of a high level of understanding is apparent from the case law. In *Re L*[117] despite being described as mature for her age the child was found not to be 'Gillick competent' because she had not been provided with all the necessary details upon which to form her view. In particular, she had not been advised of the 'horrible death' she would suffer if she did not succumb to the proposed treatment. Clearly a girl, mature for her age, had the ability to understand what was meant by a 'horrible death'. However, no matter how mature, she would not understand the nature of the death that lay ahead, if she was not so advised. By limiting information, competence can be arrested.[118] In *Re M*[119] the child was described as an intelligent 15 year old. However because events leading to the requirement of a heart transplant occurred very quickly, the court found M too overwhelmed by her circumstances to be 'Gillick competent'. In both cases the child's lack of competence rested on the wider circumstances surrounding the treatment rather than the nature of the treatment itself. The court in *Re Alex*[120] noted that it is one thing for a child to have a general understanding of what is proposed and its effect, but it is quite another to conclude that he or she has sufficient maturity to fully understand

116 New South Wales Law Reform Commission, above n 108, 1.19.
117 [1998] 2 FLR 810.
118 A Grubb, 'Commentary on Re L (Medical Treatment: Gillick Competency)' (1999) 7 *Medical Law Review* 58.
119 [1999] 2 FCR 577.
120 (2004) 31 Fam LR 503.

the grave nature and defects of the proposed treatment. The child, in that case, was found not to be 'Gillick competent'. A child who demonstrates 'Gillick competence' is not only intelligent and mature, but well informed and worldly with respect to the particular treatment.

(c) Overview

A presumption of competency arises for adults and with that is a presumption of knowledge and understanding. Provided the adult can comprehend, retain and balance the information, it is presumed he or she is competent. At common law, an adult need only have a broad understanding in order to legally consent to the proposed treatment. Additional information about the risk and consequences of the treatment may be provided to an adult, but that is to ensure against claims in negligence not as a legal requirement for consent.

Knowledge and understanding in a child must be proved and therefore demonstrated. There can be no presumptions. Firstly, the level of understanding a child must achieve from a legal perspective, is higher than that required of an adult. An ability to fully understand the proposed treatment indicates a greater knowledge than simply having a broad understanding. Secondly, that full understanding has to be demonstrated so that the person making the assessment is convinced it exists. In addition, the person making the assessment must be sure their determination is correct, so will require an even higher standard than the minimum allocated by the words of the common law test for 'Gillick competence'. In conclusion, 'Gillick competent' children are very knowledgeable, very well informed and therefore very capable of making a decision about the proposed treatment.

3 *Best Interests*

Finally, the best interests of the child are paramount. When a 'Gillick competent' child requires medical treatment which is simple or straight- forward in nature, it is unlikely to attract the court's attention. Cases which attract the attention of the court concern situations where the child's life is at risk, or there is a very real danger he or she will be left with severe permanent injuries. Legal principle indicates it is in the child's best interests to abide by the decision of the child unless there is a danger to the child's health or survival, in which case 'best interests' point to survival.[121] This is irrespective of whether or not the child is 'Gillick competent'. 'Best interests' include psychological and emotional effects on the child as well as those of a physical nature.[122] The issue of best interests raises two important questions in the context of the 'Gillick competent' child. Firstly, should a 'Gillick competent' child lose the right to determine what is in her best interests because the decision the child makes may risk loss of life or permanent injury? The following examples are provided to show there is no bright line marking where 'best interests' lie.

- Is it in a child's best interests to have a double mastectomy, contrary to her wishes, if tests indicate she is at risk, but no certainty, of contracting breast cancer? A double mastectomy is a major operation with significant risk to the patient. As well

[121] *Re W (A Minor)* [1992] 4 All ER 627.
[122] *In the Marriage of GWW and CMW* (1997) 21 Fam LR 612.

as pain and suffering, the patient will have psychological hurdles to overcome. This must be weighed against a risk of dying from breast cancer. Based on case law the court will consider the child's welfare to be paramount[123] and, if her long term health and survival are seriously at risk,[124] the court is likely to authorise treatment which will assist survival. The likely outcome of a court order, should the child refuse treatment, would be to authorise the operation.

- Should a child consent to a heart transplant when she has been in and out of hospital and subjected to a multitude of operations by the age of 13 and there is no guarantee she will be cured. Again, the likely court order would favour survival which means the court would probably authorise the transplant. This is despite hardship and further pain and suffering the child might endure. Psychological and emotional aspects of the child's view of death need to be considered. For example, knowing if she does not survive that she will die with dignity at home with family rather than in the sterile environment of a hospital may be in the child's best interests.

- Is it in the best interests of a 14 year old girl to undergo an abortion if it is so strongly against her wishes that she has to be physically restrained for the procedure? It is difficult to anticipate this decision without further factual details. However, a significant difficulty with overriding the decision of a child not to have an abortion lies largely with medical staff, who may object to carrying out a procedure, such as abortion, if it is necessary to apply force or restraint upon the child at some point.

These are very personal decisions. Medical choices in these cases would vary from person to person and views in some cases are likely to be adamant. A competent child loses this choice by virtue of their age under current court trends. Ironically, in these cases, court decisions, on similar fact scenarios, are unlikely to be uniform because there is no right and wrong answer to which form of treatment is in the child's best interests. The subjective views of the decision maker may prevail.

In certain circumstances the child's 'best interests' is a fine line which no-one except the child requiring the treatment can really understand. Only the competent patient really knows and understands what is in his or her best interests. Only the competent patient should consent or refuse medical treatment. A 'Gillick competent' child is a competent patient, even if he or she is not an adult. The 'Gillick competent' child knows his or her best interests and may have very good reasons for acting outside that which a third party considers to be his or her best interests.

It has been held in Canada[125] that the best interests of a 16 year old Jehovah's Witness with acute myeloid leukaemia were best served by abiding by the child's decision to only accept treatment which did not require blood transfusions. This was despite medical evidence that the child's refusal to accept blood or blood products could be fatal. The court found overwhelming evidence that the child was sufficiently mature and that the proposed treatment (not to administer blood) was in his best interests and his continuing health and well-being. A forced transfusion would be detrimental to his health.[126]

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123 *Re M (child: refusal of medical treatment)* 52 BMLR 124, 128.
124 *DoCS v Y* [1999] NSWSC 644 [103].
125 *Region 2 Hospital Corp v Walker* 1994 NBR (2d) LEXIS 1127.
126 Ibid [4], [8], [31].

The second issue raised by exploring the concept of 'best interests' is whether a 'Gillick competent' child should be able to make a decision with respect to medical treatment which is not in his or her best interests. In other words, if a 'Gillick competent' child's decision appears irrational to the objective observer, should that decision be respected as it would be if made by an adult? Current court trends suggest the decision would be overridden. However, comments made by Lord Donaldson in *Re W (A Minor)*[127] confirm what is seen as irrational to one person may be common sense to another: 'I personally consider that religious or other beliefs which bar any medical treatment or treatment of particular kinds are irrational, but that does not make minors who hold those beliefs any the less "Gillick competent"'.[128]

If it is accepted that 'Gillick competence' equates to adult competence (as there is only one level of competence) then the decision of a 'Gillick competent' child must be respected even if the decision carries with it the risk of death or serious damage to health. To some (or all) it may appear irrational. However, competence prevails over best interests. Irrational decisions, while heavily scrutinised in terms of competence (like an adult)[129] should be respected.

The court should exercise its discretion by not overriding the decision of a 'Gillick competent' child for the following reasons. First, a 'Gillick competent' child has capacity to consent to medical treatment of the nature proposed. As such, their autonomy and self-determination deserve respect. It is essential to our health system that medical staff is secure and ethically comfortable in the framework within which they are required to work. Second, the 'Gillick competent' child is very well informed and, potentially has a better understanding of the proposed treatment than an adult in the same position. It is submitted if a child has capacity to consent or refuse medical treatment, he or she should be treated as an adult, and the decision respected because it is made by the child in the child's interests. It may not be the best interests from the perspective of the objective bystander, but, if the child is competent, who has the right or ability to query what is in that child's best interests?

Further, if the decision is irrational it should still be respected provided competence is found. With competence comes the right of self-determination and autonomy. There is one level of competence, and if that is achieved, whether by a child, an adult or an adult with a mental illness, autonomy prevails, regardless of whether the decision is, objectively, in that persons' best interests.

VII CONCLUSION

In certain situations, the balance between the autonomy of a 'Gillick competent' child and that of society's interest in protecting children has tipped in favour of protecting persons of minority. A child cannot donate an organ, obtain a tattoo or undergo certain cosmetic surgery procedures. Parliament has ensured that not even a 'Gillick competent' child can consent to these procedures.

Where there is no legislation governing the medical treatment proposed, the autonomy of the 'Gillick competent' child should be respected and the courts should not override

127 [1992] 4 All ER 627.
128 Ibid.
129 *Re B (Adult: Refusal of Medical Treatment)* [2002] 2 All ER 449.

decisions made by competent children, regardless of the consequences of the decision. Arguments supporting this proposition are as follows:

- Whilst the *parens patriae* jurisdiction may apply to all children, a 'Gillick competent' child is not vulnerable nor in need of protection with respect to the proposed medical decision. Aspects of vulnerability may appear in other areas of the child's life, but that should not affect the child's ability to make a decision with respect to the proposed treatment for which he or she has been found to be 'Gillick competent' and about which he is well informed and knowledgeable. The *parens patriae* protects those who are incompetent. It does not apply to a competent person with a mental illness, so should not apply to a competent child. As such, the court should not exercise its discretion to invoke the *parens patriae* jurisdiction to override the decision of a 'Gillick competent' child.

- The balance between respecting the autonomy of a 'Gillick competent' child and that of protecting vulnerable members of society tips in favour of the 'Gillick competent' child with respect to the proposed medical treatment. A 'Gillick competent' child has full legal competence with respect to the medical treatment proposed. 'Gillick competence' is not a lesser form of competence. It equates with the competence of an adult. The word 'Gillick' is simply used to indicate the competence attaches to a child. He or she is able to make a fully informed decision and, as such, should have his or her autonomy respected.

- It is suggested that a 'Gillick competent' child is very well informed about the treatment decision he or she has made. When giving or refusing consent to medical treatment, the 'Gillick competent' child must prove a higher ability to understand than an adult. In addition, this ability has been demonstrated by the child and not presumed. Discourse must occur to prove competence and this will involve discussions, questions and answers. If the treatment is serious, the discussions are likely to be rigorous and onerous. As a result, a higher understanding is indicated to satisfy the test of 'Gillick competence'.

- Respecting the decision made by a 'Gillick competent' child is in that child's best interests. To override that decision is to allow a third party's view determine the child's best interests rather than the competent individual whose health is at stake. If a child has been found to be competent, then that child knows what is in his or her best interests. Formed views, beliefs and judgments should be respected. Best interests are not necessarily judged by physical aspects alone. Emotional and psychological ramifications felt only by the child must be not just considered, but respected.

Adolescence is a period of transition from childhood to adulthood. As experience of life is acquired and intelligence and understanding grow, so does the scope of decision-making ability.[130] At 18 years of age a child becomes an adult and, if competent, is given full decision- making ability in respect of medical treatment which cannot be overruled by a parent or a court. Lord Scarman noted the artificiality and lack of realism which occurs when fixed limits are imposed on the process of growing up.[131] There

130 *Re W (A Minor)* [1992] 2 FCR 785.
131 *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC 112, 186.

arrives a point in time where some children, prior to reaching 18 years, have the ability and maturity to fully understand the treatment proposed. That point is called 'Gillick competence'. The limitless bounds of the court's inherent jurisdiction combined with the fact a 'Gillick competent' child is a minor, provides the court with an inherent jurisdiction to involve itself with the treatment decisions of a 'Gillick competent' child. Exercising its discretion to utilise its *parens patriae* jurisdiction must be weighed against the child's ability to determine what is in his or her own best interests or welfare. There may be situations where sheer youth and inexperience of a child prevents a determination of competence.[132] But if a determination of 'Gillick competence' is made, then, it is submitted, that child's autonomy should be respected.

[132] *Re L (Medical Treatment: Gillick Competency)* [1998] 2 FLR 810.