Medical treatment – the child's right to decide

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A difficult case

A few months ago, Avant received a telephone call from a general practitioner. It involved a girl aged 12 years and 11 months, brought to the general practitioner by her mother, requesting Implanon for contraception.

Having not been approached by someone quite so young before, the doctor, a bit perplexed by this situation, rang to find out what she should do. After discussion with our advisers, it came to light that the girl was physically mature, having commenced her periods at about age nine. She had had at least four partners under the age of 15 and had used the morning-after pill on three occasions.

She appeared to the GP to have some self-esteem issues.. She had been born when her mother was aged 15, so the mother was about 27 when she brought the child in.

Our members approach us reasonably frequently for medico-legal advice on scenarios such as this one. Often for general practitioners the issue is whether or not a child can terminate a pregnancy. In these cases, young women usually attend without their parents and don't want the parents to know that they are pregnant. Others don't want their parents to know that they are seeking contraception. It is quite a dilemma for the doctors.

Not only GPs

These issues do not just involve general practitioners, of course. Other specialists face these issues constantly. Dr Charlie Teo, at the last Scientific Meeting, discussed doing invasive brain surgery on children. Dr Hugh Aders has kindly provided me with a copy of some draft guidelines on bariatric surgery on children and adolescents which, to excuse the pun, is probably going to be a growth area in this age of obesity. Laws about cosmetic surgery in children have recently been passed in Queensland, and Bill Madden has written on this issue in a recent article in the Journal of Law and Medicine.

Can children consent?

Do children have the right to decide on their own medical treatment? What is the extent of that right? Is there a difference between the types of medical treatment in this area of consent? For example, should decisions by children at the end of life be dealt with differently from decisions to be vaccinated, or to have a termination of pregnancy. What is the legal position of the doctor? To whose wishes does the doctor give precedence? The parents'? The child's? Is there something else which they should take into account? What if there is a dispute between the parents and the child, or between the parents and the treatment team, or between the child and the treatment team?

The Law Reform Commission's view

This complex topic was the subject of a 256-page NSW Law Reform Commission report published in October 2008. We will only skim the surface of this topic this evening, but I hope to raise some of the issues the Law Reform Commission dealt with and to look at some of the recommendations for legislative change.

The history of children's rights

Traditionally children were considered to have no rights. They were the property of their parents, under the control of their parents, and were presumed not to be capable of making decisions for themselves. This paternalistic view of children has gradually changed over recent years, culminating in the UN Convention on the Rights of the Child. Article 12.1 reads as follows:

> *States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.*

That's a great aspirational statement. How is it reflected in the law in Australia and, in particular, in New South Wales?

The Law Reform Commission, in its issues paper on minors' consent to medical treatment, stated the following about the law in New South Wales:

> *The law relating to young people's competence to consent is obscure, complicated and piecemeal. The current law results from several disparate legislative initiatives and the separate progression of the common law. The way in which the common law interacts with the legislative processes is unclear. The law embraces neither a coherent policy for making decisions about young people's medical care nor a clear legal framework within which the medical profession can work.*

It makes it very difficult for doctors practising in paediatric medicine and surgery. Submissions received by the Law Reform Commission from doctors practising in this area described the difficulties of working out whether or not, and in what circumstances, a child can consent.

The current law in NSW

The test for a child's capacity comes from a UK decision of the House of Lords in 1985,.Gillick v West Norfolk & Wisbech Area Health Authority [1985] UKHL 7 Most of you would have heard of the decision. It involved government guidelines issued to local health authorities about the circumstances in which it was appropriate to give contraceptive advice to children under the age of 16, particularly girls,-including without the knowledge of their parents. The mother of 5 daughters aged under 16 brought an action seeking a declaration that that guideline was illegal.

The House of Lords looked at the capacity of girls under the age of 16 to consent. They also looked at whether a parent could countermand the wishes or consent of a child. The test for capacity which emerged was that a child would be 'Gillick competent' if they had achieved sufficient understanding and intelligence to enable them to understand fully what was proposed.

Interestingly, this test of capacity is higher than the test for adults. Adults need only to understand the general nature of what is proposed. Children have to understand 'fully'. One might ask if children can ever understand fully, and if even adults can understand fully.

Marion's case – in Australia

The notion of Gillick competence was accepted by our High Court in Marion's case. This involved a 14-year-old intellectually disabled girl whose parents were seeking authorisation for a hysterectomy and oophorectomy (removal of the ovaries, also known as 'ovariectomy'). In the course of discussing whether it was appropriate to authorise that surgery, the court discussed the test for capacity in children. The High Court approved the Gillick test.

A treatable cancer

It is important to note that consent must be voluntary and not due to any undue influence. I recently advised a doctor involved in treating a patient aged 16 with non-Hodgkin's lymphoma, perfectly treatable with chemotherapy and radiotherapy. The parents were against chemotherapy and wanted to institute or continue some non-conventional treatment. The doctor was quite concerned about this, particularly because he thought that the father's views about non-conventional treatment were affecting the child. He wanted advice about whether or not the child would have capacity, whether the father was exerting undue pressure on the child, and whether the child could, himself, consent.

Of course we could not advise whether or not the child had capacity – this is a clinical decision for the treating doctors - but we were able to outline what the law is in this area. As it turned out this child was transferred to another treating practitioner, and I haven't heard what happened.

The role of parents

When the child has capacity to decide on their own medical treatment, what role do the parents have? In Gillick and Marion's case, the courts said that parental power to decide diminishes as the child's capacity and maturity grows; and that the power to decide terminates once the child is considered to be Gillick competent. That is all very well in theory, but applying that in practice is probably quite difficult.

The findings of the House of Lords and of the High Court, in Gillick and Marion's case respectively, are quite clear on these two principles, but the Law Reform Commission noted that this hasn't been considered by the

court since Marion's case, so there is some uncertainty about the extent of parents' powers to make decisions where a child is otherwise Gillick competent.

Confidentiality

These principles also apply in the context of the duty of confidentiality. The facts in another recent UK case Axon, R (on the application of) v Secretary of State for Health & Anor [2006] EWHC 37 (Admin) (23 January 2006) are very similar to the facts in Gillick: again a woman, with a number of daughters, wanted to challenge the health authority's guidelines about giving contraceptive advice, without her knowledge, to her daughters. The court upheld the findings of Gillick in the context of confidentiality. They found that a child who has sufficient capacity to fully understand the nature and consequences of the treatment and of the advice is entitled to keep that confidential from their parents.

Some of the arguments on behalf of the mother were quite interesting. She tried to argue that parental duty requires a parent to know information about their child, particularly in relation to sexual matters, because the parent is the one who should be giving advice about it. While the judge was partially persuaded by what he called 'family factors', he noted that he was ultimately bound by Gillick and so upheld the child's right to confidentiality.

Many doctors ask if they have to tell the parents if a girl comes in requesting a termination, or contraception. Our advice is traditionally along the lines of that UK case, that a child who has sufficient capacity has a right to confidentiality.

The child's best interests

Of course if a child is not Gillick competent, then the parents can decide on the treatment, but the *caveat* on that is that they must act in the child's best interests – this is another great aspirational comment by the courts which is difficult to apply in practice.

In Marion's case, Justice Brennan said that the problem with the best interest test is that it is dependent on the value system of the decision-maker. It doesn't really assist in identifying factors relevant to the best interests of that particular person. What a person's best interests are is inherently value-laden, and trying to work out what someone's best interests are is difficult if you are a medical practitioner who knows nothing about the family and its values and beliefs. How can you decide what is in the best interests of the patient?

Failure to act in the best interests of the child leaves parents vulnerable to a report to DoCS on the basis that the child is at risk of harm, or to a hospital's application to the court for treatment to be provided.

Parents might also be at risk of criminal prosecution if they fail to act in the best interests of the child. The recent case of R v Thomas Sam; R v Manju Sam (No. 18) [2009] NSWSC 1003 (28 September 2009) involving the nine-month-old girl who wasn't given treatment for her dermatitis is illustrative of that concept. The parents were found guilty of manslaughter for failing to give her the appropriate care.

The Guardianship Act

If the young person is aged over 16 and lacks capacity, then the New South Wales Guardianship Act applies, with its many rules about who can make decisions. Again there is an interesting distinction between the notion of capacity in the Guardianship Act and the notion of children's capacity. The Guardianship Act is similar to the adult test for competence, that is, someone has to understand 'generally' the nature of what is proposed. There is no requirement that they 'fully' understand. So a 16-year-old might or might not be competent at common law but competent under the Guardianship Act. There are some interesting legal niceties involved there.

Where the parents and the doctors disagree

If there is a dispute between the parents and the medical team, court intervention is quite often required. The Supreme Court and the Family Court both have the jurisdiction to make orders for the welfare of children. Again, the children's best interests are paramount. There have been quite a few interesting cases where the court has been called upon to make decisions for children.

In Re Alex in 2004, an application was brought by a 13-year-old genetically female child who wanted to commence hormone treatment as a precursor to gender reassignment surgery. The child had a very deeply held belief that he was male, not female. The court heard evidence from the school teachers about this child's long-standing desire to be male.. It makes interesting reading about this child's feelings and the way in which he dealt with the situation – for example he used to not go to the bathroom, or tried to use the male bathroom and school teachers gave evidence about how these things impacted upon Alex and his school life. Chief

Justice Nicholson, as he then was, Chief Justice of the Family Court, considered all of this evidence and found that it was in the child's best interests for the treatment to be provided.

Blood transfusions

Of course this situation comes up often in the context of blood transfusions and Jehovah's Witnesses. There were several cases in the early 1990s in New South Wales where DoCS and hospitals made applications for the children of Jehovah's Witnesses to have blood transfusions.

More recently in 2004 in the Supreme Court of Western Australia, the Minister for Health made an application for medical staff at an oncology ward in a hospital to give blood transfusions to a child aged 15. The parents, Jehovah's Witnesses, didn't want the child to have the transfusion, but they left the question up to the child. The child also didn't want the transfusion. Although the court found that the child was in fact competent and understood the nature and implications of the decision, it overrode the wishes of the child. It made orders permitting the transfusion on the basis that that was in the child's best interests.

Chemotherapy

Another 2003 NSW case called Re Heather involved an application by a hospital to proceed with chemotherapy in an 11-year-old, who was almost 12. She had a malignant 'yolk sac' tumour of the ovary. The evidence was that she had an 85% chance of a cure if she had chemotherapy, but less than a 50% chance without it. The parents didn't want her to have chemotherapy. They wanted her to have ozone therapy and a strict diet, which they thought might help her. A report was made to DoCS, who brought the application for a court order that the child be made a ward of the court and then an order made that chemotherapy be instituted.

The court, balancing the risks to the child of having the chemotherapy, versus the risks of not having it, overrode the objections of the parents and the wishes of the child and ordered that chemotherapy be provided.

Anorexia

In a number of cases involving anorexic teenagers, court orders have been made for them to be detained in hospital and to be treated, contrary to their wishes and often contrary to the wishes of their parents.

Special medical treatment

The Guardianship Tribunal has a jurisdiction to make decisions concerning incompetent young people over the age of 16 in the context of special medical treatment, namely medical treatment such as that contemplated in Marion's case, to render a person permanently infertile, and a number of other situations.

A recent article, again in the Journal of Law and Medicine, involves a 2008 decision of Judge Wilson in the case of State of Queensland v B . In that case, the judge extended the reasoning in Marion's case to the situation where a 12-year-old was pregnant, her parents wanted her to have a termination and the child wanted a termination. The court said that having a termination was akin to a sterilisation operation as considered in Marion's case and thus neither the 12- year-old, nor the parent could authorise it. It had to go to court to be authorised. It is an interesting case, particularly in light of the recent controversy in Queensland involving surgical and medical termination. The child and the parents wanted a medical termination in this particular case. The court ordered it in the end finding that it was in the child's best interests for her to undergo the termination, but it was of interest that the court suggested that it was something beyond the power of the parents to decide.

The doctor's role

What's the role of the medical practitioner? Under the Children and Young Persons Care and Protection Act, a doctor can provide emergency treatment without the consent of the child or the parent. There is also a provision to the same effect in the Guardianship Act. Treatment can be provided as a matter of urgency if it is required to save the life of the child or to prevent serious damage to his or her health. Many of the cases in the earlier 1990s involving blood transfusions revolved around the application of this particular provision and whether or not doctors would be acting in an emergency in giving blood transfusions.

Assessing the child's competence

Competence is a matter for the clinical assessment of the doctor.

The Law Reform Commission recognised how difficult this can be. In what circumstances can the child make the decision? When are they going to be competent? There is a considerable onus on health care professionals to decide whether or not a child is sufficiently competent to make the decision..

The Law Reform Commission found a major source of confusion in section 49 of the Minors (Property and Contracts) Act. This provision provides that a doctor is protected from a claim of assault or battery if a young

person is aged 14 years or over and consents, or if the young person is under 16 and the parents or guardians consent. There is no requirement of any capacity in this provision. The Law Reform Commission was of the view that, because of the developments of the common law, the section is largely redundant. It is interesting that it has caused much confusion amongst doctors. Many doctors who ring us have the idea that, at the age of 14, children can consent, but anything under that age is problematic. Perhaps that uncertainty has come from this provision.

Reporting to DoCS

I mentioned before that parents who don't provide appropriate care to their children are at risk of a report to DoCS. Medical practitioners do have a mandatory obligation to report a child at risk of harm to DoCS. As a result of the Wood inquiry, the mandatory report provision is about to change. Legislation passed in April 2009, but not yet in force, changes the test from 'child at risk of harm' to a 'child at significant risk of harm'. The new legislation also removes the criminal element. So the statutory penalty regime for mandatory reporters who didn't report is being taken away under the new legislation. I am not sure when that legislation is due to commence.

A medical practitioner can make an application to the court if they consider treatment is in the best interests of the child and the child or parents refuse. Many cases involve those sorts of applications. DoCS can also make an application- for a child to become a ward of the court or of the state and then make the application to have treatment.

New South Wales Law Reform Commission recommendations

The New South Wales Law Reform Commission recommends a test for competence based pretty much on the common law test under Gillick, in that a person will be competent if he or she understands the information relevant to making a decision and appreciates the reasonable foreseeable consequences of that decision.

The health professional, again, has the onus of assessing competence. The Commission suggests that it be made clear that it is not necessary to obtain acceptance or refusal from a parent or guardian. The Commission also recommends repeal of section 49 of Minors Property and Contracts Act, because it is largely redundant and a source of confusion. The Commission weighed up whether legislation should be enacted or whether the common law should be left to develop. The Commission took the view that legislation would be better, because it would set things out more clearly, despite the lack of flexibility which can sometimes occur with legislation and potential problems with interpretation.

Conclusion

What of my initial case scenario? The doctor met the girl and the mother separately and together. She consulted widely with many colleagues and with specialists in adolescent health. All but one of her colleagues were supportive of her ultimate decision. In light of her experience in providing contraception to older girls, aged 14 and 15, she felt that this particular child was not competent to make the decision herself. She spoke to the mother, who definitely preferred that her child abstain from sexual activity, but as this was not occurring, she wanted her to be protected from the risk of pregnancy.

The doctor's clinical assessment was that the girl was at greater risk if she wasn't using contraception. The colleague who did not support her took the view that it would be illegal to give the contraception. I am not quite sure of the basis of that belief. The doctor, doing the balancing act of treatment or non-treatment in this circumstance, thought that *Implanon* was the best option, considering the best interests of this child. She acceded to the mother's request to provide the *Implanon*. She provided both the mother and child with information about the risks and benefits of the contraception, the alternatives such as abstinence, and about the risks of failure and the lack of protection from sexually transmitted diseases.

She referred the girl to a psychologist to assist with her self-esteem issues and to discuss the possible sequelae of her sexual behaviour. She also reported the matter to DoCS.

That concludes my brief overview of the law in this area. Anyone who wants to read more can quite happily read the 250-page Law Reform Commission report.