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CHILD'S RIGHT TO REFUSE TO CONSENT TO MEDICAL TREATMENT

LAWS 530: Human Rights Law Seminar
2001

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2001

TABLE OF CONTENTS

ABSTRACT

To date the New Zealand courts have not had to decide whether the wishes of a competent child, who refuses medical treatment, should be overridden. The broad objective of this research paper is to examine this area of legal uncertainty. This paper will provide a critical analysis of the leading English case law in this area. There are two leading English cases. The first is the case of *Gillick v West Norfolk and Wisbech Area Health Authority*[1] which concerned the issue of whether contraceptive advice and treatment could be given to girls under the age of 16 without the knowledge and consent of their parents. The House of Lords held that some children are legally competent to consent to some medical treatment, namely children who fully understand the significance of such decisions. This case established what is called the '*Gillick* competency' test. Whether a child is *Gillick* competent is a question of fact. It is not enough that the child should understand the nature of the advice given, the child must also have sufficient maturity to understand what is involved in the treatment.[2] This paper argues that if the situation arises the *Gillick* test should be applied in New Zealand.

The second English case of *Re R*[3] concerned a child who suffered from a psychiatric condition and who refused to take anti-psychotic medication. The Court of Appeal held that the powers of a wardship judge include the power to consent to medical treatment when the ward has not been asked or has declined medical treatment.[4] Further the Court held that a parent of a *Gillick* competent child could override the child's refusal to consent to treatment. In essence *Re R* held a competent child in England can consent to medical treatment but cannot refuse medical treatment.

This research paper intends to challenge the decision of *Re R*. It is asserted that if a child is found to be *Gillick* competent then there should be no difference in his or her ability to consent to having treatment as opposed to his or her ability to

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[1] *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL) [*Gillick*].
[2] *Gillick*, above, 423 Lord Scarman.
[3] *Re R* [1992] Fam 11 (CA).
[4] *Re R*, above, 23.

refuse it. Having argued that the *Gillick* test should be applied in New Zealand, this paper will then address the legal uncertainty that is involved in the area of medical treatment and religion. It is submitted that children should not automatically be classed as incompetent on the basis of religion. If an adult is classed as competent and can refuse medical treatment on the basis of religion then a competent child should be treated in the same way.

This paper will then go on to discuss, a further contentious issue regarding the rights of parents in relation to medical treatment of their children. Do parents have an absolute right to be informed of all advice or medical treatment their children seek? Should parents be able to override his or her child's consent to medical treatment? This paper will also review the rights of parents to refuse to consent to medical treatment of their children on the basis of religion.

The text of this paper including footnotes (excluding title page, table of contents and bibliography) comprises approximately of 15, 093 words.

I INTRODUCTION

Tovia Laufau was 13 years of age when he died on 7 September 1999. He had a tumour the size of a football on his right knee. Tovia begged his family to discontinue medical treatment. As a result of the public outrage in the recent Williams-Holloway case the hospital did not apply to the court for a wardship order. This situation raises the issue of whether the court would have overridden Tovia's wishes.[5] The law in New Zealand is uncertain when a child is competent and refuses medical treatment. The question that needs to be asked is whether children should have the right to refuse to consent to treatment?

There is an ongoing debate as to how much the State should intervene between the relationship between parents and children. Many argue that the State should have greater power over the way in which our children are brought up, including the treatment and decisions that they can make. Others argue that the State should have little control over the parental decisions concerning their children and that parental autonomy should prevail.[6] Some people believe that the law should spell out the rights of the children, in a bill similar to the New Zealand Bill of Rights Act 1990 (NZBOR Act).[7]

This paper asserts that a *Gillick*[8] competent child should have the right to refuse medical treatment and that their wishes should be upheld under section 11 of the New Zealand Bill of Rights Act 1990. Section 11 provides that "[e]veryone has the right to refuse to undergo any medical treatment." The High Court has held that "everyone" means everyone who is competent.[9] This means that a *Gillick* competent child should have the right to refuse medical treatment. Further this paper asserts that the Code of Health and Disability Services Consumers Rights, and the United Nations Convention on the Rights of the Child support the right of competent children to refuse medical treatment. It is further asserted that the New Zealand

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[5] In March 2000, Tovia's parents were charged with manslaughter and with failing to provide the necessities of life under ss171 and 151 of the Crimes Act 1961. They were found guilty under s151.
[6] W R Atkin, "Parents and Children Mrs Gillick in the House of Lords" (1986) NZLJ 90.
[7] Atkin, above 90.
[8] The *Gillick* competency test derived from the case of *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 ALL ER 402 (HL) [*Gillick*].
[9] *Re S* [1992] 1 NZLR 363, 374 (HC) Baker J.

courts should follow the *Gillick* test and reject the subsequent test in *Re R.*[10] It is submitted that the *Re R* decision has unduly restricted the *Gillick* test and undermines the autonomy and human rights of a competent child.

It is also asserted that if a competent adult can refuse medical treatment on the basis of religion then a child should also be able to do so. Religion alone should not class a child incompetent. In some overseas cases involving religious rights of the child, the courts have held the child to be incompetent because the courts see the child's wishes as the wishes of the parents.[11] In other words the child has been unduly influenced, and therefore he or she is incompetent to make a decision to refuse medical treatment. This paper asserts that a child's religious beliefs in relation to medical treatment should be distinguished from situations such as psychiatric conditions where it is obvious that the child is incompetent.

The New Zealand courts under its wardship jurisdiction, have the power to authorise or withhold permission for medical treatment for a child. This power to authorise or withhold medical treatment can override the wishes of parents. This paper expresses the view that the courts have a duty to protect the child particularly in cases involving life-threatening conditions. It must be remembered that the rights belong to the child and until the child is competent to make the decision to refuse treatment for him or herself the courts should do everything possible to sustain that child's life.

II GILLICK COMPETENCE

A Gillick v West Norfolk and Wisbech Area Health Authority[12]

The *Gillick* decision can be described as a landmark decision in which the majority of the House of Lords outlined the law in relation to parental rights. The case came about after the Department of Health and Social Security circulated a

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[10] *Re R* [1992] Fam 11 (CA).
[11] *Re L* [1998] 2 FLR 591 (HC); *Re CL* [1994] NZFLR 352 (HC); *Prince v Massachusetts* 321 U.S. 158, 88 L.Ed. 645, 64 S. Ct. 438 (1944).
[12] *Gillick*, above.

memorandum to area health authorities which advised that it would not be unlawful to give out contraceptive advice and treatment to girls under the age of 16 years without parental consent.

Mrs Gillick, who had five daughters, under the age of 16 years objected. Mrs Gillick was a staunch Roman Catholic and rejected any artificial contraception. She wanted the right to determine how her daughters would be brought up without the interference from the state. Mrs Gillick wanted an assurance that while her daughters were still under 16 years, none of them would be able to obtain contraceptive advice or the contraceptive pill without her consent. When the local authority refused to provide this assurance she commenced legal proceedings seeking:

(1) That the memorandum was unlawful, because it was contrary to section 28(1) of the Sexual Offences Act 1956, which provides that it is an offence for a person to encourage the commission of unlawful sexual intercourse with a girl under 16 for whom he or she is responsible for.

(2) That it was unlawful to give advice and / or treatment to children under 16 without parental consent because it was inconsistent with parental rights.

The Court at first instance held that a doctor giving contraceptive advice and treatment to a child under 16 years was not a breach of section 28(1) of the Sexual Offences Act 1956, so long as the advice was given in accordance with the information contained in the memorandum. In relation to the second issue the Judge held that a parent's interest in his or her child is not a "right". Parents have a duty or responsibility and on that basis contraceptive advice to a girl under the age of 16 without parental consent was not unlawful.

Mrs Gillick then appealed to the Court of Appeal. The Court of Appeal overturned the Judge's decision on the basis that a child under 16 could not consent to treatment without parental consent and therefore the memorandum was unlawful. The Department appealed to the House of Lords. It was in this Court that Mrs Gillick lost her battle by a three to two majority.

The *Gillick* decision not only decided the issue of whether the medical profession could legally give out contraceptive advice without parental consent, but also had a number of other implications. Firstly, the decision addressed the issue of contraceptive advice given to minors. This addressed a number of questions such as: whether parents have an overriding right to know whether their daughter has sought contraceptive assistance? Was the medical professional required to consult parents or was the consent of a minor enough to enable the treatment to proceed? Secondly, the decision addressed the broader issue of whether parental consent is necessary for all medical procedures not just contraceptive advice. Is it necessary for the medical profession to seek parental consent for all medical treatment (not including medical emergencies)? Thirdly, the House of Lords reviewed parental rights generally in relation to children. How far does the law extend parental autonomy and can a child act independently? The majority looked at the broader principles concerning parental rights. The minority focused their judgment on the contraceptive advice only.

B The Gillick Test

The House of Lords held that children might be legally competent to consent to some medical treatment, such children being those who fully understand the significance of such decisions. In order to determine whether a child is *Gillick* competent Lord Scarman stated: [13]

> I would hold as a matter of law the parental right to determine whether or not a minor child below the age of 16 will have medical treatment terminated if and when the child reaches sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give consent valid in law…It is not enough that she should understand the nature of the advice given: she must also have a sufficient maturity to understand what is involved.

Having found that a child under the age of 16 can consent to medical treatment, the question arose when does parental consent cease? Can a parent override the wishes of a competent child under the age of 16? Lord Scarman held that parental power to consent to treatment is overridden if a child is *Gillick* competent.[14] *Gillick* competence reflects the staged development of a child, meaning the transition from childhood through adolescence to adulthood. It reflects the gradual acquisition of maturity and the capacity to consent may vary according to the gravity of the proposed treatment. This will be a question of fact.[15] For example a child might have the capacity to consent to surgical treatment for a broken arm but may not have the capacity to consent to more serious life threatening forms of treatment such as a blood transfusion.

In reaching this opinion his Lordship referred to the Canadian High Court case of *Johnston v Wellesley Hospital*[16] which held:

> But, regardless of modern trend, I can find nothing in any of the old reported cases, except where infants of tender age or young children were involved, where the Courts have found that a person under 21 years of age was legally incapable of consenting to medical treatment. If a person were unable to consent to medical treatment, he would also be incapable of consenting to other types of bodily interference. A proposition purporting to establish that any bodily interference acquiesced in by a youth of 20 years would nevertheless constitute an assault would be absurd. If such were the case, sexual intercourse with a girl under 21 years would constitute rape. Until the minimum age of consent to sexual acts was fixed at 14 years by a statute, the Courts often held that infants were capable of consenting at a considerably earlier age than 14 years. I feel that the law on this point is well expressed in the volume on *Medical Negligence* (1957) by Lord Nathan (p176): "It is suggested that the most satisfactory solution of the problem is to rule that an infant who is capable of appreciating fully the nature and consequences of a particular operation or of particular treatment can give effective consent thereto, and in such cases the consent of the guardian is unnecessary; but that where the infant is without the capacity, any apparent consent by him or her will be a nullity, the sole right to consent being vested in the guardian."

Lord Fraser stated:[17]

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[13] *Gillick* [1985] 3 ALL ER 402, 423 (HL).
[14] *Gillick*, above, 423.
[15] *Gillick*, above, 423.
[16] *Johnston v Wellesley Hospital* (1970) 17 DLR (3d) 139, 144-145.
[17] *Gillick* [1985] 3 ALL ER 402, 409.

> It seems to me verging on the absurd to suggest that a girl or boy aged 15 could not effectively consent, for example, to have a medical examination of some trivial injury to his body or even to have a broken arm set. Of course the consent of the parents should normally be asked, but they may not be immediately available. Provided the patient, whether a boy or a girl, is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises. After all, a minor under the age of 16 can, within certain limits, enter into a contract. He or she can also sue and be sued, and can give evidence on oath. Moreover, a girl under 16 can give sufficiently effective consent to sexual intercourse to lead to the legal result that the man involved does not commit the crime of rape.

Accordingly Lord Scarman and Lord Fraser were not convinced that a girl under 16 lacks the capacity to consent to contraceptive advice or treatment on the basis of her age, so long as she has sufficient understanding and intelligence to understand what is involved.[18] The majority of the House of Lords allowed the appeal.

However, the minority, Lord Brandon and Lord Templeman, disagreed with the majority but each held different views. Lord Brandon held that it was unlawful for a girl under 16 to obtain contraceptive advice and treatment whether or not the girl's parents knew of it or consented to it.[19] Lord Templeman, however, did say that a doctor in exceptional circumstances may be able to give contraceptive treatment to a child under 16 but would be bound to tell a parent.[20] His Lordship considered that exceptional circumstances could arise if the child was "unable to control her sexual appetite."[21] Both Lord Brandon and Lord Templeman held that girls under 16 were not competent as Parliament had declared pursuant to section 6 of the Sexual Offences Act 1956 that an unmarried girl was not competent to decide to practice sex.[22] The minority having arrived at these conclusions did not go further to consider the wider issue of whether children under 16 were able to consent to other medical treatment in the absence of parental consent.

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[18] *Gillick*, above, 409.
[19] *Gillick,* above, 431.
[20] *Gillick,* above, 435.
[21] *Gillick* [1985] 3 ALL ER, 402, 435 (HL).

C *Analysis of Gillick*

The *Gillick* decision has political, social, medical and religious implications.[23] The question that arises is how is this decision relevant to New Zealand? This paper asserts that all of the issues addressed in the *Gillick* decision are relevant to New Zealand. The decision represents the common law on the rights of a child to consent to medical treatment, and outlines parental responsibilities. In this regard this decision has implications for New Zealanders and not only affects the legal profession but also the medical profession, except in cases where there is an express statutory provision governing the medical treatment of minors.

So when does a child have the capacity to consent to medical treatment? This is not an easy question to answer. This paper agrees with Lord Fraser, who argued that it would be absurd to say that parents have complete control of their child until he or she attains 16 years and that when that child turns 16 he or she suddenly has full independence. His Lordship noted that parental control starts with the right to control and ends with little more than advice.[24] In fact as his Lordship pointed out most parents in today's society gradually relax control over their children as they get older.[25] Furthermore as society has changed over the years so too should the law. Indeed issues that arise in today's society have never been issues that our ancestors have had to face. Children today have far more independence.

Children today make various decisions from an early age. A child at the age of 8 might be able to take an oath and at 15 a child might be able to consent to marriage or choose his or her guardian and be able to make his or her will.[26] To say that a child is not competent to refuse medical treatment is illogical if we are to say that he or she can be competent to consent to treatment. To place an age on a child which apparently classes him or her as competent is unjust. Children do not necessarily become competent upon reaching the age of 16. You could have two 15 year-old children, one may be immature, while the other may clearly have the mental maturity and intelligence to understand the consequences of his or her decision.

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[22] *Gillick*, above, 433.
[23] W.R Atkin, "Parents and Children Mrs Gillick in the House of Lords" (1986) NZLJ 90, 91.
[24] *Gillick,* above, 411.
[25] *Gillick* [1985] 3 ALL ER 402, 411 (HL).
[26] *Gillick,* above 421.

It is acknowledged that some critics may argue that there is a difference between the capacity to make a will and the capacity to make a decision involving a life threatening condition. However, if it is medically established that the child is competent to make the decision then his or her right to refuse treatment should be upheld. Its important to remember that the *Gillick* test does not apply to cases where the child is suffering from conditions such as anorexia nervosa[27]or from a psychiatric condition[28] where the condition itself affects the child's ability to consent.

Until the child is sufficiently competent to consent to medical treatment, parental rights concerning consent to treatment remain undisturbed, except in cases where there is an emergency, parental neglect or abandonment. In such cases a doctor may proceed with treatment without parental consent.[29] However, as Lord Scarman pointed out, under the common law, while accepting that parental rights do not wholly disappear until the child reaches the age of majority, that right has never been treated as "sovereign or beyond review and control."[30] The parental rights derived from the parental duty and only existed so long as it was necessary for the protection of the person and property of the child.[31] As Lord Fraser pointed out "...parental rights to control the child existed not for the benefit of the parent but for the child. They exist for the benefit of the child and they are justified only in so far as they enable the parent to perform his duties towards the child, and towards other children in the family."[32]

Following the *Gillick* decision the law in England concerning the rights of competent children to consent to medical treatment was settled until the later decision of *Re R.*[33]

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[27] *Re W (a minor: medical treatment)* [1994] 4 ALL ER 627 (CA).
[28] *Re R (a minor)* [1991] 4 ALL ER 177 (CA).
[29] *Gillick* [1985] 3 ALL ER 402, 123-124 (HL).
[30] *Gillick*, above, 420.
[31] *Gillick*, above, 420.
[32] *Gillick*, above, 410.
[33] *Re R (a minor)* [1991] 4 ALL ER 177 (CA).

III RE R [34]

A Background

The case of *Re R* concerned a child who suffered from a psychiatric condition and who refused to take her anti-psychotic medication. R was almost 16 years old. She was well known to social services and was on the local register for at-risk children. It was considered that R had been the victim of emotional abuse at home. In 1991 R was placed into voluntary care after a fight with her father. While in care she did not want to see her father and became increasingly anxious. R's demeanor was reported as flat and expressionless. She was also experiencing visual and auditory hallucinations and at times was suicidal. R eventually became a ward of the court.

In June 1991 a social worker was contacted by a senior consultant who requested permission to administer anti-psychotic medication. The consultant believed R was in a psychotic state. Social services consented to the treatment. On the same day R contacted social services and said she refused to consent to the medication. After a lengthy conversation social services concluded that R sounded lucid and rational. She was not regarded as sectionable under the Mental Health Act 1983. However, the unit remained of the medical opinion that R needed inpatient treatment, as she admitted that she was still suffering from mood swings, suicidal thoughts, and some visual and auditory hallucinations.

B Issues before the Court

The first issue before the Court was:

> ***(i) Can the court override a competent child's refusal to consent to medical treatment?***

The Court concluded that under its wardship jurisdiction it could override a child's refusal. Staughton LJ stated "...the powers of a wardship judge do indeed include power to consent to medical treatment when the ward has not been asked or has declined."[35] Lord Donaldson stated: [36]

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[34] *Re R* [1992] Fam 11 (CA).
[35] *Re R*, above, 23.

> It is, however, clear that the practical jurisdiction of the court is wider than that of parents. The court can, for example, forbid the publication of information about the ward or the ward's family circumstances. It is clear that this jurisdiction is not derivative from the parents' rights and responsibilities, but derives from, or is, the delegated performance of the duties of the Crown to protect its subjects and particularly children who are the generations of the future.

His Lordship went on to say that he could see no reason why the court in its jurisdiction could not override the *Gillick* competent child.[37]

The second issue for the Court was:

(ii) Can parental consent to treatment override the wishes of the child?

The Court split this question into two parts. In referring to the decision of *Gillick* the Court distinguished the *Gillick* case by saying that the House of Lords in *Gillick* was only dealing with the issue of whether children could consent to treatment and not the issue of whether children could refuse to consent to medical treatment.

Lord Donaldson MR held that a doctor could lawfully administer treatment to a competent child who refuses, if the parents have given consent.[38] Conversely however, the parents could not override the wishes of a child consenting to treatment. In effect the Court held a *Gillick* competent child can consent to treatment but cannot refuse consent to treatment. Both a court and a parent could therefore override a child's refusal.

It is submitted that if a *Gillick* competent child has the right to consent to medical treatment, then once the child reached this stage the parents' right to consent or refuse to consent to medical treatment ceases.

C Analysis of Re R

Re R contradicts Lord Scarman, in the *Gillick* decision, who held that the legally mature minor's rights superseded parental power to approve or decline

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[36] *Re R*, above, 22.
[37] *Re R*, above, 22.
[38] *Re R* [1992] Fam 11, 24 (CA).

medical treatment. Although the *Gillick* case concerned the issue of whether a child under 16 could consent to contraceptive advice, the majority approached the case from a wider perspective and looked at the whole issue of consent. It is submitted that their Lordships did not make a distinction between the capacity to consent to medical treatment and the capacity to refuse medical treatment. The Court in *Re R* decided that while the *Gillick* competent child's decision to consent to medical treatment could not be usurped by the parents, a refusal to undergo medical treatment could.

Lord Donaldson MR distinguished *Gillick* on the ground that it only concerned a child's independent right to consent. This right of the child did not override a parent's right to consent on behalf of his or her child. Lord Donaldson's MR rationale was that unless an independent right to consent from a parent was recognised, doctors would be faced with an "intolerable dilemma."[39] With all due respect it is asserted that by avoiding an apparent "intolerable dilemma" a minor's self-autonomy is subordinate to legal certainty. This reasoning is also in conflict with the *Gillick* decision where the House of Lords suggested that certainty was not a significant factor for the majority of the judges.[40]

It is asserted that the New Zealand courts should not follow this reasoning on the basis of a possible "intolerable dilemma." The *Gillick* test confronts doctors with a difficult situation and raises difficult questions about a child's developmental capacity. However, it is submitted that any situation that involves assessing a person's mental capacity whether that person is a minor, elderly, or mentally incapacitated can create a dilemma for the doctor. Under the *Gillick* test before a doctor can act on a child's consent, he or she must assess the child's capacity. Assessing whether a child is *Gillick* competent would be no more difficult in cases where the child consents than in cases where the child refuses. Surely this is a better approach than to ignore the issue altogether and to render the minor's refusal invalid.

The same argument can be put forward from the child's perspective. When a child is weighing up whether to consent to medical treatment, it is natural for him or

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[39] *Re R*, above, 24.
[40] *Gillick* [1985] 3 ALL ER 402, 409 (HL).

her to also consider whether to refuse it. If the child chooses not to consent then is he or she not refusing? The distinction made in *Re R* between consenting to medical treatment and refusing medical treatment is artificial. If a child is competent to consent to medical treatment then that same child must also be competent to refuse that exact same treatment. The child still has to consider the same factors. Some critics may argue that refusing treatment could have more serious consequences, such as death, than consenting to treatment, and that it is the implications of the refusal of treatment that the child may not have the capacity to decide. It must be remembered that under the *Gillick* test the child must understand the nature and consequences of the treatment and the implications of such refusal.

This paper argues that if the decision in *Re R* is followed this would override the majority decision in *Gillick* and that separating the test (consenting and refusing to consent) causes an artificial distinction and creates uncertainty in the law for all concerned. Furthermore the argument suggested in *Re R* that the House of Lords in *Gillick* only decided whether children could consent to treatment is rejected. It is contended that when the House of Lords held a competent child could consent to treatment the House of Lords envisaged that this would include the ability to also refuse medical treatment.

D Gillick Competence and Religion

In the later English case of *Re L (Medical Treatment: Gillick Competency)*[41] a 14 year-old girl suffered very serious burns which resulted in a life threatening condition in which it was necessary to give her a blood transfusion to save her life. The girl refused the transfusion on the basis that she was a Jehovah's Witness. The child was considered mature for her age. She also had an 80 percent chance of survival following the surgery and blood transfusions, but without the proposed treatment it was inevitable that death would occur. The doctor informed her that the transfusion was necessary in order to save her life, however, the family decided that it would be too distressing for her to be told that if she did not receive the treatment her death would be slow and horrible. The medical evidence given was that her death would be grave, in that gangrene would supervene for some time and she would have

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

a very slow and painful death, which would be distressing for all concerned. The Court in this case had no hesitation in overriding her wishes. The Court found that she was not *Gillick* competent. The Judge held:[42]

> ...the girl's view as to having no blood transfusion is based on a very sincerely, strongly held religious belief which does not in fact lend itself in her mind to discussion. It is one that has been formed by her in the context of her own family experience and the Jehovah's Witnesses' meetings where they all support this view. He makes the point that there is a distinction between a view of this kind and the constructive formulation of an opinion which occurs with adult experience. This has not happened of course in the case of this young girl.
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> ...
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> She has led what has been expressed to have been a sheltered life, not an unrealistically sheltered life, but nevertheless a sheltered life. Her family circle is a tight one, in one sense, although there are a number of members of the family.

Although the girl may have meant it when she expressed that she was willing to die rather than have the blood transfusion, the Judge, however, was of the opinion that she was unable to make that decision. This was based on the fact that she had not received all the information, namely the way in which her death would occur. "...it would be right and appropriate to have [this information] in mind when making such a decision."[43] The Judge accordingly found that the girl was not *Gillick* competent and ordered that the operation and blood transfusion go ahead. As an obiter statement the Judge held that even if she was *Gillick* competent it would be appropriate to make the order as this was an extreme case and it was vital she receive the treatment.[44] The Court did not rely on *Re R* as its authority to override her wishes.

The Judge was correct to find that the girl was not *Gillick* competent. She could not have made a decision of life versus death without knowing all the facts, including the way in which her death would occur. If the family felt it was too distressing to tell her this information, one can only imagine how distressing it would have been for her in the drawn out process of dying. However, if she had been fully aware of the facts and found to be *Gillick* competent then her right to die on the basis

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[42] *Re L*, above, 813.
[43] *Re L*, above, 813.

of religion should be upheld. If a child is found to be *Gillick* competent then essentially the Court treats you as an adult. If an adult who is competent can refuse medical treatment on the basis of religion then so should a *Gillick* competent child. To override the child's wishes is to undermine his or her autonomy.

In a more recent English case[45] the Court overrode the wishes of a 15 year-old girl who refused to consent to a heart transplant. Up until this point the girl had been fit and healthy. She suddenly developed a life threatening condition. The girl's parents consented to the operation, but she refused on the basis that she did not want someone else's heart and also did not want to take medication for the rest of her life. "Equally she did not wish to die".[46] In ordering consent for the transplant the Judge held that "...M felt overwhelmed by her circumstances and the decision she was being asked to make. ... Events have overtaken her so swiftly that she has not been able to come to terms with her situation."[47] Although the Judge never said that M was not *Gillick* competent the fact that she did not want the heart and combined with the fact that she did not want to die indicates that she may not have been competent to make the decision. It was appropriate that the Court intervened and overrode her uncertain wishes. It is also interesting to note that the Court did not refer to *Re R*, although the Judge noted that a refusal by a child is important but not decisive.[48]

The English courts have taken a similar approach in other cases. In *Re E (a minor) (wardship: medical treatment)*[49] a 15 year-old Jehovah's Witness who refused a blood transfusion was held not to be competent. Although he had some concept that he would die, he did not realise the full implications of the dying process. The court "should be very slow to allow an infant to martyr himself."[50] Johnson J adopted a similar approach in *Re S (a minor) (consent to medical treatment)*[51] where a 15 year-old Jehovah's Witness refused a blood transfusion. The Judge held the girl was confused over many details, and did not know how her death would occur. The Judge

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[44] *Re L (Medical Treatment : Gillick Competency)* [1998] 2 FLR 810, 814 (FD).
[45] *Re M* [1999] Fam Law 753 (FD).
[46] *Re M*, above, 756.
[47] *Re M*, above, 756.
[48] *Re M*, above, 754.
[49] *Re E (a minor) (wardship: medical treatment)* [1993] 1 FLR 386.
[50] *Re E*, above, 386.
[51] *Re S (a minor) (consent to medical treatment)* [1994] 2 FLR 1065.

noted that the girl did not believe that a refusal would lead to her death because there might be a miracle and God might save her.[52]

E Summary of the English Position

Since the decision of *Re R* there has been much academic debate as to whether *Re R* has overruled the *Gillick* decision. Some academics argue that *Gillick* is only the authority stating that a competent child can consent to treatment without parental consent, and that *Re R* is the authority which allows both the parents and courts to override the child's refusal to medical treatment whether *Gillick* competent or not. Others have argued that the *Gillick* test meant once a child had reached maturity to make the decision and was competent to do so, then the parents lose their parental control over the decision.

What is certain is that the *Gillick* test continues to be applied and referred to. It is interesting to note that the later cases do not appear to rely on *Re R* as their authority for overriding the child's wishes. The courts will normally hold the child to be *Gillick* incompetent when the issue of refusing treatment arises. As far as the competent child and religion are concerned, the courts do not separate out the religious factor in the same way that they do for competent adults. However, in the above religious cases all of the children were held not to be *Gillick* competent because they failed to understand the consequences of refusing medical treatment or because they had not been fully informed of the consequences. Before looking at the New Zealand position it is necessary to review the law in other overseas jurisdictions. The next section in this paper will review the law in Australia, Canada and the United States, to see whether competent children in those countries can refuse to consent to medical treatment.

IV OTHER COUNTRIES

A Australia

The Australian courts like New Zealand have not had to decide a case similar to that of *Re R* where the right to refuse medical treatment was in issue. The

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[52] *Re S*, above.

Australian courts have, however, approved the *Gillick* competency test,[53] but in that case the child wanted the treatment but because of the nature of the treatment it was necessary to apply to the Court for approval. Although the child's wishes were considered, the Family Court held that she was not *Gillick* competent to make this decision.[54]

The 1983 amendments to the Family Law Act 1972 gave the High Court of Australia welfare jurisdiction. This allows the court to act as *parens patriae*. This gives the court the power to authorise medical treatment where the child is unable to consent. Under this Act the guiding criteria for the court is the "welfare of the child" or the "best interests" principle.[55]

B Canada

In Canada a competent adult has the right to refuse medical treatment, even if it has potentially fatal results.[56] The common law in Canada also recognises this right for children so long as they are "mature minors". If the child is competent then this allows the child to consent or refuse medical treatment. The capacity test involves:[57]

> ... the ability to understand the reasonably foreseeable consequences of a treatment decision in a mature and comprehensive way. The significance and repercussions of a decision are relevant in assessing capacity. Capacity is presumed at the age of sixteen. An individual may have sufficient maturity and judgment at a younger age.

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[53] *Re A* 16 Fla.L.Rev 715 (FC). This case concerned a 14 year-old child whose mother had applied to the Court to have certain medical procedures performed on A, namely to assign male sex organs. When A was born she was diagnosed as a female, but had a condition which gave her a male appearance. As a child A had surgery to give her a female appearance, but during her childhood she did not receive enough hormone replacement therapy. This resulted in the recurrence of male features. The proposed surgery would return A to a male. Given the medical and psychological evidence the Court allowed the operation to proceed.

[54] *Re A*, above, 721.

[55] Helen Rhoades "Intellectual Disability and Sterilisation -An Inevitable Connection?" (1995) Australian Journal of Family Law Lexis 25, 2.

[56] See *Fleming v Reid* (1991) 82 DLR (4th) 298 (Ont. CA).

[57] *Tarin H and Children's Aid Society of Metropolitan Toronto* 10 O.F.L.R. 82, 88.

In 1996 Ontario introduced new legislation addressing the issues of medical consent. The 1996 Consent Act was enacted to clarify the law surrounding consent to medical treatment. Section 4(1) of the Act allows a "person" who is able to understand the proposed treatment and its consequences to make his or her own decision regarding treatment. Section 4(2) has a presumption that a person is able to make his or her own decisions in relation to medical treatment. Under sections 4(3) and 10(1), unless health care providers have reasonable grounds to believe that the patient does not understand the treatment or the possible consequences of giving or refusing consent, they must abide by the patient's expressed wishes. Unless there is reason to believe otherwise health care professionals may assume that they have obtained valid consent or refusal from a person.

Under the 1996 Consent Act the term 'person' is not defined. At common law, in Canada, a human being after birth becomes a person when it takes its first breath after birth.[58] The British Columbia Court of Appeal in *Re Baby R*[59] held that the definition of "person" includes children. Under the Canadian Charter of Rights and Freedoms[60] the term "person" has been judicially defined as including children under the age of 16 years in *R v J.*[61] The law in Canada has defined the term "persons" to include children, and therefore children are presumed to be able to consent to their own medical treatment under the 1996 Consent Act. Legislation in British Columbia gives children specific rights to direct their treatment.[62] It appears that the 1996 Consent Act did not change the law, as it was previously recognised under the common law that children could direct their own treatment.

In *Johnston v Wellesley Hospital*[63] Addy J of the Ontario High Court of Justice held there is no specific age at which a minor becomes legally capable of making his or her own decisions regarding medical treatment. Accordingly minors have the right to consent or refuse medical treatment so long as they understand the nature and consequences of the treatment. The Ontario legislation entrenched this rule initially under the 1992 Consent to Treatment Act, which was repealed by the

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[58] *R v Sullivan* [1991] 1 SCR 489, 503 (SC).
[59] *Re Baby R* (1988) 15 RFL (3d) 225.
[60] Part 1 of the Constitution Act 1982.
[61] *R v J* (1982) 1 Canadian Rights Reported 202, 204, Ontario Court of Justice (Provincial Division).
[62] Infants Act, Revised Statutes of British Columbia 1996, chapter 223, section 17.

current 1996 Consent Act. Under section 6(1) of the 1992 Act, a person could consent to medical treatment if that person understood the nature and possible consequences of the proposed medical treatment. Under that Act this meant that children could consent to medical treatment so long as they understood the nature and consequences. This recognised that children may be able to consent to some treatment and not others. This test is in line with the English *Gillick* competency test.

The 1996 Consent Act expanded on many of the rights given to persons in the repealed 1992 Act. Section 15(1) of the 1996 Consent Act recognises that a person can consent to some procedures but not others, and section 15(2) acknowledges that a person may be able to consent to treatment at one time but not at another. These sections enforce the idea that as children get older they can consent to different types of treatment.

Furthermore section 16 recognises that a child may develop the required understanding during the treatment. This section applies to children suffering from chronic conditions and diseases. If this happens health care providers must respect the wishes of the child regarding ongoing treatment over those of the parents. For example a 8 year old may not understand the treatment he or she is receiving, but as he or she gets older and understands the disease and the nature of the treatment and risks associated with continuing and ending it, that child has the right to make decisions regarding ongoing treatment. The 1992 Act did not specifically allow someone to make later decisions regarding treatment if someone else provided the initial consent.

In *Re Y A*[64] and in the case of *Walker (Litigation Guardian of) v Region 2 Hospital Corp*[65] the Court upheld the children's right to refuse medical treatment. In both cases the children were 15 years old. In *Walker* provincial legislation applied to a 15 year-old child. Section 3 of the Medical Consent of Minors Act S.N.B 1976 codifies the test for a child's capacity to refuse or consent to medical treatment. Under this section it must be the medical opinion of two doctors that the child has the

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[63] *Johnston v Wellesley Hospital* [1971] 2 Ontario Reports 103 (HC).
[64] *Re Y A* (1993) 111 Nfld & P.E.I.R 91 (FC).
[65] *Walker (Litigation Guardian of) v Region 2 Hospital Corp* (1994) 4 RFL (4th) 321 (CA).

capacity to refuse or accept treatment and the decision must be in the best interests of the child.

In both the *Walker* and *Re Y A* cases, the treating doctors were satisfied that the children had the capacity to refuse treatment. In *Walker* the 15 year-old Jehovah's Witness refused life saving treatment for his leukemia because it involved blood transfusions. Hoyt CJ and Angers J in finding for the boy held that he had sufficient maturity for his wishes to be respected.[66] Hoyt J held that where minors can understand the nature and consequences of the proposed treatment, interference with their wishes cannot be justified.[67] Ryan J concurred with the result but his reasoning was different. His Honour held that while a mature minor could consent to medical treatment, he or she cannot always refuse it. The court should use its parens patriae jurisdiction to override the wishes of a parent or to protect the child's life if that life is in danger.[68] In this case the boy's condition was not life threatening and therefore his wishes had to be respected. Ryan J's reasoning is similar to that in *Re R* in that a competent child can consent to treatment but cannot refuse medical treatment. His Honour also pointed out that if the boy's condition changed he would consider forcing him to undergo treatment.

C United States

In the United States many states have statutes which allow children to consent to general medical and surgical care. In Alabama children of 14 years and older may consent to general medical care. In South Carolina the same applies although the age is 16 years. In Arkansas and Mississippi the law allows children who are sufficiently mature to understand the nature of the treatment to give consent to surgical and medical treatment.[69]

In *Prince v Massachusetts*[70] the Supreme Court held that a parent's religious freedom is subordinate to the state's interest in preserving the health and welfare of the child within its borders. The Court stated "the right to practice religion freely

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[66] *Walker,* above, 333.
[67] *Walker*, above, 333.
[68] *Walker (Litigation Guardian of) v Region 2 Hospital Corp* (1994) 4 RFL (4th) 321, 333 (CA).
[69] Patricia Donovan "Teenagers' Right to Consent To Reproductive Health Care" http://www.agi-usa.org/pubs/ib21.html (last accessed 18 March 2000).

does not include liberty to expose the child to ill health or death."[71] In *Gregory Alan Novak v United States District Court For the Northern District of Georgia, Atlanta Division*[72] the plaintiff's counsel asserted that the plaintiff had an absolute right to refuse medical treatment as part of his right to privacy. The plaintiff also argued that by denying him the right to refuse unwanted medical treatment, his First Amendment right to freedom of religion had also been violated. In this case the plaintiff purported the right to refuse a blood transfusion on the basis of religion.

The Court agreed with the plaintiff's argument that an individual's constitutional rights do not instantly appear upon an individual reaching the age of majority. Furthermore the Court agreed that minors have some level of constitutional protection with respect to religious freedom and have "a substantial liberty interest in not being confined unnecessarily for medical treatment."[73] However, the Court noted that the plaintiff's counsel were unable to cite any reported Georgia case for the proposition that a 16 year-old "mature minor" has a constitutional right to refuse a blood transfusion pursuant to either the minor's First or Fourteenth Amendment rights.

The statutory minimum age for the right of refusal to medical treatment is 18 years in Georgia. Anyone under the age of 18 years are considered minors. The plaintiff pointed to various statutory exceptions in support of his argument. These exceptions give the power to refuse medical treatment if the minor is married, pregnant or has children. In these situations the minor can consent to medical treatment for themselves, their spouse and their children. The Court went onto note that the plaintiff's citation of cases holding that a competent adult has the right to refuse unwanted medical treatment and that minors have a constitutional right to consent to an abortion were inappropriate.[74] The Court went so far as to say that these exceptions undermined the plaintiff's argument.

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[70] *Prince v Massachusetts*, 321 U.S. 158, 88 L.Ed. 645, 64 S. Ct. 438 (1944).
[71] *Prince v Massachusetts*, above, 166.
[72] *Gregory Alan Novak v United States District Court For the Northern District of Georgia, Atlanta Division* 849 F. Supp. 1559, 1563; 1994 U.S. Dist. LEXIS 5112.
[73] The Court referred to the decision of *Parham v J.R,* 442 U.S. 584, 600, 61 L. Ed. 2d 101, 99 S. Ct. 2493 (1979) as its authority for this proposition.
[74] *Gregory Alan Novak,* above, 17.

The Court stated "[i]f minors, "mature" or otherwise, possessed the power to consent to and / or refuse medical treatment, there would be no need for these statutory exceptions."[75] The Court noted that the Supreme Court has stated that "most children in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical treatment."[76] "It has been firmly established that courts [in the United States] can order compulsory medical treatment of children for any serious illness or injury...and there are no religious exemptions from these orders."[77] The plaintiff's argument that the "mature minor" exception was part of the common law of Georgia was rejected by the Court.

Furthermore it is clear that in the United States the courts will just as easily override the wishes of the parent. It has been said that "not even parents have an unbridled discretion to exercise their religious beliefs when the state's interest in preserving the health of children within its borders weighs in the balance."[78]

D Summary of overseas

In summary Australia, Canada and the United States all have similar tests to that of the English *Gillick* test. However, in Canada there is one significant difference and that is under their 1996 Consent Act where there is the presumption that children are competent unless there is reason to believe otherwise. Under the common law in the United States and Australia, minors are presumed to be incompetent to make their own decisions regarding medical treatment. The only exceptions are where the children are married, legally emancipated from their parents, or are competent to understand both the nature and the risks involved in the treatment.

Although the Australian courts have not had to consider whether a competent child can refuse medical treatment on the grounds of religion, the Canadian courts have been prepared to respect the religious wishes of competent minors in

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[75] *Gregory Alan Novak,* above 19.
[76] *Parham v J.R,* 442 U.S. 584, 603.
[77] *Application of President and Directors of Georgetown College, Inc.,* 118 U.S. App. D.C. 80, 331 F. 2d 1000, 1007-8.
[78] *Prince v Massachusetts*, 321 U.S. 158, 88 L.Ed. 645, 64 S. Ct. 438 (1944), 166-167.

circumstances that are not life threatening.[79] The American courts on the other hand have held religious beliefs to be subordinate to the state's interest in preserving a minor's life. [80]

V NEW ZEALAND'S LEGAL FRAMEWORKS AND THE CHILD'S RIGHT TO REFUSE MEDICAL TREATMNT

So far this paper has analysised the English decisions of *Gillick* and *Re R* as to whether a competent child can consent, and can refuse to consent, to medical treatment, and how other overseas countries treat competent children. This section intends to review New Zealand's legal frameworks in relation to a competent child's right to refuse medical treatment and proposes how the New Zealand courts should apply these frameworks.

A *Article 12 of the United Nations Conventions on the Rights of the Child*

Article 12 requires that children have the right to express their views in matters which affect them, and that those views be given due weight in accordance with the age and maturity of the child. The United Nations Conventions on the Rights of the Child promote the right of children to self-determination, dignity, respect, non-interference, and the right to make informed decisions. The European charter for children in hospital states that "children and parents have a right to informed participation in all decisions involving their health care. Every child should be protected from unnecessary medical treatment and investigation."[81]

Many adults are uncomfortable about letting children decide medical treatment for themselves, in particular this would seem to be when a child wishes to refuse medical treatment. It has been suggested that children are ignorant, foolish and inexperienced to know what is in their best interests.[82] This argument goes against the right to self-determination. It is self-determination which is the key to all human

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[79] *Re Y A* (1993) 111 Nfld & P.E.I.R 91 (FC); *Walker (Litigation Guardian of) v Region 2 Hospital Corp* (1994) 4 RFL (4th) 321 (CA).

[80] *Prince v Massachusetts*, 321 U.S. 158, 88 L.Ed. 645, 64 S. Ct. 438 (1944).

[81] Priscilla Alderson "European charter of children's rights." (1993) Bulletin of Medical Ethics 13-5. The charter was based on the United Nations Conventions on the Rights of the Child.

rights. The right to have a choice is the underlying essential element to right holders.[83]

B The Code of Health and Disability Services Consumers Rights

Right 7(2) presumes every consumer is competent to consent to treatment unless there are reasonable grounds to presume otherwise. Under Right 7(3) if you have diminished competence because you are a child you should be allowed to consent to medical treatment to the level of your ability. This would seem to imply that whether a child is competent is a matter of fact and will depend on each child's situation and the type of treatment he or she is consenting too. Right 7(7) provides that every individual has the right to refuse medical treatment. The *Gillick* test seems to be reflected in the above rights.

C Guardianship Act 1968

Parental rights in New Zealand are normally associated with the rights given to guardians. Normally the parents will be the guardians. This comes through in section 6 of the Guardianship Act 1968. Guardianship means the guardian has the right of control over the upbringing of a child.[84] The word upbringing is defined to include education and religion of the child. A child means anyone under the age of 20 years. It would appear from the definition of guardian that parents have control over all decisions affecting the child, and that this is strengthened by the provisions in section 14 which provides a procedure where children over the age of 16 years can dispute a parental decision. In such cases the matter goes to a Family Court Judge.

These provisions imply that Parliament has intended to restrict the decision making ability of children between the age of 16 and 20 years and that such children do not have the self-autonomy to make decisions for themselves except in provisions which are expressly provided in the Act.[85]

Section 33 provides that the Guardianship Act 1968 is to be a code, except as otherwise expressly provided in this Act. The code replaces the common law and

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[82] Alderson, above, 13.
[83] Alderson, above, 13.
[84] Section 3 of the Guardianship Act 1968.

equity.[86] The question then becomes to what extent does the Guardianship Act override the common law and are the decisions of *Gillick* and *Re R* irrelevant in New Zealand? It is important to note that the Act does not cover every situation. The courts have the scope to develop the law. This can be seen through provisions such as section 23 which states that the welfare of the child is the first and paramount consideration. These are words that allow a large scope for interpretation.[87]

Section 25(1) and (2) provide that all people 16 years and over, and all married people, can give a valid consent to operations. Section 25 states:

> **25 Consents to operations**
> (1) Subject to subsection (6) of this section, the consent of a child of or over the age of 16 years to any donation of blood by him, or to any medical, surgical, or dental procedure (including a blood transfusion) to be carried out on him for his benefit by a person professionally qualified to carry it out, shall have the same effect as if he were of full age.
> (2) The consent of or refusal to consent by a child to any donation of blood or to any medical, surgical, or dental procedure (including a blood transfusion) whether to be carried out on him or on any other person, shall if the child is or has been married have the same effect as if he were of full age.
> (3) Where the consent of any other person to any medical, surgical, or dental procedure (including a blood transfusion) to be carried out on a child is necessary or sufficient, consent may be given—
> (a) By a guardian of the child; or
> (b) If there is no guardian in New Zealand or no such guardian can be found with reasonable diligence or is capable of giving consent, by a person in New Zealand who has been acting in the place of a parent; or
> (c) If there is no person in New Zealand who has been so acting, or if no such person can be found with reasonable diligence or is capable of giving consent, by a [District Court Judge] or the [[chief executive]].
> (4) Where a child has been lawfully placed for the purpose of adoption in the home of any person that person shall be deemed to be a guardian of the child for the purposes of subsection (3) of this section.
> (5) Nothing in this section shall limit or affect any enactment or rule of law whereby in any circumstances—
> (a) No consent or no express consent is necessary; or
> (b) The consent of the child in addition to that of any other person is necessary; or
> (c) Subject to subsection (2) of this section the consent of any other person instead of the consent of the child is sufficient.
> (6) Except to the extent that this section enables a blood transfusion (as defined in subsection (1) of section 126B of the Health Act 1956) to be administered to a child without the consent of any other person, nothing in this section shall affect the provisions of the said section 126B.

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[85] For example section 25 and 25A of the Guardianship Act 1968.
[86] Section 33(1) of the Guardianship Act 1968.
[87] W R Atkin "Parents and Children Mrs Gillick in the House of Lords" (1986) NZLJ 90, 91.

The question that needs to be addressed is whether section 25 would override the *Gillick* test. Under subsections (3) and (5), consent may be given by a guardian or by a person who has been acting in the place of a parent. Subsection 5(a) preserves the common law whereby no consent or no express consent is necessary. "This subsection does not expressly refer to any rule whereby the consent of the child alone will be sufficient, but arguably a rule about the non-necessity of parental consent could fall within the exception (a)."[88] Subsection 5(a) does not expressly state whose consent need not be obtained. It could reasonably be argued that given the context of the section, subsection 5(a) embraces the situations identified in the *Gillick* case.[89] It appears that under subsection 5(a) no parental consent is necessary because Parliament has expressly provided that a child can give sufficient consent.

The co-existence of the *Gillick* test and section 25 can be seen in section 25(3) where the subsection states "where the consent of any other person...is necessary or sufficient." The subsection does not describe the circumstances in which another person's consent is necessary or sufficient.[90] This leaves situations in which the courts will be left to decide whether the child is competent to consent to medical treatment.

However, section 25 does not deal specifically with a parent's right to override the refusal of a child, nor does this section address whether the consent of a minor under 16 could be effective consent. There is no evidence that Parliament intended this provision to mean that a child under 16 cannot consent to medical treatment. Although the Guardianship Act has provided that a child is competent to consent to medical treatment from 16 years and above, it has not stated what are the rights of competent children under 16. Even though guardianship includes the right to control over the upbringing of a child, this is not a right which is exclusive or allows complete control.[91] As W R Atkin stated:[92]

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[88] Atkin, above, 92.
[89] Atkin, above, 92.
[90] W R Atkin "Parents and Children Mrs Gillick in the House of Lords" (1986) NZLJ 90, 93.
[91] Atkin, above, 91.
[92] Atkin, above, 91.

> It is not a licence for unreasonable discipline, or for keeping a child out of the education system, or for starvation diets, if one happens to believe in these as part of bringing up children.

However, notwithstanding section 25 of the Guardianship Act, section 25A allows any female child of whatever age to consent to an abortion. Under subsection (b) a child can also refuse to consent to an abortion. The child's consent or refusal to consent has the same effect as if she were of full age. One may wonder why Parliament has expressly provided a provision which recognises that a child is competent to consent to an abortion but not to other treatment? The lengthy first, second and third parliamentary readings shed no light on this. The general comments throughout the debates support the policy decision that people should have the right to choose, although others would not necessary have an abortion themselves.[93] It was recognised that if women were not able to have abortions it would result in back street abortion clinics or women flying to Australia where abortions could be performed.[94] The issue of children was not specifically addressed.

Section 25A, although enacted before the *Gillick* decision, provides that children can be competent in some circumstances to consent and refuse to consent to medical treatment which affects them. It is also interesting to note that New Zealand legislation provides that if a child is married or has been married he or she may consent or refuse to consent to medical treatment and this shall have the effect as if he or she was of full age.[95]

Why is it that Parliament has provided that a minor who has married, for parental consent is necessary, is from that moment on classed as legally competent to consent and competent to refuse to consent to medical treatment? But for his or her marriage is that child not the same child which may or may not be competent to consent? Does marriage suddenly make a child competent? Does this not provide an artificial distinction? For example, if you have two 14 year-old children who both require a blood transfusion, and who both refuse on the basis of religion, is it not artificial to say that the child who is married would legally have his or her wishes up

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[93] (11 October 1977) 414 NZPD 3520, 3566.
[94] (15 December 1977) 416 NZPD 5384, 5391.
[95] Section 25(2) of the Guardianship Act 1968.

held but the one who is not married will not? Surely we should be looking at whether the child involved is competent to make such a decision and not whether he or she is married? As Lord Scarman stated:[96]

> If the law should impose upon the process of 'growing up' fixed limits where nature knew only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change.

Further section 23(1) of the Guardianship Act 1968 provides that the welfare of the child is the first and paramount consideration. Section 23 states:

> **23 Welfare of child paramount**
> (1) In any proceedings where any matter relating to the custody or guardianship of or access to a child, or the administration of any property belonging to or held in trust for a child, or the application of the income thereof, is in question, the Court shall regard the welfare of the child as the first and paramount consideration. The Court shall have regard to the conduct of any parent to the extent only that such conduct is relevant to the welfare of the child.
> [(1A) For the purposes of this section, and regardless of the age of a child, there shall be no presumption that the placing of a child in the custody of a particular person will, because of the sex of that person, best serve the welfare of the child.]
> (2) In any [proceedings under subsection (1) of this section] the Court shall ascertain the wishes of the child, if the child is able to express them, and shall, subject to [section 19(4) or section 19A(2)] of this Act, take account of them to such extent as the Court thinks fit, having regard to the age and maturity of the child.
> (3) Nothing in this section shall limit the provisions of [section 22C of this Act or of] sections 64 and 64A of the Trustee Act 1956 [or of Part 1 of the Guardianship Amendment Act 1991].

Although section 23(1) relates to any matter relating to the custody or guardianship it is argued that when the court is acting in its wardship role it is essentially acting in the place of the parents as the child's guardian. Under section 23(2) a court exercising its jurisdiction is required to ascertain the wishes of the child, if the child is able to express them, and shall take account of them to such extent as the court thinks fit, having regard to the age and maturity of the child. Under the wardship jurisdiction the court has the discretion as to the weight that should be attached to the child's wishes, but is not bound to act on them. However, under section 23(1) the welfare of the child is the first and paramount consideration.

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[96] *Gillick* [1985] 3 ALL ER 402, 421 (HL).

This implies that the child's wishes should be taken into account. Therefore in any proceedings involving a decision as to medical treatment, the wishes of the child must be considered. As Lord Scarman said the rigid parental rights at any particular age will not provide a solution to the problem. The solution "depended upon a judgment of what was best for the welfare of the particular child."[97] Furthermore it is argued that because the court does not have to act in cases where a competent child has the ability to consent, it need not act on a *Gillick* competent child's refusal.

The statements in the *Gillick* decision are consistent with the statutory provisions in the Guardianship Act 1968. Until Parliament makes the decision to intervene, the courts should apply the *Gillick* test in New Zealand, and as Lord Scarman stated "the principle should be flexible enough to enable justice to be achieved by its application to the particular circumstances proved by the evidence placed before them."[98]

New Zealand has one other major legal framework, namely the New Zealand Bill of Rights Act 1990. The next section in this paper will review the relevant provisions of that Act and how they support a competent child's right to refuse medical treatment.

D The New Zealand Bill of Rights Act 1990 (NZBOR Act)

The core sections that are relevant to this paper are section 11, 13 and 15 which state:

> **11 Right to refuse to undergo medical treatment**
> Everyone has the right to refuse to undergo any medical treatment.
>
> **13 Freedom of thought, conscience, and religion**
> Everyone has the right to freedom of thought, conscience, religion, and belief, including the right to adopt and to hold opinions without interference.
>
> **15 Manifestation of religion and belief**
> Every person has the right to manifest that person's religion or belief in worship, observance, practice, or teaching, either

[97] *Gillick*, above, 420.
[98] *Gillick*, above, 421.

> individually or in community with others, and either in public or in private.

The question that arises is: what is the ambit of the rights contained in the above provisions? It is submitted that section 11 was intended to have a wide ambit, given the use of the words "any medical treatment". This implies that it was Parliament's intention not to limit the scope of this right. In the White Paper report to Parliament on the Bill of Rights,[99] it was noted that this provision is unique to New Zealand and that there has been no equivalent provision in the International Covenant, nor in any other international human rights provisions.[100] The report envisaged that the right to refuse to undergo any medical treatment would permit individuals to be treated against their will only where it is necessary to protect the health and safety of other persons and not in cases where a refusal will detrimentally affect their own health.[101] The report then goes on to state that under the current law children are incapable of consenting on their own behalf, and that parents, guardians and certain other persons may consent and override their wishes. The report notes that there are exceptions, namely section 25, and 25A of the Guardianship Act 1968. The report, however, did not specifically state that this right does not apply to competent children and the courts have since held that 'everyone' means everyone who is competent.[102]

The ambit of sections 13 and 15 is not so clear. What is the definition of the key terms in sections 13 and 15? What does freedom of thought, conscience, religion and belief mean? How wide are the rights and what type of situations did Parliament envisage would fall within these rights? It is submitted that a competent child's right to refuse blood products on the basis of his or her religious beliefs would come within the ambit as a right to hold his or her opinion without the state interference. Jehovah's Witnesses, hold the belief that individuals should not receive blood products. This belief forms part of their religious practice. The freedom to choose and practise a religious belief is fundamental to an individual's autonomy to conduct

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[99] New Zealand Government White Paper, *A Bill of Rights for New Zealand* (Government Print, Wellington, 1985).
[100] New Zealand Government White Paper, above, A.6.
[101] New Zealand Government White Paper, above, A.6.
[102] *Re S* [1992] 1 NZLR 363, 374 (HC).

his or her life without interference from the state.[103] Surely, a competent child's refusal on the basis of religious beliefs would come within the right to manifest his or her religious practice.

The White Paper report does not elaborate on the extent of these rights, although it notes that these rights might have to be tested against the limitations in section 5 of the NZBOR Act.[104] The difficulty with the NZBOR Act arises in the following sections. Section 6 of the NZBOR Act 1990 provides that:

> **6 Interpretation consistent with Bill of Rights to be preferred**
> Wherever an enactment can be given a meaning that is consistent with the rights and freedoms contained in this Bill of Rights, that meaning shall be preferred to any other meaning.

And sections 4 and 5 provide:

> **4 Other enactments not affected**
> No court shall, in relation to any enactment (whether passed or made before or after the commencement of this Bill of Rights),—
> (a) Hold any provision of the enactment to be impliedly repealed or revoked, or to be in any way invalid or ineffective; or
> (b) Decline to apply any provision of the enactment—
> by reason only that the provision is inconsistent with any provision of this Bill of Rights.
>
> **5 Justified limitations**
> Subject to section 4 of this Bill of Rights, the rights and freedoms contained in this Bill of Rights may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Since the enactment of the NZBOR Act there has been much debate surrounding the analysis of the above provisions.[105] The courts will have to look at the NZBOR Act when considering the best interests of the child under the Guardianship Act 1968. If the New Zealand courts override the wishes of competent

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[103] Grant Huscroft, Paul Rishworth *Rights and Freedoms* (Brookers, Wellington, 1995) 226.
[104] New Zealand Government White Paper, *A Bill of Rights for New Zealand* (Government Print, Wellington, 1985) A.6.
[105] F M Brookfield, "Constitutional Law"(1992) NZ Recent Law Review 231, 237; Andrew Bulter, "Judicial Indications of Inconsistency – A New Weapon in the Bill of Rights Armoury?" (2000) NZLR 43.

children, the courts, in terms of section 5, must constitute only such reasonable limitation on freedom of expression, freedom of religion, and the right to refuse medical as can be demonstrably justified in a free and democratic society.[106] If the courts consider that the rights have been made subject to an unreasonable limitation, which cannot be demonstrably justified in a free and democratic society, there arises a breach of section 5 of the NZBOR Act 1990.[107] Because section 5 is subject to section 4, that breach does not invalidate the court's wardship jurisdiction to override the child's or the parent's wishes.

The relevant provisions of the NZBOR Act 1990 must be given full weight. Section 6 of the NZBOR Act requires that where an enactment can be given a meaning that is consistent with the rights and freedoms contained in the NZBOR Act, that meaning shall be preferred to any other. If there are two meanings, the one which is most in harmony with the NZBOR Act must be embraced.[108] As noted by Tipping J, section 5, when read with section 6, fulfills a similar role. If an enactment limits the rights and freedoms contained in the NZBOR Act the enactment should be given such tenable meaning and application as constitutes the least possible limitation.[109]

In most cases some limits will need to be placed on rights contained in the NZBOR Act, but the combined effect of sections 4 and 5 results in a need to emphasise the words "promotes or supports" a meaning which impinges as little as possible on the rights. Looking at the long title of the NZBOR Act it indicates that a commitment to individual constitutional rights is not only required by international law, but that that commitment must develop. "Affirm", "protect" and "promote" are all words used which suggest activity.[110] The Act should be interpreted to support a competent child who appreciates the significance of the treatment, and chooses to refuse it. The treatment should not be imposed on the child.

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[106] *Moonen v Film and Literature Board of Review* [2000] 2 NZLR 9, 16 (CA).
[107] *Moonen,* above, 16.
[108] *Moonen,* above, 16.
[109] *Moonen*, above, 16.
[110] *Re S* [1992] 1 NZLR 363, 374 (HC).

The Court of Appeal has held that the NZBOR Act requires a "generous interpretation suitable to give individuals the full measure of the fundamental rights and freedoms referred to."[111] A purposive approach should be taken when determining the extent of the rights. Cooke P has stated "[i]n previous Bill of Rights cases I have tried to emphasise the importance of a straightforward and generous approach to the provisions of the Act."[112] It would seem that the rights have been defined widely and if an individual's right has been prima facie breached, then it will be necessary for the court to look at section 5 to see whether there should be a justified limitation.

If the New Zealand courts were to override a competent child's right to refuse medical treatment, on the basis of religious grounds, it is submitted, this would be a violation of the rights contained in sections 11, 13 and 15 of the NZBOR Act 1990. Although the New Zealand courts have not been faced with this issue, it is argued that a child who is competent should be treated no differently from that of an adult, and that this situation should come within the ambit of the above rights. A competent adult in New Zealand has the right to refuse medical treatment and practice his or her religion. There is nothing in the NZBOR Act which suggests that the Act does not apply to competent children.

The other remaining question under the NZBOR Act 1990 is whether the courts should override the refusal of parental consent to medical treatment of their children, particularly in cases involving religious grounds. It is apparent that the courts are willing to hold, in cases where the child is too young to express his or her wishes, that a child's right to life under section 8 of the NZBOR Act overrides parental rights to religious freedom.[113] The right to life, regardless of the parental wishes, will be overridden when a child's life or well-being is in serious jeopardy and there is no other reasonable medical treatment available.[114]

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[111] *Ministry of Transport v Noort* [1992] 3 NZLR 260, 268 (CA).
[112] *Simpson v Attorney-General* (1994) 1 HRNZ 42, 57 (CA).
[113] *Healthcare Otago Ltd v Williams-Holloway* [1999] NZFLR 805 (FC); *Re Norma* [1992] NZFLR 445 (HC); *MJB v D-GSW* [1996] NZFLR 337 (CA).
[114] *Healthcare Otago Ltd v Williams-Holloway*, above; *Re Norma*, above; *MJB v D-GSW*, above.

Should there be a distinction between parents' rights and the child's rights in cases involving medical treatment? This paper asserts that yes there should. Section 25(3)(a) of the Guardianship Act 1968 allows a parent or guardian to consent to treatment of their child. However, in cases where the parent refuses to consent to life saving treatment then section 8 of the NZBOR Act should override the parents' refusal. It is argued that the rights under the NZBOR Act belong to the individual, in this case the competent child not the parents. The fundamental right to life or right to refuse medical treatment belongs to the child. If the child is unable to consent because he or she is incompetent, meaning too young to understand the nature of the decision, then the courts should do everything to maintain the child's life, even if this means overriding the parents wishes.

In cases involving religion the parents normally argue that section 13 of the NZBOR Act applies, (the right to freedom of religion) and section 15, (the right to practice one's religion) but it is argued that those rights do not belong to them as parents. The rights should not be enforced on the child or another individual. In such cases the court has a duty when acting in its wardship jurisdiction to sustain the child's life. The parents' religious beliefs are their beliefs. However, once a child is found to be *Gillick* competent then those religious beliefs or rights belong to him or her. At this point he or she should be treated no differently from any other competent adult. It is submitted that the State has a duty to protect children until such time as they are able to make the decision for themselves.

E Summary of New Zealand's Legal Frameworks

It is asserted that regardless of the decision in *Re R,* section 6 of the NZBOR Act directs the New Zealand courts to interpret section 25 of the Guardianship Act 1968 consistently with section 11 of the NZBOR Act. However, rights under the NZBOR Act are subject to the justified limitation clause under section 5, thus unless departure from the right amounted to a justified limitation, section 25 of the Guardianship 1968 should be read as consistent with section 11 of the NZBOR Act. It is submitted that there could only be a justified limitation if the child does not fully

understand the implications of his or her decision. It must be remembered that it is the child who has to live with the outcome of the medical treatment.[115]

Furthermore the *Gillick* test is reflected in Right 7(2) of the Code of Health and Disability Services Consumers Rights, which presumes that every consumer is competent to consent to medical treatment unless there are reasonable grounds. If you have a diminished competence because you are a child, under Right 7(3) you should be allowed to consent to the level of your ability. Every individual also has the right to refuse services under Right 7(7). Article 12 of the UN Conventions on the Rights of the Child[116] requires that children have the right to express their views in matters which affect them, and that those views be given due weight in accordance with the age and maturity of the child.

VI PARENTS' WISHES AND THE RIGHT TO REFUSE MEDICAL TREATMENT

A Can the New Zealand courts override the wishes of the parents?

In New Zealand, and as the oversea cases demonstrate, the court under its wardship jurisdiction can override the wishes of the parents. Wardship has been used for a number of reasons. One example has been to permit blood transfusions when refusal is based on religious grounds.[117]Another example has been to authorise cancer treatment over the preference for traditional Samoan medicine.[118] In that case the Court held, "[the] welfare must be dominated by one aspect, namely the chance of saving her life."[119]

Although in these cases the children were too young to express their wishes, the cases demonstrate how the court can and will override the parents wishes. When parents make decisions for their children, the benefit must be the benefit of the child

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[115] J P H Shield, JD Baum "Children's consent to treatment." (1994) British Medical Journal 1182, 1183.
[116] Ratified in New Zealand in 1993.
[117] *Re CL* [1994] NZFLR 352 (HC). Four-year-old Jehovah's Witness child.
[118] *Director-General of Social Welfare v M* (1991) 8 FRNZ 498 (HC). Also see *Healthcare Otago Ltd v Williams-Holloway* [1999] NZFLR 804 (FC).
[119] *Director-General of Social Welfare v M* above 505.

and not a benefit for the parents.[120] This argument reflects the decisions in religious cases, where the court's first interest is to preserve the life of the child, and not the wishes or beliefs of the parents. This is also reflected in the NZBOR Act 1990 where it can be argued that the rights belong to the child and not the parents. This paper supports the decisions to override the parents' wishes on the basis that the rights belong to the child and not the parents. The state has a duty to maintain the life of the child until such time as the child is competent to make medical decisions for him or her self. Parental rights are not absolute.

It is, however, recognised that the majority of medical decisions involving children under 16 years are normally carried out only with the parental approval.[121] There are other statutory provisions which empower officials to act without parental consent. Under section 125 of the Health Act 1956, official medical officers can enter public schools (private schools if the school has requested) and child centres to examine the children. Parental consent is not necessary, but parents may be notified of any condition that the child is suffering from.

Mrs Gillick argued that the hospital memorandum adversely affected her rights and duties as a parent. She argued that she had an absolute right to be informed of any advice and treatment given to her daughters while they were under 16 years. This of course would be subject to unusual situations where there was a court order or abandonment of parents' duties. Lord Fraser, in reviewing parental rights, stated that "...parental rights to control a child do not exist for the benefit of the parent."[122] Lord Fraser went on to reject the historical argument that a father had almost an absolute authority over his children until the age of 21. His Lordship referred to the historical case of *Agar-Ellis v Lascelles*[123] where such authority was accepted. His Lordship noted how the case had been criticised and in his opinion with good reason.[124] Lord Denning had this to say about the decision:[125]

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[120] W R Atkin "Parents and Children Mrs Gillick in the House of Lords" (1986) NZLJ 90, 92.
[121] Atkin, above, 92.
[122] *Gillick* [1985] 3 ALL ER, 402,410 (HL).
[123] *Agar-Ellis v Lascelles* (1883) 24 Ch D 317.
[124] *Gillick* above, 411.
[125] *Hewer v Bryant* [1969] 3 ALL ER 578, 582 (CA).

> I would get rid of the rule in *Re Agar-Ellis* and of the suggested exceptions to it. That case was decided in the year 1883. It reflects the attitude of a Victorian parent towards his children. He expected unquestioning obedience to his commands. … The common law can, and should, keep pace with the times.

Lord Scarman, having considered the past generations' decisions in order to identify the principles underlying parental rights, found plenty of indications as to the governing law regarding parental rights and the child's right to make his or her own decisions.[126] His Lordship acknowledged that parental rights do exist and that they do not completely disappear until the child attains the age of majority. Parental rights, his Lordship noted, related to both the child and the child's property. However, the common law "never treated such rights as sovereign or beyond review and control. Nor has the law ever treated the child as other than a person with capacities and rights recognised by law."[127] The parental duty continues to exist so long as the child is in need of protection and or the property of the child. However, this principle is subject to certain statutory provisions where certain age limits have been set by Parliament. The courts have also "…declared an age discretion at which a child acquires before the age of majority the right to make his (or her) own decision. But these limitations in no way undermine the principle of the law, and should not be allowed to obscure it."[128]

Lord Scarman proceeded to compare the parental rights with the equivalent provision to section 23(1) of the Guardianship Act 1968. When a court has to address the issue of the care and upbringing of a child the court is bound by the provisions in the Guardianship Act and must treat the welfare of the child as the first and paramount consideration. His Lordship noted that this principle governs the "exercise of parental rights of custody, care and control."[129] This principle recognises the parent as a natural guardian but the parental right must be exercised in accordance with the welfare principle. This means the parents' wishes can be challenged, or overridden.[130]

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[126] *Gillick* [1985] 3 ALL ER 402, 420 (HL).
[127] *Gillick*, above, 420.
[128] *Gillick*, above, 420.
[129] *Gillick*, above, 420.
[130] *Gillick* [1985] 3 ALL ER 402, 420 (HL).

The underlying principle behind the parental right to control medical decisions of their children is based on the parental right or power of control of the person and property of his or her child. This right exists primarily so that the parent can discharge his or her duty of maintenance, protection and education until such time as the child reaches an age where he or she can decide the decisions alone. Although New Zealand has a statutory provision[131] which has declared a child's right to consent to medical treatment from the age of 16 years onwards, there is however no statute which has outlined the extent and duration of parental rights in respect of their children under the age of 16.

In summary parental rights are not absolute. It is submitted that any decision involving the treatment of children the decision must be for the benefit of the child and not for the benefit of the parents. In cases where the child is too young to express his or her wishes and the parents refuse to consent to medical treatment on the basis of religion, the courts should protect the child and override the parents' wishes where the refusal places the child in a life-threatening situation.

VII CONCLUSION

The *Gillick* competent child should have the right to refuse to consent to medical treatment and his or her wishes should be upheld under section 11 of the NZBOR Act. A child's right to refuse medical treatment should only be limited when a minor lacks the understanding of the decision. For example, where the child's views have clearly been influenced by the views of the parents or in cases where the minor is suffering from a psychiatric condition which effects his or her capacity to understand the nature of the decision. Applying the *Gillick* test to section 11 of the NZBOR Act, the child's individual autonomy and self-determination is recognised. In addition the presumption of competence under the Code of Health and Disability Consumers Rights, and the UN Conventions on the Rights of the Child indicate that in cases like that of Tovia Laufau, if the child is *Gillick* competent, he or she should have the right to refuse medical treatment. If the New Zealand courts are faced with this decision in the future, it is submitted that the test in *Gillick* should be followed

[131] Guardianship Act 1968, s25.

and *Re R* should be rejected, as it has unduly restricted the *Gillick* test and undermines the autonomy of the competent child. The statutory provisions in the Guardianship Act[132] have not overridden the House of Lords decision in Gillick. The *Gillick* decision would allow the New Zealand courts to permit a competent child under the age of 16 years the right to refuse to consent to medical treatment.

The courts can and should override the wishes of parents. The courts have a duty to protect the child particularly in cases involving life-threatening conditions. It must be remembered that the rights belong to the child and until the child is competent to make the decision to refuse treatment for him or herself the courts should do everything possible to sustain that child's life.

[132] Section 25.

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LAWS 530: Human Rights Law Seminar
2001

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