

ARTICLE

Does the *Gillick* Competency Test Apply in New Zealand Given the Special Nature of Sexual Health Care Services?

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This article considers whether the watershed House of Lords decision in *Gillick v West Norfolk and Wisbech Area Health Authority*, which allowed mature minors to consent to medical treatment, can be incorporated into New Zealand jurisprudence in order to allow minors to consent to sexual health services. The article frames sexual health services as necessary health services for anyone who is sexually active, and examines the changing position of children in society, as well as the relationship between children and parents before the law. New Zealand's legislative framework for consent and minors is also investigated. Ultimately, this article argues that s 36 of the Care of Children Act 2004 (which allows a child over 16 years to consent to medical treatment which is in their best interests) can be interpreted consistently with *Gillick*, in order to allow mature minors under this threshold to consent. The traditional status-based interpretation of s 36 is rejected in favour of a competency-based consent test.

I Introduction

The view that any medical procedure, no matter how trivial, is unlawful, unless authorised by valid consent, is of pivotal importance to the principle of autonomy. This dates back to 1914, when Cardozo J proclaimed:¹

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1 *Schloendorff v Society of New York Hospital* 105 NE 92 (NY 1914) at 93 per Cardozo J.

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.

Recently, children in Western society have also been accorded such rights, although the consent may come from a proxy. Sexual intercourse, pregnancy and termination are fundamentally personal experiences. When engaged in by a minor, they are often challenged, rightly or wrongly, in a manner that threatens to undermine the child's autonomy and confidentiality.² However, if the child is engaging in sexual activity, contraception becomes a necessity.

Given New Zealand's unique medico-legal environment, the legal position for minors' capacity receives fleeting judicial comment, as the issue is not directly presented to the courts. The law is therefore fragmented and inconsistent, resulting in unnecessarily conservative medical decision-making.³ New Zealand's diverse population requires the law to accommodate cultural and religious differences while protecting the child. Media commentary shows that society is not *ad idem* on the issue, especially in balancing tensions between parental and child rights.⁴

Sexual health services pose many issues. While not falling squarely under emergency treatment, where the doctrine of necessity allows doctors to proceed without obtaining consent by lawful justification, such services can be deemed necessary, given the potential adverse outcomes. A number of studies show an emerging trend that young women are engaging in sexual intercourse earlier than in previous generations, and a sizeable minority—between 10 and 30 per cent—of New Zealand teenagers have sexual intercourse before 16 years of age.⁵ This emphasises the importance of considering contraceptive access for all adolescents, not just those over 16.

Contraception is defined as a substance, device or technique intended to prevent conception or implantation.⁶ Contraception may serve the adolescent's best interests but is an often-disputed behavioural choice. Commentators and industry groups argue confidential distribution will reach the most adolescents, especially those most at risk.⁷ Evidence exists that some doctors, given the legal uncertainty, take a conservative approach.⁸ However, other groups advocate a more liberal approach allowing competent minors to consent.⁹ Significantly, health practitioners have the right to conscientiously

2 Jordi Ribot "Underage Abortion and Beyond: Developments of Spanish Law in Competent Minor's Autonomy" (2012) 20 *Med L Rev* 48 at 51.

3 Carol Peters "Consenting to medical treatment: legal requirements vs medical practice. Are healthcare providers exposing themselves to potential legal action?" (2009) 122(1300) *N Z Med J* 50 at 50.

4 Editorial "Abortion law best left as it stands" *The New Zealand Herald* (online ed, Auckland, 14 September 2004); Bill English "Pregnant girls more at risk if parents kept in the dark" *The New Zealand Herald* (online ed, Auckland, 12 October 2004); and Tapu Misa "When it comes to abortion, mothers surely know best" *The New Zealand Herald* (online ed, Auckland, 14 September 2004).

5 Ministry of Health *Our Children's Health: Key findings on the health of New Zealand children* (June 1998) at 132.

6 Contraception, Sterilisation, and Abortion Act 1977, s 2.

7 Joshua A Douglas "When is a 'Minor' also an 'Adult'? An Adolescent's Liberty Interest in Accessing Contraceptives from Public School Distribution Programs" (2007) 43 *Willamette L Rev* 545 at 551; and "Sexuality — Young People and Their Rights" (2007) *Family Planning* <www.familyplanning.org.nz>.

8 Peters, above n 3.

9 "Sexuality — Young People and Their Rights", above n 7.

object to providing contraception-related services, but are obligated to inform the patient that these services are available elsewhere.¹⁰ In practice, however, normative opinions could influence clinical judgement.¹¹

The law must strive to reach a balance between protecting the vulnerable and allowing safe development. This article focuses on the extent to which New Zealand law allows minors less than 16 years of age to consent to sexual health services, what happens to the proxy consent and whether the current practice is legally reconcilable. The focus will be on female minors, who have the possibilities of prescribed contraceptives beyond condoms available to them, although the reasoning could be extended more generally to males.

II Importance of Consent

Autonomy requires that the free and informed decisions of competent patients are respected, as self-determination is the principle justification requiring informed consent.¹² The modern obligation to obtain informed consent stems from the Nuremberg Code 1947, and the Helsinki Declaration 1964. While healthcare's main mechanism of recognising autonomy is through the right to refuse treatment,¹³ this article is concerned with the competency required to give positive consent.

Autonomous individuals must have the capacity to envisage and comprehend short- and long-term consequences of actions so as to be able to choose between possible futures in light of their own needs, desires and values. In a healthcare context, this requires comprehension of the relevant health-related ideas, general decision-making capacities, the ability to weigh options and preferences and to have deliberately formed values.¹⁴ The law has traditionally assumed that, by virtue of their immaturity, young people lack capacity. Inability to consent can be perceived as a barrier to service accessibility, especially if the minor is opposed to parental involvement. Traditionally, parents are considered the most appropriate person to determine what is in their incompetent child's best interests, given their proximity to, and intimate knowledge of their child. However, this is increasingly challenged with the growing independence of children.¹⁵ The Care of Children Act 2004 (CoCA) uses a proxy framework where a guardian or court can consent on a child's behalf.¹⁶

Autonomy granted to competent patients peaked when Lord Donaldson MR claimed that refusal of medical treatment is legally effective even if the patient will likely die.¹⁷ Informed consent is a process rather than a single act and has three elements:

10 Contraception, Sterilisation, and Abortion Act, s 46; and Health Practitioners Competence Assurance Act 2003, s 174(2).

11 Ellie Lee "Young Women, Pregnancy and Abortion in Britain — A Discussion of Law 'In Practice'" (2004) 18 *IJLPF* 283 at 286.

12 Ribot, above n 2, at 49; and Lucy Thomson "Whose Right to Choose? A Competent Child's Right to Consent to and Refuse Medical Treatment in New Zealand" (2001) 8 *Canta LR* 145 at 149.

13 New Zealand Bill of Rights Act 1990, s 11.

14 Ralph Pinnock and Jan Crosthwaite "When parents refuse consent to treatment for children and young persons" (2005) 41 *J Paediatr Child Health* 369 at 371; and *Re L (A Minor) (Medical Treatment: Gillick Competency)* [1998] 2 *FLR* 810 (Fam) at 812.

15 New South Wales Law Reform Commission *Young People and Consent to Health Care* (Report 119, 2008) at [6.3].

16 Care of Children Act 2004, s 36(3) [CoCA].

17 *Re T (Adult: Refusal of Treatment)* [1993] 1 *Fam* 95 (CA) at 115.

voluntariness, information and competence.¹⁸ Voluntariness is also explicitly required in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (The Code).¹⁹ Subtle external pressures such as parental religious beliefs can overcome free will required to consent.²⁰ Young girls, especially if pregnant, are vulnerable to such pressures.²¹ Information concerns the nature and quality of information communicated by the doctor to the patient. Informed consent often blurs with competency, which focuses on the quality of the patient's understanding of the proposed treatment.²² Competence forms the greatest obstacle for young people, and hence is the current focus.

Consent is sought by the doctor to prevent liability. However, as Accident Compensation Corporation legislation bars civil actions for personal injury,²³ consent is ill-defined in New Zealand.²⁴ Given that keys can unlock, but also lock, Lord Donaldson MR uses an analogy of a "flak jacket" protecting the doctor from litigious claims.²⁵ This flak jacket of consent can arguably be provided either by the *Gillick*-competent child or the guardian. Importantly, it can be revoked, but the doctor only needs single consent to be protected, provided he has this, the doctor can proceed legally.

Exemplary damages are preserved²⁶ only in instances amounting to "outrageous conduct"²⁷ or "flagrant disregard"²⁸ for the patient's rights. Criminal sanction is also remotely possible.²⁹ However, such prosecution is unlikely, as a doctor customarily performs professional obligations in good faith, negating the requisite mental elements.³⁰ More pertinent is the ability of aggrieved patients, concerned parties, or parents, to complain to the Health and Disability Commissioner (HDC). This can lead to professional discipline if found to breach a right within The Code.³¹

Research on New Zealand doctors found that a functionally competent 14-year-old girl was considered unable to consent to the removal of a prominent mole on her face by 83.5 per cent of the sample, whose patients regularly included adolescents.³² The majority responded that an aggrieved parent would be more likely to complain at the mole's removal than a competent minor in regards to it not being removed, therefore highlighting the risk-adverse approach medical professionals take. The law requires greater clarity to guide healthcare providers who are not legal experts.³³ This view of a parent being more

18 Ministry of Health *Consent in Child and Youth Health — Information for Practitioners* (December 1998) at 41.

19 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, right 2.

20 *Re T*, above n 17.

21 Ribot, above n 2, at 55.

22 New South Wales Law Reform Commission, above n 15, at [1.11].

23 Accident Compensation Act 2001, s 317.

24 Charlotte Paul "The New Zealand cervical cancer study — Could it happen again?" (1988) 297 *BMJ* 533; and Thomson, above n 12, at 147.

25 *Re W* (A Minor) (Medical Treatment: Court's Jurisdiction) [1993] 1 Fam 64 (CA) at 78.

26 Accident Compensation Act, s 319.

27 *Taylor v Beere* [1982] 1 NZLR 81 (CA) at 89; and *Green v Matheson* [1989] 3 NZLR 564 (CA) at 571.

28 Health and Disability Commissioner Act 1994, s 57(1)(d).

29 Crimes Act 1961, ss 196 and 190.

30 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (HL) at 190.

31 Health and Disability Commissioner Act, s 57(1).

32 Peters, above n 3, at 53.

33 At 57.

likely to complain is not without merit. In a complaint to the HDC, a mother objected that her competent son, at age 14, had consented to a tetanus vaccination for which she would have refused consent.³⁴

III Children, Society and Medicine

There is no universal definition of a “child”, as childhood is contextually defined and influenced by class, gender and ethnicity.³⁵ This fuels debate that age is insufficient to determine maturity. For the purposes of this article, the focus is on girls aged 12 to 16. This is because the CoCA allows for proxy consent of the guardian on the child’s behalf but also allows a child over 16 to grant consent, as if an adult.³⁶ In contemporary liberal society, parents have legal rights to raise their minor children according to their values.³⁷ While European cultures value independence, collectivist decision-making is embraced by Maori and Pacific peoples.³⁸

A Children’s position in society

Historically, a legitimate child was treated as the father’s property, as a mother had no independent legal status.³⁹ This view was considered a “historical curiosity” by Lord Fraser in *Gillick v West Norfolk and Wisbech Area Health Authority*.⁴⁰ Parental rights of control are no longer perceived as existing for the parents’ benefit, but conversely held to exist for the child’s benefit and justified only insofar as they enable performance of duties owed to the child.⁴¹ These parental duties derive from multiple sources within the law and beyond, enshrined in religious and ethical principles.⁴² However, these conferred “rights” are better termed responsibilities, being not absolute, but limited by the child’s needs.⁴³ In terms of medical treatment, they include making healthcare decisions based on the child’s best interests, as generally the parents are best positioned to understand those interests.⁴⁴

While this right is to protect, not control, these are hard to distinguish. The child must be able to express their views and have them respected.⁴⁵ The United Nations Convention on the Rights of the Child (UNCRC) provides for children to be heard before major decisions are taken involving their person, so their view aids determination of their best

34 Health and Disability Commissioner *General Practitioner, Dr C: Nurse, Ms D* (Opinion 01HDC02915, 6 March 2002).

35 Fiona Miller “Wake up COCA! Give children the right to consent to medical treatment (2011) 7 NZFLJ 85.

36 CoCA, s 36. See also High Court and Family Court jurisdiction to render consent (whether given by *Gillick*-competent minor or guardian) subject to the Court’s Guardianship authority.

37 Lainie Friedman Ross *Children, Families, and Health Care Decision Making* (Oxford University Press, Oxford, 2002) at ch 8.

38 Ministry of Health, above n 18.

39 J Bridgeman “Young People and Sexual Health: Whose Rights? Whose Responsibilities?” (2006) 14 Med L Rev 418.

40 *Gillick*, above n 30, at 173.

41 Bridgeman, above n 39.

42 BM Dickens and RJ Cook “Adolescents and consent to treatment” (2005) 89 Int J Gynecol Obstet 179 at 179.

43 Pinnock and Crosthwaite, above n 14, at 370.

44 At 370.

45 CoCA, ss 3(2)(c) and 6.

interests.⁴⁶ Incorporated into the CoCA in s 6(2)(a) and (b) is the requirement that the child is to have a reasonable opportunity to express their views on matters affecting them and that these views must be taken into account. The Ministry of Social Development further advocates for the child to take responsibility and participate in decisions when and to the extent capable.⁴⁷ Therefore, incompetent children are still entitled to give or withhold assent.⁴⁸ However, traditional paternalism that views minors as vulnerable, regardless of their proven capacity to understand, remains pervasive, despite redefining *parental rights* as *parental responsibilities* to prevent the family's rights subsuming the child's.⁴⁹

Provision of contraceptive or abortion advice and treatment is fraught with tension between the child's autonomy interest, and the interests of parents and state.⁵⁰ Adolescence can be tumultuous, commonly involving conflict with parents, and family relationships can dilute the effect of self-determination. Even in supportive family relationships, some young people feel uncomfortable talking to their parents about sexuality, creating conflict as the young person seeks to assert autonomy. This is particularly so for young people with cultural or religious backgrounds that disapprove of premarital intercourse.⁵¹ Arguably, parents may not be in the best position to assess their adolescent child's best sexual health interests.

B *Determining capacity*

The extent of a child's right to choose ultimately rests upon whether one adopts a traditional status-based approach founded on age, or a capacity-based approach premised on individual capacity to understand, requiring individualised contextual determination of capacity.⁵² Capacity, as discussed above, sets a minimum standard of decision-making skills, developed through maturity and experience, required to recognise a decision's validity.⁵³ Most children under 10 years of age lack the deliberative competence and maturity needed to make important decisions. In contrast, adult status automatically confers the presumption of capacity to choose treatment.

Status-based tests provide the certainty desired by the medical profession, being easy to administer across the population.⁵⁴ A status-based test whereby after a fixed age one is presumed competent, or a presumption of incompetence under a fixed age, is tempting because of certainty but can prove inflexible, arbitrary and irrational.⁵⁵ Ian Kennedy argues that status-based tests are invalid, as merely belonging to a given class "does not entail incapacity, except and unless that class is defined by reference to lack of capacity".⁵⁶ Statutes provide deemed capacity for discrete tasks, recognising the maturation process:

46 United Nations Convention on the Rights of the Child 1577 UNTS 3 (opened for signature 20 November 1989, entered into force 2 September 1990), art 12.

47 Ministry of Social Development *New Zealand's Agenda for Children: Summary Report* (June 2002).

48 Dickens and Cook, above n 42, at 183.

49 Ribot, above n 2, at 50; and Pinnock and Crosthwaite, above n 14, at 370.

50 Ribot, above n 2, at 51.

51 New South Wales Law Reform Commission, above n 15, at [6.89].

52 Pinnock and Crosthwaite, above n 14, at 370.

53 New South Wales Law Reform Commission, above n 15, at [1.7]; and Miller, above n 35.

54 Peters, above n 3, at 57.

55 *Gillick*, above n 30, at 186.

56 Ian Kennedy *Treat Me Right: Essays in Medical Law and Ethics* (Oxford University Press, Oxford, 1991), at 56.

for example, determining criminal responsibility,⁵⁷ consenting to sexual intercourse⁵⁸ and voting. For these functions, arbitrary ages are acceptable. Ascertaining competence for electoral votes would otherwise be administratively impossible.⁵⁹ This difficulty is absent from medical decisions. Arbitrary ages, below which even mature minors require parental consent to receive sexual healthcare, both therapeutic and preventative, are frequently dysfunctional, as they prejudice both the girl's health and wellbeing and that of her partner. Further, this approach is incompatible with the progression of society's views, recognising children's rights and increasing independence.⁶⁰

An understanding-based model acknowledges that, while legally minors, some youths have sufficient maturity to be accorded practical autonomy.⁶¹ This approach encumbers the doctor with arbitrating competence while maintaining integrity. This requires a mechanism to ensure doctors actually pursue the enquiry with maturity as the primary determinant.⁶² Using a presumption, despite rejecting status-based approaches, only serves to readopt an age criterion in forming the presumption. However, no test will universally distinguish competent minors from incompetent ones.⁶³ Furthermore, as a legal framework that radically departs from current or ideal practice is unhelpful, a competency-based model is preferable to ensure sexual health service access. However, a competency-based approach requires the girl to satisfy an evidential test, demonstrating to the doctor that she has achieved the requisite degree of competence. Further, this threshold must be ascertained so as not to be set at an unattainable level.⁶⁴

IV *Gillick*: The Watershed Case

The House of Lords in *Gillick* recognised (3:2) a child's legal competence in making decisions provided that she had sufficient understanding and intelligence to enable full understanding of the proposition.⁶⁵ Mrs Gillick, a Catholic, sought two declarations, responding to a Health Authority's circular allowing discretionary contraceptive treatment and advice for minors. First, that contraceptive advice was unlawful and amounted to encouragement of doctors to commit offences, by causing or encouraging unlawful sexual intercourse with girls under 16. Secondly, which is more relevant to this article, that such advice was inconsistent with parental rights and duties.

Woolf J in the first instance dismissed both actions, holding that if the child had sufficient maturity to understand the advantages and disadvantages of the proposed treatment, she was competent to consent.⁶⁶ The Court of Appeal held to the traditional nuclear family model, where the child remains under parental control until 16.⁶⁷ However

57 Children, Young Persons, and Their Families Act 1989, s 272(1); and Crimes Act 1961, ss 21 and 22(1).

58 Crimes Act, s 134.

59 Sarah Elliston "If You Know What's Good For You: Refusal of Consent to Medical Treatment by Children" in Shelia AM McLean (ed) *Contemporary Issues in Law, Medicine and Ethics* (Dartmouth Publishing, Aldershot (England), 1996) 29 at 42-43.

60 United Nations Convention on the Rights of the Child; and Thomson, above n 12, at 150.

61 Pinnock and Crosthwaite, above n 14, at 370.

62 Kennedy, above n 56, at 58.

63 Pinnock and Crosthwaite, above n 14, at 371.

64 Elliston, above n 59, at 29.

65 *Gillick*, above n 30, at 188.

66 *Gillick v West Norfolk and Wisbech Area Health Authority* [1984] QB 581 (QB) at 596.

67 *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 2 WLR 413 (CA).

this archaic viewpoint is unrealistic and necessitates a status-based test.⁶⁸ Furthermore, the case⁶⁹ relied upon was later held “horrendous” given vast social changes.⁷⁰

The majority of the House of Lords professed the view that parental rights are instrumental only in facilitating the fulfilment of duties. Proclaiming that children are individuals who grow in intelligence, competence and autonomy as they move towards adulthood, the mature minor doctrine—or *Gillick* competency—was conceived.⁷¹

Lord Scarman stated that when the child is a competent minor, the doctor need not inquire further into wider interests.⁷² His Lordship adopted Lord Denning’s dissent that the parental right of control is a “dwindling right”, which begins with a right and ends with only the ability to give advice.⁷³ Naturally, the degree of parental control practically exercised will vary.⁷⁴ Not divesting parents of all guardianship rights, his Lordship clarified that these rights exist only so as to enable parents to discharge their obligations to the child. They must thereby be exercised with the child’s interests in mind, rather than the parents’, and do not wholly disappear until the age of majority.⁷⁵ As parental rights must be exercised in the child’s interests, if capable, the child must be allowed to determine their own interests.⁷⁶ Under Lord Scarman’s formulation, once the child reaches requisite legal capacity so as to have sufficient maturity to understand, and intelligence to enable full understanding of a proposition, parental rights to determine healthcare for their child “terminate”, yielding to the competent minor. Lord Scarman’s judgment is the clearest and is unequivocal in respect of parental rights; later retreats from this position were met by vociferous commentator complaints.

Public policy and changing social customs underpinned all judgments, especially Lord Fraser’s speech, which was tailored specifically towards contraception provision.⁷⁷ That said, given that statutory provisions for minor consent do not differentiate between contraceptives and other treatment, Lord Fraser infers that minors either have potential capacity to assent to all treatments or none.⁷⁸ However, cautious in requiring some legal constraint, Lord Fraser provided guiding criteria to regulate appropriate circumstances for a doctor to prescribe contraception to girls under 16 years, by vesting the doctor with authority to determine the girl’s best interests. Thus, the girl’s consent is necessary to protect bodily integrity, but not sufficient, as the doctor must inquire into her best interests beyond the purely medical, including wider social and moral factors.

By requiring a doctor to judge the girl’s best interests, as well as the minor’s self-evaluation, Lord Fraser could be saying that public policy requires the final decision to be the doctor’s rather than the parents’.⁷⁹ This exception is justified, as children are notoriously reluctant to confide in parents on sexual matters and doctors are often

68 Kennedy, above n 56, at 62; and Morag McDowell “Medical Treatment and Children — Assessing the Scope of a Child’s Capacity to Consent or Refuse to Consent in New Zealand” (1997) 5 J L & Med 81 at 81.

69 *Re Agar-Ellis, Agar-Ellis v Lascelles* (1883) 24 Ch D 317 (CA).

70 *Gillick*, above n 30, at 182.

71 Ministry of Health, above n 18.

72 Ian Kennedy and Andrew Grubb *Medical Law* (3rd ed, Butterworths, London, 2000) at 1141–1142.

73 *Hewer v Bryant* [1970] 1 QB 357 (CA).

74 *Gillick*, above n 30, at 171.

75 At 184.

76 At 186 and 189.

77 At 171.

78 At 169.

79 Kennedy, above n 56, at 94 and 100.

entrusted with discretion beyond strict clinical judgment. Further, doctors are best positioned to discharge this inquiry.⁸⁰ Attempting to find a practical solution, Lord Fraser requires bona fide medical judgement of best interests. However, by giving doctors this discretion, he fails to accord the level of autonomy a competent child would have under Lord Scarman's formulation. One difficulty arising under Lord Fraser's formulation is, should the doctor think treatment is not in the child's best interests without parental consent, the girl may require parental involvement. Contraceptive treatment is held to be in the tiny minority of healthcare where the best judge of an incompetent child's welfare is not the parent.⁸¹

Accordingly, doctors should try to persuade the minor to tell her parents about the advice sought, or receive permission to inform, but proceeding can be justified without parental consent or knowledge, provided the following satisfy the doctor:⁸²

- (a) The minor will understand medical advice; and
- (b) She cannot be persuaded to inform parents; and
- (c) She is likely to begin or continue to have sexual intercourse with or without contraceptive treatment; and
- (d) Unless receiving contraceptive treatment, her physical or mental health, or both, are likely to suffer; and
- (e) Best interests require contraceptive advice and treatment without parental consent.

These guidelines apply *Gillick* competency specifically to contraceptive treatment. The emphasis on health suffering without treatment, in Lord Fraser's criteria, frames the situation as an access issue and creates an argument for the basis of this extension from the doctrine of necessity, as otherwise health will suffer.⁸³ This view contrasts with Lord Brandon's thinking that young girls demanding contraception was "tantamount to blackmail" and that the law should reply with abstinence until 16 years.⁸⁴

Lord Bridge opined that the criminal law seeks to protect young women from untoward consequences of sexual intercourse. In circumstances where criminal sanction will not afford protection it is not contrary to public policy to provide contraception as the sole effective means of protection and avoidance of sexually transmissible infections (STIs) and undesired pregnancy.⁸⁵ Thus provision of contraceptives effectively fills the lacuna that legal protections provide to young females to prevent harm from sexual activities.

Within the majority, there is inconsistency on the standard required to be *Gillick*-competent. They agree that rather than total inability to consent, there is a presumption of incompetence that the girl can rebut by demonstrating capacity.⁸⁶ However, Lord Fraser's standard of competence requires the young woman's and the doctor's view of her best interests to coincide, whereas Lord Scarman bases the test on full comprehension of medical issues, without mentioning best interests.

The minority judgments indicate a difference between ordinary medical and contraceptive treatment. While agreeing that a mature minor could consent to an ordinary therapeutic operation, opposed by parents and acknowledging a dwindling parental right, Lord Templeman differentiates between provision of medical services, and sexual health

80 *Gillick*, above n 30, at 173.

81 At 173.

82 At 174.

83 McDowell, above n 68, at 81.

84 *Gillick*, above n 30, at 197.

85 At 194.

86 Elliston, above n 59, at 30.

services, as a lifestyle choice rather than a treatment.⁸⁷ A girl's decision to practice sexual intercourse requires not only factual knowledge of the dangers of pregnancy and disease, but also comprehension of emotional consequences on all involved, and daily discipline in the oral contraceptive pill's case, to ensure efficacy. His Lordship expressed doubt in a minor's ability to balance such considerations.⁸⁸ Further, he expressed concern that Lord Fraser's formulation can be reduced to replacing parental consent with that of the doctor.⁸⁹ However, Lord Templeman clarified that parental rights may have been renounced if the girl is discovered not to be living with a parent and is allowed in a dangerous environment with sexual intercourse, or if parental rights are abused, such as when there is sexual abuse in the home environment.⁹⁰ Nonetheless, a girl may desist from obtaining contraceptive treatment if aware that an investigation into abuse would ensue.

Autonomous adults and *Gillick*-competent minors must bear the consequences of their choices, including those not made in their objective best interests. *Gillick* requires the health practitioner to determine whether the child possesses the understanding and maturity to form a balanced judgement regarding proposed treatment, so as to be treated without needing parental consent. This accords a wide discretionary basis for determining maturity but provides little guidance. With cases like contraceptive treatment, it is now arguable that the doctor is a better judge of the advice and treatment conducive to a girl's welfare.⁹¹ However, a mature minor upholding bodily freedom is diametrically opposed to traditional parental rights, which remains a pervasive view.⁹² However, attempting to balance interests, and prevent a licence for doctors disregarding parental wishes, the law Lords stressed that practitioners should encourage the child's involvement of a parent or trusted adult in medical decisions. Nevertheless, refusal to do so should not preclude treatment if the practitioner is satisfied of their maturity.⁹³ This allows the common law to acknowledge developing maturity and autonomy, and diminishing parental control, rather than a stringent arbitrary age which until reached is subject to the decision-making authority of, parents or guardians.

Gillick has been adopted in Canada and Australia.⁹⁴ In a Canadian case, Kerans JA dismissed an appeal which sought an injunction to prevent their mature minor child's abortion. Confirming parental rights do not wholly disappear until the age of majority, the termination of parental rights for medical decisions occurs upon achieving full understanding.⁹⁵

In *Re A*, Bodey J considered the bounds of a vulnerable adult's understanding on which to refuse contraceptive treatment.⁹⁶ He considered that a capacity test should ascertain the woman's ability to understand and weigh up immediate medical issues. This shows a

87 *Gillick*, above n 30, at 201.

88 At 201.

89 Kennedy, above n 56, at 94.

90 *Gillick*, above n 30, at 204.

91 JC Smith and DJ Birch "Case and Comment: Aiding and Abetting" [1986] Crim LR 113 at 114.

92 Jessie Hill "Medical Decision Making by and on Behalf of Adolescents Reconsidering First Principles" (2012) 15 J Health Care L & Poly 37 at 62.

93 *Gillick*, above n 30, at 174.

94 *AC v Manitoba (Director of Child and Family Services)* 2009 SCC 30, [2009] 2 SCR 181; and *Secretary, Department of Health and Community Services v JWB* (1992) 175 CLR 218 (HCA) [*Marion's Case*].

95 *JSC v Wren* (1986) 76 AR 115 (CA) at [13].

96 *Re A (Capacity: Refusal of Contraception)* [2010] EWHC 1549 (Fam), [2011] 1 Fam 61.

narrower scope than that considered in *Gillick*, where full understanding and recognition of the impact on relationships was mentioned.⁹⁷ Immediate medical issues included:⁹⁸

- (a) reasons for requiring contraceptive treatment and its purpose;
- (b) the different types of available contraception and their methods of use;
- (c) advantages and disadvantages of each type;
- (d) possible side effects of each and how to deal with them;
- (e) the relative ease of changing methods of contraception; and
- (f) the generally accepted effectiveness of each type.

Obiter indicates that consideration regarding the woman's understanding of the practicalities of child rearing is not required, as this is subjective, and reality can materially change.⁹⁹ If appreciation of what is involved for caring and raising a child is required, this gets close to requiring woman to make sensible decisions and take minimal risks. It was held that this would blur the requirements of capacity and best interests, therefore limiting to immediate medical issues surrounding contraception.

V Great Britain's Response to *Gillick*

Axon was a judicial review application contesting the Health Authority guidance on confidential advice on sexual health matters, the decision discussed confidentiality bounds for mature minors.¹⁰⁰ Silber J confirmed that parents are ordinarily the best judges of a young person's welfare.¹⁰¹ It is inherent within application of the *Gillick* mature minor test that the medical practitioner in some circumstances need not notify parents as loss of confidence would deter some young people and would run contrary to the public policy factors and autonomy foundations of the *Gillick* principle.¹⁰² Importantly, Silber J acknowledged that *Gillick* is the litmus test covering all medical treatment scenarios without parental knowledge or consent.¹⁰³ However, the high knowledge standard is maintained, requiring full understanding.¹⁰⁴ This suggests a higher competency threshold, in terms of understanding, for minors than for adults.

In *Re L*, L, who was 14, required blood transfusions to prevent gangrene.¹⁰⁵ However, as a Jehovah's Witness, she refused. Rigid religious convictions were distinguished from the kind of formulated opinion one constructs through experience.¹⁰⁶ Given that experience and its consequent wisdom is a requirement, this means that the threshold may not be met by minors. Therefore, L was found not to have capacity and a court order was granted, as it was deemed in her best interests to receive a blood transfusion. This indicates that when a minor chooses to proceed in a manner not in her objective best interests, she may be classed incompetent.

97 *Gillick*, above n 30, at 171, 189 and 201.

98 *Re A*, above n 96, at [64].

99 At [64].

100 *R (Axon) v Secretary of State for Health (Family Planning Association intervening)* [2006] EWHC 37 (Admin), [2006] QB 539 (QB).

101 At [2].

102 At [59] and [69].

103 At [86]–[87].

104 At [90].

105 *Re L*, above n 14.

106 At 812.

P, a competent 15-year-old, sought an abortion against her father's wishes; the court found that the father's objection did not override her consent, despite other cases where parental objections prevail.¹⁰⁷ Paternalistic notions continue to exist, as the court retained protective power, stating that it may veto if this is considered as in the child's best interests. However, medical opinion viewed the abortion as in her best interests.

Logically, *Gillick* competency may be thought to extend to consent refusal, but in subsequent cases the English Court of Appeal in *Re R* and *Re W* held that *Gillick* meant a competent child could consent, but that refusal did not have the same force, and so could be countermanded by the court or parents.¹⁰⁸ This retreat is based on society's unwillingness to trust teenagers in decisions that will irreparably damage their long term interests requiring a higher threshold of capacity for life-threatening refusals.¹⁰⁹ However, surely this is invalid for contraceptive treatment. Provision of contraceptives could require a lower threshold as it inherently seeks to prevent pregnancy and STIs that carry long term consequences so as to be potentially in what the doctors and courts collectively consider to be in the woman's best interests.

In *Re R*, a 15-year-old with psychosis indicated unwillingness to consent to antipsychotic drugs whilst lucid. Lord Donaldson MR stated that a child's right to consent is not exclusive but runs concurrently to the parents' several and joint right to give valid consent.¹¹⁰ Given their concurrency, only single consent is needed to continue, as both keys turn the lock.¹¹¹ Therefore the court, parents, or mature minor can consent to treatment. So for a *Gillick*-competent minor, despite attaining their own legal capacity to consent, the parents also retain their right to consent, but cannot veto their competent minor's consent. This parental right is significant because if a competent minor refuses, the parental consent enables lawfully rendered treatment.

Gillick was further diluted in a case regarding a 16-year-old's anorexia nervosa treatment.¹¹² While affirming the Court's virtually limitless inherent powers under *parens patriae*, which extend beyond rights of parents and include ability to override competent minors, the court allowed parents to also effectively override a refusal.¹¹³ Ian Kennedy and Andrew Grubb heavily criticise *Re W* and question how reconcilable it is, given that a competent child is entitled to have their confidences respected; if a child refuses, how can a parent consent to treatment without undermining this confidentiality?¹¹⁴ There may be a public interest exception allowing disclosure but this would severely undermine the essence of competence.

Although the retreat is inherently paternalistic, Morag McDowell acknowledges that, from a policy perspective, the justification of a stringent test is the protection of the minor from unwise decisions and saving of the child when a refusal could lead to death or disability.¹¹⁵ Given the intimate nature of contraceptives and controversy around abortion, it would seem a greater invasion of autonomy if parents could enforce contraceptive

107 *Re P* [1986] 1 FLR 272 (Fam). Compare *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] 1 Fam 11 (CA) at 26.

108 *Re R*, above n 107; and *Re W*, above n 25.

109 Nigel Lowe and Satvinder Juss "Medical Treatment — Pragmatism and the Search for Principle" (1993) 56 MLR 865.

110 *Re R*, above n 107, at 24.

111 At 22.

112 *Re W*, above n 25.

113 At 81.

114 Kennedy and Grubb, above n 72, at 984–987.

115 McDowell, above n 68, at 89.

treatment or pregnancy termination. Lord Donaldson MR opined the possibility of an abortion being enacted by doctors upon parental consent despite the child's refusal, stating the court's jurisdiction was open to protect the child should the abortion not be in her best interests.¹¹⁶ While he stated that this is a hair-raising possibility, the law may allow terminations upon parental consent despite ethical objections. If there is no consensus between the young woman, parents and doctors as to her best interests, there is the possibility that a parental consent could suffice. New Zealand's Family Court and High Court have similar jurisdictions. However in CoCA s 38(1)(b), the abortion-specific section, it is stated a refusal is effective as if she were of full age. Further, s 36(1) includes "refusal" for minor's consent generally, potentially signalling that any retreat from *Gillick* by *Re R* and *Re W* is not an intended part of the New Zealand jurisprudence.

VI The Law in New Zealand

The HDC and ACC regimes have effectively reduced litigation on consent in New Zealand, resulting in little direct authority. The Family Court has observed the change of perception of a child's worth consistently with majority's reasoning in *Gillick* in guardianship disputes.¹¹⁷

Judge Ullrich held that a 15-year-old was competent to consent to vaccination against parental wishes and should be permitted to make their own decision so that the consent prevailed over parental views.¹¹⁸ This is consistent with the *Gillick*-competent minor doctrine where such minors are accorded rights to positive consent.

The idea of competency and expressing views often arises in guardianship disputes. *Gillick* competency has been used in resolving a conflict over the doctor consulted by a 14-year-old girl in a guardianship dispute, as she was competent to form her own decision.¹¹⁹ Judge Ullrich also came close to declaring *Gillick* as applying in New Zealand; after quoting Lord Scarman's sufficient understanding test, she stated that this principle has been applied in New Zealand.¹²⁰

The most authoritative case is *Re J*, which concerned a 3-year-old whose parents were Jehovah's Witnesses who refused consent for blood transfusions for a life-threatening nose bleed.¹²¹ The authority is limited, not directly being applicable to minors formulating their own decisions; however, the Court of Appeal applied the reasoning from *Gillick* that the parental right was never absolute.¹²² In the High Court, Ellis J applied *Gillick* as stating the correct position for infant minors; a parent having custody and responsibility for the infant is entitled to consent or reject treatment on the infant's behalf, if the parent considers it not in the child's best interests.¹²³ Further, if doctor and parent disagree, the court has jurisdiction and is not tardy in response.¹²⁴

116 *Re W*, above n 25, at 79.

117 *PN v BN* (2006) 25 FRNZ 536 (FC) at [28].

118 *Re JFC* Wellington FAM-2004-085-1046, 3 November 2005.

119 *ARB v KLB [Guardianship Dispute]* [2011] NZFLR 290 (FC).

120 *Re SPO* FC Wellington FAM-2004-085-1046, 3 November 2005 at [25].

121 *Re J (An Infant): B v Director-General of Social Welfare* [1996] 2 NZLR 134 (CA).

122 At 143 and 145.

123 *Re J (An Infant): Director-General of Social Welfare v B* [1995] 3 NZLR 73 (HC) at 86.

124 At 87.

A *Contraception, Sterilisation and Abortion Act 1977*

The only statutory section referring to provision of contraceptives to children under 16 years was repealed in 1990.¹²⁵ Section 3 of the Contraception, Sterilisation and Abortion Act 1977 made it illegal to provide services for advice or access to contraceptives to anyone under 16, unless the provider fell within an exception, severely limiting contraceptive access. The exceptions included parents, registered medical practitioners, pharmacists, social workers and counsellors. Both a friend persuading a peer to practice safe sex or a child knowingly procuring or attempting to procure contraceptives from anyone but an authorised person would have committed an offence.¹²⁶

Today, unlike abortion services, there is no specific statutory right to access or ability to consent to contraceptive treatment.¹²⁷ This means that contraceptive supply to minors is subject to the general rules governing consent. Parliamentary intention of reducing barriers to contraception could be seen as inviting the common law to develop in parallel rather than at odds.¹²⁸

While condoms, a barrier method of contraception, are now openly available, as a method they rely on cooperation, access and use in each instance of intercourse. They are insufficient, as use can be erratic or denied, especially if the young girl is subject to abuse. Lainie Friedman Ross argues that this over-the-counter access is pragmatic, allowing accessibility while neither attempting to override parental moral values, nor condone adolescent sexual activity.¹²⁹ However, this does not help to determine competency.

The previous HDC referred favourably to *Gillick*.¹³⁰ In a presentation, the HDC discussed a complaint from a parent concerned about her lack of knowledge of the contraceptive advice and prescriptions received by her 15-year-old daughter from a Family Planning Association (FPA) clinic. The response emphasised that there is no statutory restriction on advice or contraception prescription supply to people of any age.¹³¹

B *Care of Children Act 2004*

Young males and females under 16 years have no statutory capacity to consent to medical treatment.¹³² Prior to 1 July 2005, the law was contained in the Guardianship Act 1968. CoCA poses the greatest obstacle for adopting *Gillick*, as it encroaches on common law except where otherwise expressed.¹³³ If it was not for s 36, “without doubt” people under 16 would have capacity to give legally effective consent for criminal and tortious liability.¹³⁴

125 Contraception, Sterilisation, and Abortion Amendment Act 1990, s 2(1).

126 Contraception, Sterilisation, and Abortion Act 1977, ss 3(2) and 3(6)

127 CoCA, s 38.

128 J Beatson “The Role of Statute in the Development of Common Law Doctrine” (2001) 117 LQR 247 at 256; and Andrew Burrows “The Relationship between Common Law and Statute and the Law of Obligations” (2012) 128 LQR 232 at 233–235.

129 Ross, above n 37.

130 Health and Disability Commissioner, above n 34.

131 “The Informed Consent Process and the Application of the Code to Children” (6 August 1998) Health and Disability Commissioner <www.hdc.org.nz>.

132 Except for s 38 which concerns abortions.

133 CoCA, s 13.

134 PDG Skegg “Capacity to Consent to Treatment” in PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) 171 at [6.3.1(3)(b)].

This would not mean all children could consent, as even for adults consent is not an all or nothing matter, but would depend upon ability and understanding of the decision's significance.

(1) Section 36

Only two changes were made from s 25 of the Guardianship Act to the new CoCA s 36; first, s 36(1) was clarified to include consent refusal¹³⁵ and s 36(2) applies also where that child is living as a de facto partner. The lack of clarification regarding children under 16 has been held as a lost opportunity, there being no indication that proxy consent is always required so the position of under 16-year-olds remains unclear.¹³⁶ The first change is critical, explicitly including positive consent and refusal, so minors over 16 years do not have the post-*Gillick* implications whereby parents can countermand a competent minor's refusal of consent.¹³⁷

Some commentators held that by not mentioning the legal position of those under 16, such people, by implication, cannot give effective consent.¹³⁸ This is based on the canon of construction *expressio unius est exclusio alterius*, so the express mention of ability to consent if over 16 years excludes the ability of those below. Section 38 purports to override s 36, allowing abortion consent at any age as if s 36 prevents legal validity. Burrows warns that, while a valuable guide, such canons need not be "slavishly" adhered to.¹³⁹ Section 36 can be interpreted as continuing an orthodox status-based test whereby all minors below 16, by reason of their age, are incapable of giving legally effective consent. Parents' right to control, manifest through their right to consent, could be construed as implying that the child's consent is unnecessary. Tompkins J in the High Court supported the orthodox view that consent must be obtained from persons other than the child aged under 16 before treatment is administered, given lack of explicit reference in s 25(3) Guardianship Act 1968.¹⁴⁰ However, this position is not universally held. The Court has acknowledged that it is positioned to take into account a 12-year-old's views; however, the child and parents expressed similar wishes.¹⁴¹

By allowing a purposive interpretation of s 36 which accommodates *Gillick*, the common law can fill the lacuna for children aged under 16.¹⁴² The modern trend has been towards purposive interpretation, as mandated by s 5(1) of the Interpretation Act 1999, so that words are read in their fullest context thereby working in the intended manner of the legislation.¹⁴³ The meaning of a provision must always be cross-checked against the purpose of the provision itself and the Act's wider social objectives.¹⁴⁴ This is advantageous

135 "A consent, or refusal to consent, to any of the following, if given by a child of or over the age of 16 years, has effect as if the child were of full age ..."

136 Graham Rossiter "Medical treatment of minors" [2006] NZLJ 10; Thomson, above n 12, at 171; and Miller, above n 35, at 86.

137 *Re R*, above n 107; and *Re W*, above n 25.

138 Ministry of Health, above n 18.

139 JF Burrows and RI Carter *Statute Law in New Zealand* (4th ed, LexisNexis, Wellington, 2009) at ch 8.

140 *Auckland Healthcare Services Ltd v Liu* HC Auckland M812/96, 11 July 1996 at 7.

141 *Auckland Healthcare Services Ltd v T* [1996] NZFLR 670 (HC).

142 Robert Ludbrook and Lex de Jong *Care of Children in New Zealand: Analysis and Expert Commentary* (Brookers, Wellington, 2005) at [CC36.06].

143 Burrows and Carter, above n 139, at ch 7.

144 *Commerce Commission v Fonterra Co-operative Group Ltd* [2007] NZSC 36, [2007] 3 NZLR 767 at [22].

if arguing that *Gillick* should be applied in New Zealand, as a purposive interpretation holds that an Act's interpretation should not obstruct its own purpose¹⁴⁵ unless it is clear in doing so. It is not explicit and refusal of consent capacity consent is not necessarily implied.¹⁴⁶ Further, obiter in a guardianship dispute is noteworthy; Heath J sought to apply parental duties rather than rights, holding *Gillick* philosophy as consistent with CoCA's purpose.¹⁴⁷

One interpretation is that there is a presumption of consent for those above the set age of 16, but given the silence on the matter, those below 16 have a presumption of incompetence, subject to rebuttal by way of *Gillick* mature minor competence in relation to the procedure.¹⁴⁸ Tiered approaches are already contained within CoCA. Section 16 adopts a tiered approach for the guardian's powers regarding important matters affecting the child, including non-routine medical treatment. This means a guardian can sometimes determine the matter for the child, but can also assist the older child's decision making by proffering information and advice.¹⁴⁹ This is consistent with parental control being neither exclusive nor complete and reflective of the duties owed by the parent to the child¹⁵⁰ and the purposes of CoCA.¹⁵¹

Section 36 does not purport to place children aged 16 to 17 years in an adult position. There is an important qualification in s 36 (1)(b) that the health service must be in the child's best interests. Best interests are held to be the first and paramount consideration in s 4. Section 5 contains principles relevant to determining these paramount best interests. Arguably, it is consistent with the overall purpose of the Act that this restriction would also apply if ability to consent is extended to under-16-year-olds. However, if a child is sexually active, contraception is doubtless in his and her best interests. However, s 5 does raise issues, as it provides that:

(a) the child's parents and guardians should have the primary responsibility, and should be encouraged to agree to their own arrangements, for the child's care, development, and upbringing:

...

(d) relationships between the child and members of his or her family, family group, whānau, hapu, or iwi should be preserved and strengthened, and those members should be encouraged to participate in the child's care, development, and upbringing ...

This has potential use in strengthening claims of parental involvement, negating minors' need for capacities to consent. However, this seems inconsistent with the Act as a whole; to focus on a couple of principles has the potential to undermine the other principles

145 CoCA s 3:

“(1) The purpose of this Act is to—

(a) promote children's welfare and best interests, and facilitate their development, by helping to ensure that appropriate arrangements are in place for their guardianship and care;

...

(2)(c) respects children's views and, in certain cases, recognises their consents (or refusals to consent) to medical procedures ... ”

146 Burrows and Carter, above n 139, at ch 7.

147 *Hawthorne v Cox* [2008] 1 NZLR 409 (HC) at [61].

148 *AC v Manitoba*, above n 94.

149 Ludbrook and de Jong, above n 142, at [CC36.04].

150 *Re J*, above n 121, at 145.

151 CoCA, s 3(1)(a) and (b); and *PN v BN*, above n 117, at [22].

contained within, especially given that best interests are considered paramount and the child's views are deemed as relevant to the best interests.¹⁵²

Section 36(2) provides that a child who is married, in a civil union or in a de facto relationship can consent to and refuse treatment for themselves or another person. There is, therefore, a statutory right for young people who have attained parenthood to consent to their child's healthcare, grounded on their increased need for independence.¹⁵³ Further, minors can be accorded competency through marriage, civil union or de facto relationships. This does not create tensions with parental rights, which have been completely terminated in the emancipated minor's favour. Additionally, given the qualification that treatment must be to the child's benefit is not in s 36(2), such children are closer to adult status than "ordinary" 16- to 17-year-olds.

Section 36(5) seems to reduce the chance of importing *Gillick* competency.¹⁵⁴ This section purports to prevent s 36 from being an overriding statutory provision unless expressly stated. Subsection (5)(c) seemingly revitalises the *Re W* scenario, whereby parental consent overrides a child's refusal, as parental consent is sufficient except in the circumstances in (2) where they have forfeited parental rights. Section 37 grants medical professionals immunity from legal suits if complied with when administering a blood transfusion despite nonconformity with s 36. Common law defences of necessity are authorised by s 36(5)(a).

Lord Diplock has recommended caution when developing common law based on an elderly statute that is incompatible with modern thinking or politically controversial.¹⁵⁵ Unfortunately, the CoCA is recent legislation, albeit largely unmodified from its predecessor. More importantly, the statute states nothing regarding under-16-year-olds, so common law must develop. It is at least arguable that in some senses it is incompatible with modern thought. It must be remembered that the additions to s 36 have enhanced, rather than restricted, a minor's capacity to consent to medical treatment, consistent with the overall purpose. An important feature of purposive interpretation is that when multiple possible meanings exist, the one in best accordance with the purpose should be effected.¹⁵⁶ Furthermore, courts are often reluctant to accept a statute's entire subsumption of common law.¹⁵⁷

Section 13 provides that the CoCA is to act as a code. The section does not assist further arguments that *Gillick* can apply. As *Gillick* is not expressly mentioned within the CoCA, there is no argument that this part of the common law is preserved.¹⁵⁸ Further, the High Court retains powers it had prior to 1970 for matters not provided for within the Act, but *Gillick* was decided in 1986.¹⁵⁹

152 CoCA, s 4(6).

153 New South Wales Law Reform Commission, above n 15, at [6.26].

154 "Nothing in this section affects an enactment or rule of law by or under which, 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), the consent of any other person instead of the consent of the child is sufficient."

155 *Warnink v Townend & Sons (Hull) Ltd* [1979] AC 731 (HL) at 743.

156 Burrows and Carter, above n 139, at ch 8.

157 Ludbrook and de Jong, above n 142, at [CC36.14]; Beatson, above n 128; and Burrows, above n 128.

158 Section 13(1).

159 Section 13(2).

(2) Section 38

Section 38 overrides s 36 and any ambiguities created in subpart (2). Since 1977, all women have been able to consent to or refuse an abortion. The provision replicated within the CoCA without alteration.¹⁶⁰ However, this was debated, especially the confidentiality implications. A Supplementary Order Paper to the Bill requiring parental notification of girls under 16 seeking an abortion was rejected 75:45.¹⁶¹ Bill English proclaimed the law “repugnant” in allowing girls to return to school having had an abortion without parental knowledge, as the parents and girl, not the professional, have to live with the “consequences”.¹⁶² While Tapu Misa acknowledged that there was no right answer to the problem, she knew her position if her own daughter were implicated.¹⁶³ However, parents cannot blame the law for their child’s secrecy.¹⁶⁴ Surely this is the correct position, as it would infringe rights of bodily integrity if one were forced to terminate a wanted pregnancy,¹⁶⁵ or denied a desired termination that could be obtained but for lack of consent capacity.

Section 38 provides that age is not determinative of capacity to consent, but certainly capacity is still relevant. It does not unequivocally state that all females can give effective consent to pregnancy termination; rather, their age is an irrelevant consideration. As competency is still required,¹⁶⁶ the *Gillick* mature minor test would be appropriate. Medical practitioners must consult other practitioners to assess the woman’s mental condition and likely effects of continuation or abortion of pregnancy.¹⁶⁷ Age is an insufficient criterion to form incompetence, but is still relevant for meeting exclusion criteria from criminal liability.¹⁶⁸

However, as an exception to the rule, s 38 is insufficient. For example, it allows consent to an abortion, but if a complication arises, applying strict interpretation of s 36 without *Gillick* competency, parents would have to consent to further treatment. To consent, they would require sufficient information.

C New Zealand Bill of Rights Act 1990

Prima facie, all children are entitled to the rights accorded within the New Zealand Bill of Rights Act 1990 (NZBORA), as only s 12 has age restrictions. Section 11 expressly provides that “everyone” has the right to refuse medical treatment. “Everyone” has been defined by the High Court as solely people competent to consent.¹⁶⁹ Therefore, a minor must be *Gillick*-competent to be accorded the right to refuse treatment under the NZBORA.

160 “(1) If given by a female child (of whatever age), the following have the same effect as if she were of full age:

- (a) a consent to the carrying out on her of any medical or surgical procedure for the purpose of terminating her pregnancy by a person professionally qualified to carry it out; and
- (b) a refusal to consent to the carrying out on her of any procedure of that kind.”

161 Supplementary Order Paper 2004 (292) Care of Children Bill 2003 (54-2).

162 English, above n 4.

163 Misa, above n 4.

164 Editorial, above n 4.

165 New South Wales Law Reform Commission, above n 15, at [6.85].

166 Nicola Peart “Prevention and Termination of Life Before Birth” in PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) 473 at [17.3.6].

167 Contraception, Sterilisation, and Abortion Act 1977, s 34.

168 Crimes Act, s 187A(2).

169 *Re S* [1992] 1 NZLR 363 (HC).

While the NZBORA cannot be used to override other Acts, a consistent interpretation is preferable; *Re J* depicts definitional balancing to prevent inconsistency between rights.¹⁷⁰ While observing that no court can decline to apply the provision due to inconsistencies in NZBORA, Gault J held that J's parents' right to religion was not allowed to extend to imperilling J's life or health, entitling the Court to intervene and consent to treatment.¹⁷¹ While not dealing with a mature minor, Gault J applied the reasoning behind the *Gillick* mature minor doctrine that parental rights are determined by the extent of required parental duties and the paramount interests of the child. Even incompetent minors' best interests are to be held paramount and protected against parental rights to manifest their religion.¹⁷² An orthodox Catholic parent's opposition to contraception, therefore, should not override their child's best interests.

D *The Code*

Gillick is reflected in The Code, delegated legislation authorised by the Health and Disability Act 1994.¹⁷³ The Code goes beyond common law with all rights applicable to all consumers, regardless of age. Right 7 is dedicated to competency and consent and does not provide a set age for deemed competency.

Right 7(2) provides a presumption of competence for all health consumers to make an informed choice, except where common law or any enactment provides otherwise. Significantly, s 36 CoCA is ambiguous regarding the position of those under 16, so The Code is not necessarily subverted. Lord Scarman held no support for presuming the competence of minors; he emphasised the need for individualised assessment.¹⁷⁴ McDowell argues, even with a presumption, determination is still on a case-by-case basis so is consistent with *Gillick*.¹⁷⁵ However, a presumption may reflect reality.¹⁷⁶ Nonetheless, a doctor interpreting the right might apply a status-based approach, using age as reasonable grounds for concluding incompetency. Therefore, greater clarity of the legal position is required for a consistent approach. Skegg argues that seeking to determine competence is more desirable than presuming it. By seeking to ascertain capacity, one is provided the chance of making a more autonomous decision.¹⁷⁷ This would allow a consistent starting point, although naturally the degree of inquisition into competence would differ depending on age.

Right 7(3) allows for the involvement of those with diminished competence commensurate to their level of competence, thus allowing for incompetent minors' involvement. Right 7(4) applies in the case of incompetence.¹⁷⁸ Treatment provided must

170 New Zealand Bill of Rights Act, ss 4 and 6.

171 *Re J*, above n 121, at 146. See also Guardianship Act 1968, s 25(3)(a).

172 *Re J*, above n 121, at 146. See also Guardianship Act, ss 13 and 15.

173 Health and Disability Commissioner Act, s 20(1).

174 *Gillick*, above n 30, at 189.

175 McDowell, above n 68.

176 PDG Skegg "Presuming Competence to Consent: Could Anything be Sillier?" (2011) 30 UQLJ 165 at 180.

177 At 178–179.

178 "Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where—

(a) it is in the best interests of the consumer; and

(b) reasonable steps have been taken to ascertain the views of the consumer; and

(c) either,—

be in the best interests, and the person administering treatment must take reasonable steps to ascertain the patient's views, also taking into account those of other persons involved in the child's welfare. Therefore, when confronted with an incompetent minor, the doctor must strive to assess the child's views and their alignment with proposed treatment, or must consider parental views to be in the child's best interests. The Code proposes these as alternatives. However, as The Code is not designed to displace other laws, parental consent on the incompetent minor's behalf would still likely be required.

Importantly, in some situations, The Code places an obligation on the health professional to assess competency and best interests, the same obligation required by *Gillick*. Further, at no point is there a status-based test. Right 7(7), recognising every consumer's right to refuse services, in conjunction with the inclusion of refusal in ss 36 and 38, bolsters rejection of the English Court of Appeal's arbitrary decisions.

It is significant that the HDC feels there is scope for *Gillick* under The Code. A mother's complaint against a local medical centre giving her 14-year-old son a tetanus vaccination after a minor injury at school was found not to have been a breach.¹⁷⁹ Right 7(2)'s presumption of competency, in the previous Commissioner's view, allows for a competency-based assessment. In applying *Gillick*, competency should not be determined solely on an age basis, but rather determined by ability to understand information regarding risks and consequences of any decision and the situation's relative seriousness. Allowing a mature minor test would satisfy the objective of Right 3, to ensure services optimise the consumer's independence.¹⁸⁰

However, power was not conferred by Parliament to alter the general law relating to consent.¹⁸¹ Thus, The Code cannot be inconsistent with other enactments. If it is, the practitioner should follow the other enactment.¹⁸² Despite The Code's capability to be interpreted consistently with *Gillick*, it must be reconciled with s 36(1), which prevails in cases of inconsistency. This means orthodox interpretations of s 36 could prevail. However, a more satisfactory interpretation of reconciling *Gillick* exists; s 7(2) reasonable grounds can accommodate the mature minor test, highlighting autonomy which is consistent with the rights-based origin of The Code.¹⁸³

E *International Obligations*

Almost universally ratified, UNCRC limits parental powers and duties based on adolescents' "evolving capacities" for self-determination.¹⁸⁴ New Zealand's international obligations increasingly emphasise the child, rather than rights exercised on their behalf by guardians, and bolster the adoption of the common law approach.¹⁸⁵

-
- (i) if the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or
 - (ii) if the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider."

179 Health and Disability Commissioner, above n 34.

180 "The Informed Consent Process and the Application of the Code to Children", above n 131.

181 Skegg, above n 134, at [6.3.1].

182 Clause 5: "Nothing in this Code requires a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by any enactment."

183 Thomson, above n 12, at 177; and McDowell, above n 68.

184 Dickens and Cook, above n 42, at 181.

185 At 181.

Article 12 stipulates that children are entitled to assume control of their affairs upon developing the capacities enabling them to do so. This is consistent with a competency-based, rather than status-based, consent model. Article 24 is a right to health, and in paragraphs (b) and (f) specifically includes developing primary healthcare and family planning education and services.

Article 12's ideology is reflected in the purposes of the Children's Commissioner Act 2003's, where the Commissioner is to be conferred powers to better effect New Zealand's obligations under UNCRC and to have regard to the Convention when exercising duties and powers.¹⁸⁶ Fraser J regarded the UNCRC as a legitimate source from which to derive doctrines and rules regarding children's welfare.¹⁸⁷ Furthermore, international instruments are considered to be relevant in exercising discretion and interpretation of statutes is to be in a manner that gives effect to international obligations.¹⁸⁸ Therefore international obligations add weight to the argument that *Gillick* competency can apply in New Zealand.

VII Confidentiality

Confidentiality is vital and stems from the general obligation of respect implicit in doctor-patient relationships.¹⁸⁹ It increases youth confidence and cooperation, ensures honesty regarding risky behaviours, and thereby permits proper appraisal of infection risks and appropriate advice. However, this conflicts with parents' natural desire to be informed about their child's life.¹⁹⁰ Parental notification of girls seeking abortions or contraception forgets that boys too, are implicated in the lifestyle choice the parents are challenging. The New South Wales Law Commission reported that requiring parental consent or notification in sexual health services deters many youths from seeking treatment.¹⁹¹ Despite this, during the review of the Care of Children Bill, attention focused on the clause replicating the status quo allowing a girl of any age the right to consent to or refuse a pregnancy termination without mandatory notification. Kennedy asserts that adults, claiming a right to be informed, often present their argument unattractively, harking back to traditional chattel ideology.¹⁹² Mandatory notification ignores the reality that reactions will likely be severer than if the daughter discloses voluntarily.¹⁹³

There are strict exceptions for disclosure under the Health Information Privacy Code 1994 (HIPC) as parents have no automatic right to their child's health information.¹⁹⁴ The HIPC draws no distinction between adults and children, and adopts an understanding-based test in order to exercise HIPC rights.¹⁹⁵ Rule 11 prohibits disclosure of health information save for where an exception applies, and is discretionary in application. A "representative" is someone with a degree of access to, and control over, a person's health

186 Children's Commissioner Act 2003, s 3(c) and (d).

187 *H v F*(1993) 10 FRNZ 486 (HC) at 499.

188 *Tavita v Minister of Immigration* [1994] 2 NZLR 257 (CA).

189 Kennedy, above n 56, at 63.

190 Kennedy and Grubb, above n 72, at 1076.

191 New South Wales Law Reform Commission, above n 15, at [6.62].

192 Kennedy, above n 56, at 61.

193 Melissa Prober "Please Don't Tell My Parents: The Validity of School Policies Mandating Parental Notification of a Student's Pregnancy" (2005) 71 Brook L Rev 557 at 580.

194 Sarah Kerkin "Disclosing children's health information — A legal and ethical framework" (6 August 1998) Privacy Commissioner <privacy.org.nz>.

195 Ministry of Health, above n 18, at 26.

information, including a child under 16's parent or guardian.¹⁹⁶ Under s 22F of the Health Act 1956, a representative has limited rights to information about their child. The Privacy Commissioner notes that, while the laws surrounding health information may allow disclosure, health practitioners must consider both legal obligations under HIPC and ethical obligations of confidentiality; the law's allowance of disclosure does not necessarily render it ethical.¹⁹⁷ This is significant, given the particularly sensitive nature of sexual health services.¹⁹⁸ A representative's request is treated as equivalent to a patient's request for health information; however, it can be refused if perceived as against the child's interests.¹⁹⁹

Once the patient is 16, parents no longer have rights to their health information per se. However, rule 11(2)(b) will permit a health practitioner to disclose information to a principal caregiver if compatible with professional practice, or if getting the patient's permission is undesirable—for example, if they are unconscious, not if they are attempting to obtain something potentially objectionable like an abortion.²⁰⁰ Rule 11(2)(d) permits disclosure without consent if necessary to prevent serious threats to the life or health of the individual concerned. This is unlikely to extend to the unborn "child" in a proposed termination. Sometimes the practitioner's role is to encourage parental acceptance of the value of their child's autonomy.²⁰¹

The FPA states they will encourage the girl to tell her parents, as *Gillick* holds, but her refusal is not sufficient for a doctor to ignore her confidentiality. If disclosure was standard, future patients may be deterred.²⁰² Naturally, there will be compromises. Where the adolescent is monetarily dependent on a guardian, the provider may be unable to conceal the fact that gynaecological services were rendered, but non-specific details may be given.²⁰³ However, given that most sexual health services in New Zealand have government subsidies, this compromise is minimal.

Kennedy requires that one must have the legal capacity to entrust in order to bind the doctor to such an obligation.²⁰⁴ Therefore, prima facie when the child is incompetent, the doctor is obliged to disclose information gained, to the parents. This is consistent with the paramount concern of child's interests. If competent, however, the balance does not favour disclosure.²⁰⁵ This must be true, as status-based confidence rights would ignore the fact that children often acquire autonomy before their sixteenth birthday and would undermine the therapeutic relationship.²⁰⁶

196 Health Information Privacy Code 1994, cl 3.

197 "Health Information Privacy Fact Sheet 3: Disclosure of health information — the basics" (2011) Privacy Commissioner <privacy.org.nz>.

198 "Health Information Privacy Code 1994: Incorporating amendments and including revised commentary" (December 2008) Privacy Commissioner <privacy.org.nz>.

199 Rule 11(4)(b).

200 "Health Information Privacy Fact Sheet 4: Dealing with requests for health information" (2011) Privacy Commissioner <privacy.org.nz>.

201 Ministry of Health, above n 18.

202 Kennedy, above n 56, at 65.

203 Dickens and Cook, above n 42, at 183–184.

204 Kennedy, above n 56, at 115.

205 *R (Axon) v Secretary of State for Health*, above n 100.

206 Kerkin, above n 194.

VIII Australia

Despite adoption of *Gillick* in common law jurisprudence,²⁰⁷ some states have opted to legislate. New South Wales allows minors to consent to medical or dentistry treatment in certain circumstances.²⁰⁸ The provision requires the minor to be 14 or older, so that treatment undertaken with prior consent of the minor is lawful, with relation to claims of battery or assault, as if the minor were the age of majority. This is similar to s 36 but deems competency at a younger age. The New South Wales Law Commission believes that a young person, even if incompetent to give consent, should nonetheless have access to contraceptive advice and treatment if she will otherwise have, or continue to have, unprotected intercourse, risking pregnancy and STIs.²⁰⁹ The health practitioner in such circumstances could exercise discretion to act in the patient's best interests, and so would dispense with required parental involvement in both mature and immature minors. In doing so, the pivotal requirement of consent is removed, thereby providing a workable framework for the situation. This possibly goes too far in bending legal principles in applying also to incompetent minors, albeit achieving a desirable result.

Section 12 of the Medical Treatment and Palliative Care Act 1995 (SA) contains a statutory framework for when medical treatment can be administered to a child 15 years or less: if the child consents, the doctor believes it capable of understanding the treatment, treatment is in the child's best interests, and another doctor who has examined the child has written supporting the proposed treatments. The final requirement provides consistency in practice, but will inherently create delays and increased costs in treatment as time is required for a second opinion.

XI New Zealand

It is unhelpful to have a legal framework that ideal practice and reality significantly depart from.²¹⁰ Given that legislation does not differentiate between contraceptive treatment for children and adults and there is no express denial of capacity for under-16-year-olds, it is possible to apply *Gillick* in New Zealand, especially given the favourable mention it has enjoyed.²¹¹ McDowell argues that absolutely requiring parental consent is overly conservative.²¹² Skegg recommends that the better view is that, common law capacity not being extinguished by legislation, the consent of those under 16 is sometimes effective in law.²¹³

An adolescent engaging in sexual relations may require treatment for STIs or contraception to prevent pregnancy, and those who seek these services may have more maturity than those who fail to.²¹⁴ The FPA provides free sexual health consultations and treatment in the community and applies the "Fraser Guidelines". The "Fraser Guidelines", as interpreted by the FPA, require competency "to make informed decisions on a daily

207 *Marion's Case*, above n 94.

208 Minors (Property and Contracts) Act 1970 (NSW), s 49.

209 New South Wales Law Reform Commission, above n 15, at [6.92].

210 Lee, above n 11, at 301.

211 Contraception, Sterilisation, and Abortion Amendment Act 1990, s 2(1); and CoCA, s 36(1).

212 McDowell, above n 68, at 81.

213 Skegg, above n 134, at [6.3.1(3)(b)].

214 Dickens and Cook, above n 42, at 182.

basis”.²¹⁵ Thus it seems while the courts have yet to formally adopt *Gillick* competency, the *Gillick* test is already applied by doctors. Importantly, and consistent with the “Fraser Guidelines”, the FPA expects their health professionals to encourage the child’s communication with parents but acknowledges this is not always possible.

The Medical Council’s statement is less structured. It interprets s 36 as not automatically prohibiting effective consent from persons under 16, and recommends that doctors assess the child’s competency and form an opinion on their capability to give informed consent.²¹⁶ A competent child is “able to understand the nature, purpose and possible consequences of the proposed investigation or treatment, as well as consequences of non-treatment”.²¹⁷ This is seemingly a lower and narrower standard, limited to medical matters, than advanced in *Gillick*. Self-assessment of best interests, postulated in common law, requires consideration and balancing of physical, psychological and social effects of proposed treatment.²¹⁸ In practice, it is important to establish rapport and support the young person by encouraging discussion of implications beyond medicine, and reinforce—despite confidentiality of consultation—that the young person should discuss this choice with a trusted adult.²¹⁹ Overall, the medical profession has already adopted *Gillick*.

While *Gillick* is not necessarily excluded by legislation, and is unlikely to be endorsed by any higher authority, statutory provision would be ideal. The HDC, which governs most healthcare disputes, speaks favourably of *Gillick*. The Family Court has applied the wider principles in guardianship disputes, and the FPA has adopted the “Fraser Guidelines” to govern their practice in providing contraceptives, so there is scope for application. I personally propose that to best align practice with the law would require legislating for *Gillick* competency for those under 16 in a statutory amendment. Amendment would reduce the scope of interpretation of s 36.²²⁰ Such provision would be consistent with New Zealand’s legislative matrix, but most importantly in line with practice. Recognising increasing autonomy with maturity in a clinical setting is appropriate and feasible, reducing need to rely on status-based competency. Furthermore, it is arguable that matters with such far-reaching social implications are best left to Parliament, which has the benefit of written submissions and is capable of rapid law change of outdated law.²²¹ While the controversial nature of such provision may hinder rapid legislation, it would provide the requisite clarity.

X Recent Updates

Since the completion of this article in 2012, Judge Somerville’s judgment in the Family Court has further affirmed the position of this article whilst looking at s 16 CoCA, which concerns the exercise of guardianship.²²² It was acknowledged that guardians’ rights dwindle with the age of the child and yield to the child’s right to make their own decision

215 “Sexuality — Young People and Their Rights”, above 7.

216 “Information, choice of treatment and informed consent” (March 2011) Medical Council of New Zealand <www.mcnz.org.nz> at [28].

217 At [28].

218 *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (HL).

219 BPAC “Contraception in early adolescence” (2011) (35) BPJ 24.

220 Miller, above n 35.

221 Burrows and Carter, above 139, at ch 16.

222 *Webb v Swanson* [2013] NZFC 6792 at [12].

when reaching a sufficient understanding and intelligence to be capable of making independent decisions. This is a further restatement of Lord Scarman's speech, showing acceptance of *Gillick* as part of New Zealand law.²²³ Judge Somerville considered that the guardian's role in general decision-making for a child is staged, beginning with determining important matters for the child, moving to determining them with the child, and ending with helping the child to determine questions for themselves to prepare the child to have the freedom to make their own decisions.²²⁴ This changing, tiered role of guardians aligns with the view that age alone cannot determine competency to consent and one of the interpretations of s 36 CoCA discussed above.

XI Conclusion

Blanket age restrictions based on a status model of capacity are archaic and restrictive of children's rights by insisting that all below this arbitrary age are incompetent and not the best judge of their own interests.²²⁵ Given capacity is changing alongside the child's individual development, a competence-based consent is required.²²⁶ The *Gillick* mature minor test is also potentially applicable in other necessary treatment, mental health services and drug addiction services, or even general non-emergency healthcare. The "Fraser Guidelines", which enshrine the *Gillick* competency principle specifically for contraceptives, have already been adopted by major health providers in New Zealand. *Gillick* should be adopted and embraced to achieve a greater balance between the interests of parents, children and the state,²²⁷ while also according with the demands of reality. Legislative amendment to explicitly fill this gap would create clarity and consistency of practice, and is more likely than judicial declaration on the point. Although it may be met with resistance, it would be merely aligning the law to society's practice:²²⁸

The law relating to parent and child is concerned with the problems of the growth and maturity of the human personality. If the law should impose upon the process of "growing up" fixed limits where nature knows 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.

223 *Gillick*, above n 30.

224 *Webb v Swanson*, above n 222, at [12].

225 Thomson, above n 12, at 145.

226 Ministry of Health, above n 18.

227 WR Atkin "Parents and Children: Mrs Gillick in the House of Lords" [1986] NZLJ 90 at 91.

228 *Gillick*, above n 30, at 186 per Lord Scarman.