CONTROLLING MINORS' FERTILITY

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INTRODUCTION

(1) Sexual Activity and Contraceptive Practices of Minors

Several recent studies report that minors today are becoming physically mature earlier than in the past.[1] Moreover, young people are using this capacity. The Australian Federation of Family Planning Associations, for example, found the 25% of 14 and 15 year olds had had sexual intercourse.[2] 40% of these young people were using either no contraception or withdrawal, a particularly unsucessful method, with a failure rate of between 15 and 38 pregnancies per 100 women a year.[3] An earlier survey[4] of 200 women giving birth at the Queen Victoria Hospital found that even in 1969, 71% of those having premarital intercourse (142 of the sample) claimed to have had sexual intercourse while they were still legally minors (and 11% while under 16).

ABS figures suggest that in 1981 at least 31,000 teenagers (under 20) became pregnant, although the NSW Family Planning Association suggests that the figure may be much higher, up to 40,000.[5] Of these, Siedlecky suggests about 12% marry, 39% have an ex-nuptial birth, and 49% have an abortion.[6] Wainer, in her survey of abortion clinic patients, found an over-representation of young unmarried women: 33% of patients at the Fertility Control Clinic were aged between 15 and 19, whereas this group made up 20% of the Victorian population at that time (1973-1974). Of these teenagers, 74% were not using any form of contraception, except perhaps withdrawal, at the time they became pregnant.[7] Wainer attempted to ascertain the reasons for this lack of contraception: The most common reason given was classified as "ignorance", which included misinformation and ignorance of

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[1] See, for example, a study by Fogelman, cited in Goldman R. & Goldman J. *Children's Sexual Thinking*, Routledge & Kegan Paul, London, 1982, at 25: of subjects born in 1958 in the United Kingdom, interviewed at the age of 16, 2.2% of the young women reported they had begun menstruating at the age of 10, 15.2% by 11, 39.2% by 12 years of age and more than 73% by the age of 13. See also Royal Commission On Human Relationships, *Final Report* Vol 3, Part IV: Sexuality and Fertility (hereinafter Royal Commission Report).

[2] *The Age*, 12 November 1984. The survey results were not available from the Federation at the time of writing.

[3] Royal Commission Report at 26.

[4] Wood, C. & Shannugian, N., "The risks of premarital conception" *Medical Journal of Australia*, 2 August 1969, 228.

[5] Wootten, V., "Teenagers & Fertility control: Legal & ethical issues for doctors", (1984) 3 *Healthright* 6; and NSW Family Planning Association memo, October 1983.

[6] Siedlecky, S., "Abortion figures", *The Age*, 16 July, 1984.

[7] Wainer, J., "Pathways to abortion", *La Trobe Sociology Papers* No. 8, 1975, at 24.

the benefits and side effects of contraceptives;[8] some 11% of teenagers apparently mentioned that they were scared of going to the doctor or were refused contraception by a doctor.

Clearly minors are engaging in sexual intercourse, many without adequate contraception. This article explores minors' legal capacity to consent to fertility control treatment and their actual ability to give an informed consent. It concentrates particularly on the position of minors under the age of 16.

(2) What is an Informed Consent?

The necessity for informed consent to medical treatment has been variously described as resting on the notion that "the physical integrity of every person is inviolable",[9] as being "a recognition of the patient's right to self-determination"[10], or as protecting the "autonomy of the person".[11] Because a person's body is inviolable, a doctor cannot provide treatment that involves physical touching without the consent of the patient. To do so would, in law, amount to a battery.

Robertson has also suggested that one purpose of the doctrine of informed consent is to "encourage rational decision making".[12] Because of this function and the overarching right to self-determination, the doctrine of informed consent requires doctors to provide information to patients about the proposed treatment. This requirement has been expressed as "knowledge on the part of the patient sufficient to enable him [or her] to give a truly effective informed consent".[13] A second requirement is that the person has the competence or capacity to consent.[14] The third requirement is that consent be voluntary, that is, obtained without "undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion".[15]

(i) *Sufficient Knowledge*

Precisely what is sufficient knowledge to support an informed consent has been the subject of litigation. In general, it appears that very little information has to be disclosed to the patient in order to support a consent adequate to protect a medical practitioner from an action in battery or trespass to the person.[16] However, when consent is in issue, courts have been inclined to explore doctors' liability as a liability for negligence. The duty to inform is

[8] Id, at 25.
[9] Stansfield, M.P., "Malpractice: Towards a viable disclosure standard for informed consent" (1979) 32 *Oklahoma Law Review* 868.
[10] Robertson, G., "Informed consent to medical treatment" (1981) 97 *Law Quarterly Review* 102 and 102.
[11] Somerville, M.A., *Consent to Medical Care*, Protection of Life Series, Law Reform Commission of Canada, 1979, at 3.
[12] Robertson, op. cit., at 111.
[13] Stansfield, op. cit., at 871.
[14] Ibid.
[15] Somerville, op. cit., at 46, quoting United States DHEW regulations.
[16] See, for example *Chatterton* v *Gerson* [1981] 1 All ER 257 and *F* v *R* (1983) 33 SASR 189.

thus subsumed under the general duty of care, which may, in turn, allow information required to be pared back to a minimum. Similar considerations apply to both minors and adults. A minor's capacity to receive information will be discussed in more detail in Section II.

(ii) *Competence*

The competence requirement is taken for granted in the case of "normal" adults but is a matter of some contention in relation to minors. It is explored here in two parts: the legal capacity of minors to consent to their own treatment (Section I) and their actual competence (Section II).

(iii) *Volntariness*

The requirement of voluntariness is again a matter that is comparatively straightforward in relation to adults but the subject of debate when one considers a minor's informed consent. This is also explored in Section II.

SECTION I: MINORS AND FERTILITY CONTROL – LEGAL ISSUES

Minor's Legal Capacity to Consent

While there are few writers who have adamantly maintained that a minor has no legal capacity to consent to medical treatment it has clearly been seen by many as an area of uncertainty:[17] Samuels is one of the few who have declared that the common law establishes that minors cannot consent to medical treatment on themselves.

Samuels[18] asserts that as a minor at common law is in the custody and control of her parents, any interference with her body without parental consent therefore constitutes a trespass. He cites in support of his argument a number of cases including *In re P (a Minor)*[19] and *In re D (a Minor) (Wardship: Sterilisation)*.[20] The latter case concerned the sterilisation of a mentally disabled minor aged 11. Her mother wished to have her sterilised and a doctor was prepared to perform the operation. An educational psychologist with the local authority intervened to stop the operation and the *parens patriae* jurisdiction of the court was invoked. The court refused to allow the operation because it would take away D's fundamental right to have a child and "if performed on a woman for non-therapeutic reasons and without her consent, a violation of such right".[21] The doctors stated that they intended to

[17] See for example *Report of the Committee on the Working of the Abortion Act* (The Lane Committee) Cmnd 5579, 1974, at para. 243.
[18] Samuels, A., "Can a minor (under 16) consent to a medical operation" (1983) 13 *Family Law* 30 at 31; cf. Samuels A., "Contraceptive advice and assistance to a child under 16" (1982) 22 *Medicine, Science and the Law* 215 at 218.
[19] (1982) 80 LGR 301.
[20] [1976] Fam 185.
[21] Id. at 193.

get the minor's consent to the operation. The court said: "[T]he evidence also shows that she is unable as yet to understand and appreciate the implications of this operation and could not give a valid or informed consent."[22] Samuels argues that this case indicates that minors cannot consent to their own medical treatment. To the contrary, it could be argued that the court was (rightly) concerned with the mental capacity of this particular prospective patient and her ability to understand the implications of the operation. Hence the court was concerned with the *evidence* of D's mental ability; the decision cannot be read as making any more general comment on the legal capacity of minors generally to consent.

P's case is perhaps of more direct relevance. At the time of this application to the court Shirley P was just over 15 and pregnant. She had been placed in the care of the local authority some years before and already had one child for whom she cared. She wanted to have an abortion, which her parents opposed. Although the local authority, according to the court, had the "rights and obligations" of a parent and (impliedly) therefore the power to authorise the abortion, they were reluctant to go against the wishes of the parents. They wanted her made a ward of the court so the court could decide on the termination. The local authority clearly assumed that the young woman could not consent on her own behalf. Samuels argues that the court also assumed that she was unable to consent; but in fact, the court's attitude was more equivocal. Certainly the assumption of the local authority was not challenged. This may have been because the young woman was herself unrepresented and thus no one was likely to challenge the assumption. After all, she wanted the abortion and may not have felt like attempting to establish a general legal principle, at the risk of her own immediate wishes. Butler-Sloss J. did say: "I would not like it to be thought that because she says she does not want the child her wishes should be given such paramount importance as to mean that for that reason only she should have an abortion."[23] But Shirley P's wishes were not then immediately counterposed to the wishes of her parents. The judge considered instead whether she came within the terms of the UK *Abortion Act*. Such an inquiry would be essential to any consideration of an adult's right to have an abortion. Admittedly Butler-Sloss J. did not conclude that once P came within the Act, her decision was overriding and valid. Rather, she stated that P's interests were the "first and paramount consideration". The judge went on to say that she had to take into account the parents feelings as a factor in the case in considering the best interests of the minor. The judge in *P's*, as well as ording a termination, also directed that P be fitted with an IUD, "again with the approval and at the request of the mother". This direction does suggest that the court did recognise an independent (though not determinative) right and legal capacity of a young woman to consent to her own medical treatment.

Arguably, this case comes within what Wilkins[24] has referred to as the

[22] Id. at 196.
[23] (1982) 80 LGR 301 at 309.
[24] Wilkins L.P., "Children's rights. Removing the parental consent barrier to medical treatment of minors" [1975] *Arizona State Law Journal* 31 at 55.

"best interests of the child exception": "The matter under consideration by the courts is not the minor's right to determine for himself [or herself] whether the treatment will be given, but rather, the minor's right in general to receive beneficial treatment". Even if the court is not recognising an inviolable right of a minor to consent to her own medical treatment, *P's* case hardly establishes Samuel's proposition that the parents of a minor are the only ones able to consent to treatment of a minor.

Skegg[25] has pointed out other difficulties with the view that the common law required parental consent for any interference with a minor's body. He argues that if one accepts that because of their age minors are incapable of consenting to medical treatment, it follows that they are also incapable of consenting to other touchings. This would mean, for example, that children could not play any game in the school playground which required body contact without their parents consent. This proposition seems absurd. In *R* v. *Williamson*,[26] Williamson was convicted of unlawful and indecent assault of a woman below the age of 16 under the then section 55 of the *Crimes Act* 1958 (Vic.), which provided that her consent was no defence. He appealed against a lower court decision that he could not be convicted of the lesser offence of common assault. The Supreme Court held that the lower court decision was correct: While a woman cannot consent to the sexual offence, she could consent to common assault. Therefore, if she had consented, the sexual offence was committed but common assault was not.[27]

Cases on court-ordered blood testing are also relevant. In *W* v. *W*,[28] the court decided that it could not order a blood test on an unconsenting adult because that would be an assault. That clear cut right has not been recognised in relation to children. Lord Denning stated in *B(B.R)* v. *B(J) & Another*[29] that a court could order a blood test on a child "of tender years – say under 7 years" without consulting the child, on the assumption that such a child would be unable to consent. Where a minor is older, and Lord Denning mentioned here a 14 or 15 year old, they should be consulted, but the minor's views "are never decisive" and the court could order the test "even if the child is difficult ... if it is clearly in the interests of the child". Lord Denning here seems to be recognising a minor's actual ability to consent, though not the legal right to do so, at least where the court considers the test to be in the "best interests of the child". It is at least arguable that a 7 year old is capable of understanding the blood testing procedure and its implications if properly explained,[30] although Lord Denning's views may have greater support. On the other hand, few would question that that same capacity exists in a 14 or 15 year old.

The issue is also somewhat different in relation to most decisions on fer-

[25] Skegg, P.D.G., "Consent to medical procedures on minors" (1973) 36 *Modern Law Review* 370.
[26] [1969] VR 696.
[27] cf. the much earlier decisions of *R* v *Banks* 8 Car & P 575 (no assault on a 9 year old girl who had consented) and R v *Martin* 9 Car & P 213.
[28] [1963] 2 All ER 841.
[29] [1968] 2 All ER 1023.
[30] Skegg op. cit. (1973), at 373.

tility control where the capacity to consent lies either with the minor or the parents, rather than, in the case of a court-ordered blood test, where the capacity to consent is with either the minor or the court. the court in the blood test situation is exercising its *parens patriae* jurisdiction.[31] The court's jurisdiction over minors must not be seen as the same as the parents' jurisdiction over minors. Indeed, the *parens patriae* power is used to override parental control of minors (see for example *D's* case). Sachs L. J. in *Hewer* v. *Bryant*[32] contrasts the two powers:

> "This strict personal power of a parent or guardian physically to control infants, which is one of the rights conferred by custody in its wider meaning, is something different to that power over an infant's liberty up to the age of 21 which has come to be exercised by the courts 'on behalf of the crown as *Parens Patriae*' ... It is true that in the second half of the last century that power was so unquestionably used in aid of the wishes of the father that it was referred to as if its resultant exercise was a right of the father ... In truth any powers exercised by way of physical control in the later years of infancy were not the father's personal powers but the more extensive ones of the Crown."

Notwithstanding this contrast, it remains true that, in the context of a court ordered blood test, minors have not been accorded the same legal rights, and have not been viewed as having the same legal capacity to consent, as adults.

The court in *Hewer* v. *Bryant* also examined the rights and duties encompassed in parental custody. Denning L. J. stated: "[Custody] is a dwindling right which the courts will hesitate to enforce against the wishes of the child the older he is. It starts with a right of control and ends [at 18] with little more than advice."[33] Lord Denning cautioned against using older cases to ascertain a legal definition of custody, or indeed the rights of parents. He referred to the decision in *Agar-Ellis*[34] which said, "the law of England ... is that the father has the control over the person, education and conduct of his children until they are 21 years of age" and rejected this statement. He said, "It reflects the attitude of a Victorian parent towards his children. He expected unquestioning obedience to his commands. If a son disobeyed, his father would cut him off with one shilling. If a daughter had an illegitimate child, he would turn her out of the house. His power only ceased when the child became 21. I decline to accept a view so much out of date. The common law can, and should, keep pace with the times."[35]

Some further discussion of the case law, specifically concerned with consent to treatment, is required. Like the decision in *P's*, some of this appears equivocal. For example, in *Burrell* v. *Harmer*,[36] the court refused to overturn a conviction of assault against a tattooist who had tattooed two 13 year old boys. He had argued that the boys consented. The court concluded that

[31] See *B(BR)* v *B(J)* at 1025.
[32] [1969] 3 All ER 578 at 584-5.
[33] Id. at 582.
[34] (1883) 24 Ch.D 317.
[35] [1969] 3 All ER 578 at 582.
[36] (1966) 116 *NLJ* 1658; [1967] Crim. LR 168.

the apparent consent of the children was no consent at all because they were unable to appreciate the nature of the act. By contrast, in *R* v. *Dilks*,[37] Dilks was charged with assault and indecent assault for tattooing a nude figure on the arm of a 13 year old boy. The boy had sought the tattooist out and already had some 20 tattoos. The court decided that the charges should be dismissed as the boy had consented to the tattooing.[38] The commentary in the *Criminal Law Review* on *Burrell* v. *Harmer* suggests that the case has more to do with then current objections to tattooing and says: "If the boys knew that the effect would be to put a picture of some kind in their arms which would be irremovable, in what sense did they not understand the nature of the act? Was it because they did not appreciate that their arms would become inflamed and painful? That would hardly seem to be a misunderstanding of the nature of the act." On the contrary, surely there *was* a misunderstanding of the nature of the act – if the boys did not understand that their arms could become inflamed they had not understood the nature of tattooing and had not given a truly informed consent, and that should vitiate their apparent consent.[39] It seems that what the courts have done in both these cases is to make their own enquiries as to whether the children are capable of consenting, a capability which is not necessarily dependent on age. In other words they are *not* assuming an automatic legal incapacity arising from minority status.

Other cases, particularly American and Canadian cases, have recognised the legal capacity of minors to consent where they have the actual ability to do so, especially where the minor is older. In *Younts* v. *St. Francis Hospital and School of Nursing Inc.*,[40] a 17 year old woman injured her finger in a hospital door while visiting her mother. The young woman consented to a skin graft operation to repair her finger and later claimed damages for, among other things, the hospital's failure to get parental consent before operating. Her mother was recovering from a general anaesthetic and was only semi-conscious and thus incapable of giving her consent and no one else was available. The court concluded the young woman's consent was valid: "Under the circumstances the daughter was mature enough to understand the nature of the consequences and to knowingly consent to the beneficial surgical procedure."[41] In *Johnston* v. *Wellesley Hospital*[42] a minor of 20 years of age had given his consent to skin treatment. A claim was later made alleging that the consent was inadequate because of his age. Addy J. commented on the absurdity of holding that a 20 year old who was able to vote was unable to

[37] (1964) 4 *Medicine, Science and The Law* 209.

[38] The note on this case in *Medicine, Science and the Law* points out that consent is no defence to a charge of indecent assault, and suggests that there may have been nothing indecent in Dilks' acts.

[39] Skegg, P.D.G. " 'Informed consent' to medical procedures" (1975) 15 *Medicine, Science and The Law* 124 at 126: "As the clients presumably knew what a tattoo was, it must have been the consequences (inflamed arms) which distinguished the touching which took place from those to which they had consented."

[40] Kan., 469 P. 2d 330.

[41] Id. at 338.

[42] (1971) 17 DLR (3d.). 139.

consent to his own medical treatment. He quoted from *Medical Negligence* (1957) by Lord Nathan with approval: "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."

Apart from the tattooing cases mentioned above, early English courts have also recognised this "mature minor" rule. In *Agnew* v. *Jobson and Others*[43] an 18 year old woman[44] prisoner had been accused of concealing the birth of a child and a medical examination was undertaken to discover whether she had recently had a child. The Vigilance Association for the Defense of the Personal Rights of Woman and Children instituted an action and the court held that the medical examination was illegal and constituted an assault because Annie Agnew had not consented.

The House of Lords in *R* v. *D*[45] also appears to have recognised the concept. One of the issues in that case was whether a child under the "age of discretion" could give consent to her or his "kidnapping", thus providing a lawful excuse to the kidnapper, or whether the consent had to be given by the child's parent. The House of Lords concluded: "I see no good reason why, in relation to the kidnapping of a child, it should not in all cases be the absence of the child's consent which is material whatever its age may be ... *In the case of an older child ... it must ... be a question of fact for* a jury whether the child concerned had sufficient understanding and intelligence to give its consent."[46]

The more recent decision in *Gillick* v. *West Norfolk and Wisbech Area Health Authority*[47] confirmed the common law principles. Mrs. Gillick was the mother of ten children, five of whom were females under the age of 16. She applied for two declarations: One to the effect that the instructions issued by the Department of Health and Social Security, indicating that the decision as to whether to supply contraceptives to a woman under 16 could be made by the doctor,[48] was wrong in law; and a second that the local Area Health Authority would not give contraceptive advice or treatment to any

[43] (1877) 13 Cox CC 625.
[44] At the time of the decision, she was legally a minor.
[45] [1984] 2 All ER 449.
[46] Id at 457, per Lord Brandon.
[47] [1985] 3 All ER 402.
[48] The guidelines stated: "There is widespread concern about counselling and treatment for children under 16. Special care is needed not to undermine parental responsibility and family stability. The Department would therefore hope that ... the doctor, or other professional, will always seek to persuade the child to involve the parent or guardian ... at the earliest stage of consultation, and will proceed from the assumption that it would be most unusual to provide advice about contraception without parental consent. It is, however, widely accepted that consultations between doctors and patients are confidential ... To abandon this principle for children under 16 might cause some not to seek professional advice at all. They could then be exposed to the immediate risks of pregnancy and of sexually transmitted diseases, as well as other long-term physical, psychological and emotional consequences which are equally a threat to stable family life. This would apply particulary to young people whose parents are, for example, unconcerned, entirely unresponsive, or grossly disturbed ... The Department realises that in such exceptional cases ... the decision whether to prescribe contraception must be for the clinical judgment of a doctor." *Gillick* [1985] 3 All ER 402 at 405-6.

of her daughters without her permission. The trial judge refused[49] to grant either declaration, stating that in order to receive either one, Mrs. Gillick had to show that what the DHSS or the Area Health Authority was doing was unlawful. Once the court decided that the action of these authorities was not unlawful, because it neither involved complicity in the offence of unlawful sexual intercourse, (discussed in detail below), nor were doctors committing trespass to the person by accepting the consent of the young woman, the declarations would not be granted. Mrs. Gillick appealed and the Court of Appeal[50] reversed the trial judge's decision and granted the declarations. The House of Lords allowed an appeal by the DHSS against the grant of the first declaration and overruled the second.

Although the House of Lords, by a majority, overturned the Court of Appeal decision and refused the declarations sought, any clear statement of "the decision" is difficult as the five law lords gave separate and by no means easily reconcilable judgments.

Lord Scarman, after reviewing the statutory context, (which gave little guidance), and the common law, concluded that a minor has the legal capacity to consent to her own medical treatment when she or he "achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed".[51] He went on to explicitly recognise the mature minor doctrine as enunciated by Addy J. in *Johnston* v. *Wellesley Hospital*.[52] Lord Fraser stated: "Provided the patient whether a boy or a girl is capable of understanding what is proposed and of expressing her or his 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 [or woman] to make the examination or give the treatment which he [or she] advises."[53] He based this conclusion on the fact that minors can enter into contracts (within limits), can sue or be sued, can give evidence on oath and can consent to sexual intercourse so as to prevent the assailant being guilty of rape.[54] Lord Bridge concurred with Lords Fraser and Scarman.[55] Although Lord Templeman doubted whether minors could consent to contraceptive treatment because of their lack of maturity,[56] as indicated by the sexual assault provisions of the criminal law,[57] he agreed that minors have the legal capacity (and actual ability) to consent to some forms of medical treatment. He said: "The effect of the consent of the infant depends on the nature of the treatment and the age and understanding of the infant. For example, a doctor with the consent of an intelligent boy or girl of 15 could in my opinion safely remove tonsils or a troublesome appendix."[58]

[49] [1984] 1 All ER 365.
[50] [1985] 1 All ER 533.
[51] [1985] 3 All ER 402 at 423.
[52] See text at footnote 42 above.
[53] Op. Cit. at 409.
[54] *R* v *Howard* [1965] 3 All ER 684.
[55] [1985] 3 All ER 402 at 428.
[56] Addressed in Section II of this paper.
[57] See below, footnotes 84 and 88.
[58] Op. cit. at 432.

Lord Brandon did not discuss the issue because of the view he took of the criminal law.[59]

Thus, four out of five law lords (Lords Fraser, Scarman, Bridge and Templeman) held that at least some minors have the legal capacity to consent to some types of medical treatment, and a majority of the law lords (Lords Bridge, Fraser and Scarman) decided that this legal capacity also allows consent to contraceptive treatment.

This decision is of particular relevance to the discussion here, not least because it concerned the power of those under 16 years old to consent to contraceptive treatment. It was not a dispute between a minor and a member of the medical profession, the minor attempting to bring an action on the basis of lack of consent because of the difficulties of obtaining redress for treatment with which the minor was not satisfied under any of the more familiar tort actions. This appears to have been the case in *Johnston* and may have influenced the court to find "in favor" of the minor on the consent issue and thus to avoid imposing liability on the doctor. Nor is the *Gillick* decision one made under the court's *parens patriae* jurisdiction: Decisions under this jurisdiction do not necessarily tell us who, as between parent and child, can consent to medical treatment.

Parents Versus Children

If the view is taken that the minor does not have the legal capacity to consent, and no consent is obtained from a parent (or a court), the doctor would be liable for trespass to the person, and may have a criminal liability for battery, if he or she went ahead and conducted, for example, a vaginal examination.

Where the minor is considered to have the legal and factual capacity to consent, and does not do so, but the parents (purport to) give a substituted consent, the liability of a doctor is unclear. Logically, once it is accepted that a "mature minor" can consent on his or her own behalf to medical treatment, he or she should be considered to have the same capacities and rights as any other legally competent adult. This suggests that someone else's consent is invalid, indeed irrelevant.

These issues were, of course, directly raised by the *Gillick* litigation. Lord Scarman gave a clear answer: "Parental rights yield to the child's right to make his [or her] own decisions when [s]he reaches a sufficient understanding and intelligence . . ."[60] Lord Templeman is also of the view that the opposition of parents is no bar: "A doctor may lawfully carry out some forms of treatment with the consent of an infant patient and *against the opposition of a parent* based on religious or any other grounds."[61]

Lord Fraser's views may be different. While he accepted that there was

[59] See text below "Minors Under 16: Aiding and Abetting".
[60] Op. cit. at 422.
[61] Id at 432, emphasis added.

no legal bar to minors consenting to their own treatment, the relationship between minors' capacities (or rights) and parents' capacities (or rights) in the making of the decision is more complicated. He laid down five guidelines a doctor should follow in prescribing treatment to a minor:

> (1) that the young woman is capable of understanding the advice.
> (2) that she cannot be persuaded to tell her parents or allow the doctor to inform them.
> (3) that she is "very likely" to commence or continue sexual activity with or without contraception.
> (4) that unless she receives contraceptive treatment her physical or mental health is likely to suffer.
> (5) that the best interests of the minor require that the doctor give her contraceptive advice, treatment or both without the parental consent."[62]

Guideline 5 is obviously controversial. Lord Fraser suggest that though normally parents are in the best position to decide what is in the child's best interest, sometimes the doctor is better placed. In other words, what he seems to be doing is passing the capacity to consent not from parents to minors but from parents to doctors.[63] Lord Brandon stated that he agreed with both Lord Fraser and Lord Scarman on these issues and Lord Bridge did not consider them because of his very strong views on the implications of the criminal law. Lord Fraser concluded that in relation to a doctors liability for trespass to the person, it is possible that a minor of sufficient understanding, can give a consent that will protect a doctor from liability, but that parents (or doctors) maintain some supervisory role. Eekalaar[64] suggests that such a view is a possible resolution of Lord Fraser's decision. A doctor would only be liable in tort if the minor was factually unable to give consent and no parental consent was obtained; if guideline one is fulfilled, but the health care worker failed to satisfy one of the others, it would be a matter for professional disciplinary action only. Surely, though, if a minor is capable of giving an informed consent to medical treatment, she is also capable of deciding what is in her best interests.[65] Given what is required for an consent to medical treatment – that it be given intelligently, knowingly and voluntarily – it would seem that, as part and parcel of that decision, she will also have to decide what is in her best interests.[66]

Notwithstanding Lord Fraser's views, a majority of law lords (Lords Scarman, Templeman and Brandon) agreed that parental rights terminate once

[62] Id at 413.

[63] See A. N. Parkinson "The Gillick Case – Just What Has it Decided?" (1986) 16 *Family Law* 11.

[64] Eekalaar, J. "The Eclipse of Parental Rights" (1986) 102 *Law Quarterly Review* 4 at 7. See also Eekalaar, J. "Gillick in the Divorce Court" (1986) 136 *NLJ* 184.

[65] Subject only to the inter intervention of the court in its *parens patriae* jurisdiction. Eekalaar (1986) 102 LQR 4 at 7-8 suggests that while courts could intervene, there would be strong objections to them doing so "How can the Crown, as *parens patriae*, claim a right and to intervene in the lives of minor children which it denies to those children's parents?" Provided it is remembered that the courts' powers are different to parents' power, there would seem to be less room for objection.

[66] What is required for an informed consent is discussed in detail in section Two.

the minor has sufficient understanding. Although only Lord Templeman specifically referred to a decision in which treatment of a minor in opposition to her parents was held to be valid, it is presumably implicit in the termination of parental rights that, at common law, a minor can consent to her own medical treatment independently of her parents and indeed against their expressed wishes. The latter is obviously more controversial and is discussed in more detail below in relation to the NSW decision in *K* v. *Minister for Youth and Community Services*.[67]

Where the government has legislated to clarify the position of minors, this particular situation is somewhat clearer. Section 49(1) of the *Minors (Property and Contracts) Act* 1970 (NSW) provides that the consent of the parent or guardian of a minor less than 16 to medical treatment on the minor protects the doctor from a claim for assault or battery by treating the consent as if the minor was 21 or older and "had authorised the giving of the consent". It appears from this provision that a parent can override the refusal of a minor under 16 to medical treatment and the doctor would remain protected, presumably against a claim for both tortious and criminal battery. *Prima facie* then, the parents could consent to a doctor performing an abortion on their daughter, even is she did not want it.

But section 49(2) of the same act provides that the consent to medical treatment of a minor aged 14 or upwards protects a doctor from a claim for assault and battery as if that consent was given by a 21 year old. Woods[68] suggests that, together, the two sub-sections mean that a parent could not force a 14 or 15 year old girl to have an abortion against her wishes. He suggests that the courts have long recognised that parents do not have the right to consent to an operation that is not "for the benefit of the child" and an abortion that a 14 or 15 year old did not want could not be said to be "in her best interests" or for her benefit. While this may be accepted, would the doctor be protected if he treated the minor on the parental consent, against the minor's wishes? Woods claims: "that while the parent may be entitled to override the positive objection of a child under 14, the existence of section 49(2) suggests that he should not be entitled to override the actual objections of a 14 or 15 year old ... He [the parent] should only be able to supply consent, for the benefit of the doctor, where the 14 or 15 year old is unable herself to consent."[69] Hayes and Hayes[70] disagree on the effect of section 49 and argue that if a minor is under 16, consent by a parent will be effective, despite opposition by the minor.

The section has been interpreted in *K's* case,[71] subsequent to Woods' article. Helsham C.J. in Equity adopted a similar view on this point to Hayes and Hayes. Helsham C.J. stated that the section took away a right of the

[67] [1982] 1 NSWLR 311.
[68] Woods, G. D. "Fertility control & the Law in Australia" in Finlay, H. A. and Sihombing, J. E. *Family Planning and the Law*, 2nd edition, Butterworths, Sydney at 149-150.
[69] Woods, op. cit. at 149-150.
[70] Hayes S. & Hayes R. *Mental Retardation: Law, Policy & Administration*, Law Book Co., Sydney, 1982.
[71] [1982] 1 NSWLR 311.

minor: the right to sue for assault or battery where her parents had consented. In other words, on the Chief Justice's analysis the doctor would be protected if he performed an abortion on a non-consenting minor if her parents had consented.

While a minor patient may not be able to sue a medical practitioner for trespass to the person where her parents have consented but she has not, there is a need to consider the effect of this section on a minor's legal capacity to consent to her own treatment (a) independently of parental involvement and (b) against their wishes.

Section 49(2) of the *Minors (Property and Contracts) Act* provides that the consent of a minor 14 years or older to medical treatment is effective, at least in any claim for assault or battery. Medical treatment is defined in section 49(4) as treatment either by a medical practitioner or given under his or her direction, in the course of the practice of medicine or surgery. The definition is broad and would apply, it is suggested, to the prescription of contraceptives, internal examinations and abortion. These would all be considered "treatments" in the course of the practice of medicine or surgery. Thus, irrespective of the common law position, a young woman who is at least 14 years old appears to have the statutorily granted right to consent to her own contraceptive treatment, independently of her parents. This conclusion has not been directly litigated, but may have been muddied by the decision in *K's* case.

K v *Minister for YACS*[72] was an application by a fifteen and a half year old ward of the Minister for a court order to allow her to have an abortion. The Minister, as her guardian, had refused permission for the termination. Counsel for K argued that her desire for and consent to the termination should override the refusal of the Minister as section 49(2) of the *Minors (Property and Contracts) Act* gave her the right to consent on her own behalf. Helsham C.J. stated: "I do not think this can be elevated into a conferring of power or right of a minor aged between 14 and 16 to give consent to medical treatment in a way that sets at nought a guardian's power in this area ... It does not take away any power of a guardian to withhold consent or to refuse."[73] This decision does not necessarily affect what it has been suggested is the minor's legal capacity to consent without her parents involvement. However, where there is a dispute between parents and a minor over treatment on the minor, *K's* case tends to suggest that the parents' still have a role.

Helsham C.J.'s views here appear to be similar to those of Lord Fraser in *Gillick*. Although Lord Fraser suggests, in relation to contraceptive treatment, that the doctor has the right, and indeed responsibility, to decide what is in the minor's best interests, this appears to be based on some capacity in the parents (or guardian) to make this decision in most circumstances. Once again, we are faced with the difficulty of deciding the extent of health care worker's liability, if they acted on the consent of a minor with the necessary capacity, but against the wishes of the parents. If the minor has the

[72] Ibid.
[73] Id. at 321.

capacity to give consent, and has done so, the health care worker could be protected from liability for battery or trespass to the person (presuming a "touching" occurred), at common law and under the NSW (*Minors (Property and Contracts) Act*. Helsham C.J. does not suggest any form of liability: What he does seem to be concerned about is the attitude of a court when a dispute between a parent and a guardian comes before it; in other words, the role of the court in its *parens patriae* jurisdiction. It has been argued here that when exercising that function, the powers and duties of the court *are* different to those of parents. Perhaps then, it could be argued that a court may wish to take account of parents' wishes when it is deciding what is in a child's best interests, but a health care worker may act on the minor's views alone, if he or she has sufficient capacity. It must also be remembered that a majority of law lords in *Gillick* have found that parental rights terminate, once the child is of suficient capacity. The author would certainly suggest that this is the better view.

Finally it should be noted that section 49 of the *Minors (Property and Contracts) Act* makes no mention of the minor's ability to understand the nature of the treatment, it merely sets an apparently arbitrary age limit to the capacity to consent. The section includes a sub-section (3) which provides: "This section does not affect (a) such operation as a consent may have otherwise than as provided by this section." This preserves what, it has been argued, is a younger minor's common law right to consent to treatment, if he or she understands the nature and implications of the proposed treatment.

Other Legal Difficulties in relation to minors and fertility control

Only one case of which the writer is aware imposed liability on a doctor for contraceptive treatment on a minor without parental consent. In the Canadian case of *Re 'D' and Council of the College of Physicians and Surgeons of BC*,[74] a doctor was found guilty of "infamous or unprofessional conduct in inserting a birth control device in a 15 year old patient" without the consent of her parents. Fortunately this finding can be confined to the particular facts of this case. The young woman's mother had become involved in her daughter's treatment by the time of her daughter's second visit to the doctor and the doctor had failed to tell the mother that he had not removed the IUD, as requested: "By that time the doctor could no longer successfully contend that he was bound by an oath of secrecy to his child patient, because the mother had already been brought into the situation by her daughter."[75] Counsel for the College conceded that "taking a 15-year-old girl as a patient and giving her medical treatment without the consent of her parents . . . and by his oath as a doctor to keeping secret from everyone, including the parents of the child, what transpires" was not infamous or unprofessional conduct, "in some circumstances".[76] The court's finding that the doctor had "conduc-

[74] (1970) 11 DLR (3d) 570.
[75] Id. at 575.
[76] Id. at 577.

ted himself indecently" with the same young woman may also have influenced the court in its conclusion as to consent.[77]

Minors Under 16: Aiding and Abetting

Under section 323 of the Victorian *Crimes Act* "a person who aids, abets counsels or procures the commission of an indictable offence may be tried, indicted or presented and punished as a principal offender". Regardless of who has the power to consent to contraceptive treatment on the minor, the treating doctor may be liable for participation in a crime of unlawful sexual intercourse where the minor is below the age of consent to sexual activity. Although McNiff suggests this is a "strained but theoretically possible viewpoint",[78] there is at least some suggestion that it is a fear some doctors hold.[79] It was the subject of a specific inquiry on behalf of the South Australian Family Planning Association to the Attorney-General in 1976 and the question has indeed been litigated.[80] Therefore the issue merits discussion.

Lord Goddard C.J. in *Wilcox* v *Jeffery*[81] said that a person will be liable for aiding and abetting "provided that the aider and abettor knows the facts sufficiently well to know that they would constitute an offence in the principal". It seems difficult to suggest that a doctor giving contraceptive advice or prescribing contraceptives to a young woman would "know the facts sufficiently well". For example, at least in Victoria, the commission of an offence is dependant on the age of the young woman's partner as well as her own age (section 48(4)(b)). The doctor would not be likely to have this information especially if the woman visited the doctor alone; furthermore, there are defences to the crime, for example, that the accused reasonably believed the "victim" to be over 16 (section 48(4)(a)). Furthermore, for liability as an aider and abettor, presence at the commission of the crime appears to be required.[82] Even if presence at the criminal offence is not necessary for commission of the offence, the intention of the health worker is clearly relevant, an issue which will be discussed below.

Would a health care worker who prescribed contraceptives for a woman under 16 be guilty of counselling or procuring? In *Attorney-General's Reference (No. 1 of 1975)*[83] Lord Widgery stated: "A person who counsels the commission of a crime by another, almost inevitably comes to a moment when he is in contact with that other, when he is discussing the offence with

[77] See Gosse, R., "Consent to medical treatment: a minor digression" [1974] *Univ. of Brit. Columbia Law Review* 56 at 59.

[78] McNiff, F. V. "Commentary on Woods ..." in Finlay H. A. & Sihombing J. E. *Family Planning & The Law*. 2nd edition, Butterworths Sydney at 156.

[79] See for example, Wadlington, W. "Minors & Health care: the age of consent" (1973) 11 *Osgoode Hall Law Journal* 115; AMA, NSW Branch Monthly Bulletin referred to in Gerber, P. "Law & Family Planning" *MJA*, 21 January 1984, 89.

[80] *Gillick* [1985] 3 All ER 402.

[81] [1951] 1 All ER 464 at 466.

[82] *R* v *Russell* [1933] VLR 59. cf. the South Australian Crown Solicitor's opinion in response to the FPA query: that officer agrees that presence is a requirement for aiding and abetting.

[83] [1975] 2 All ER 684 at 686.

that other . . ." The Court of Appeal suggested that for aiding, abetting or counselling some sort of "agreement or discussion as to the form of the offence" was required. Again a doctor prescribing contraceptives is unlikely to come to any agreement about the form of the offence. The same court defined "procure" as "to produce by endeavour. You procure a thing by setting out to see that it happens and taking the appropriate steps to produce that happening". A doctor providing contraception to a young woman is not endeavouring to procure unlawful sexual intercourse, but rather to prevent its consequences. Of course, if the health worker encouraged the commission of the offence of unlawful sexual intercourse the situation may be different though, again, questions of the knowledge of the offence are raised. It is also important to note that when a doctor provides contraceptives to a young woman, he or she does not usually have contact with the principal in the unlawful sexual intercourse. That is, the young woman is not guilty of an offence (unless her partner is also under 16, as the *Crimes Act* offences are non-gender specific), only her male partner may be. The cases on participation in a criminal offence are generally premised on some contact with the principal offender: There is none in the standard provision of contraceptive advice and contraceptive devices to young woman. (A possible exception to this is noted below in the discussion of *R* v *Cooper and Wicks*.)[84]

Mrs Gillick originally alleged that a doctor prescribing contraceptives to a woman under 16 would be aiding and abetting a man to have unlawful sexual intercourse. The issue was considered by all five law lords. Lord Fraser noted that by the time the case reached the Court of Appeal counsel for both sides conceded that whether a doctor was so liable "would depend on the circumstances" and the relevant circumstances were the doctor's intention. "[T]his appeal is concerned with doctors who honestly intend to act in the best interests of the girl, and I think it is unlikely that a doctor who gives contraception advice or treatment with that intention would commit an offence under section 28."[85] Lord Fraser went on to say that he regarded the question as irrelevant to the matter they had to to decide because, he argued, that if the doctor committed an offence, he did so even where the parents consented.

Lord Scarman[86] and Lord Bridge[87] are both happy to rely on the analysis of Woolf J. in the original *Gillick* decision.[88] Woolf J. had also emphasised the intention of the doctor: "A doctor who is misguided enough to provide a girl who is under the age of 16, or a man, with advice and assistance with regard to contraceptive measures *with the intention thereby of encouraging* them to have sexual intercourse is an accessory before the fact to an offence

[84] (1833) 5 Car. & P. 535.
[85] *Gillick* [1985] 3 All ER 402 at 413. Section 28 of the *Sexual Offence Act* (UK) provides "It is an offence for a person to cause or encourage . . . the commission of unlawful sexual intercourse with . . . a girl under the age of sixteen for whom he is responsible".
[86] Id at 425.
[87] Id. at 428.
[88] [1984] 1 All ER 365.

contrary to s.6."[89] He pointed out that for a doctor to act with this intention would be highly unusual. He went on to say that "contraceptives do not in themselves assist in the commission of unlawful sexual intercourse ... The pill prescribed to a woman ... [is] a palliative against the consequences of the crime".[90]

Lord Templeman's views are somewhat less clear. He stated that the *Sexual Offences Act* "does not, however, in my view, prevent parent and doctor from deciding that contraceptive facilities shall be made available to an unmarried girl under the age of 16 whose sexual activities are recognised to be uncontrolled and uncontrollable ... if the girl cannot be deterred then contraceptive facilities may be provided, not for the purpose of aiding and abetting an offence (under s.6) but for the purpose of avoiding the consequences, principally pregnancy ..."[91] On the issue of criminal liability, this seems to support the intention analysis of the other law lords.[92]

The fifth Lord, Lord Brandon, takes a quite distinctive view: "On the footing that the having of sexual intercourse by a man with a girl under 16 is an unlawful act, it follows necessarily that for any person to promote, encourage or facilitate the commission of such an act may itself be a criminal offence, and must, in any event, be contrary to public policy ... to give such a girl [one under 16] advice about contraception, to examine her with a view to her using one or more forms of protection and finally to prescribe contraceptive treatment for her, necessarily involves promoting, encouraging or facilitating the having of sexual intercourse, contrary to public policy, by that girl with a man."[93] What Lord Brandon has done is to ignore the issue of the intention of the doctor (or parent or social worker, who, in his analysis, may also "promote, encourage or facilitate" commission of the crime) which featured so strongly in the decisions of the other law lords, and which is undoubtedly a fundamental attribute of (most) criminal liability. Secondly, even he is prepared to go nly as far as suggesting that the provision of contraceptives to an under age minor, *may* be a criminal offence, he suggests that it is at least contrary to public policy.[94]

The view of the majority, that any liability for complicity in the offence of unlawful sexual intercourse depends on the intention of the health care worker, is preferable and accords with the prior common law.

[89] Id. at 371. Section 6 of the UK *Sexual Offences Act* provides: "It is an offence ... for a minor to have unlawful sexual intercourse with a girl under the age of sixteen".

[90] Id. at 372.

[91] [1985] 3 All ER 402 at 431.

[92] The issue of parents' and doctors' rights and duties has been discussed above. It seems unlikely that Lord Templeman is presenting the view that parental consent prevents criminal liability: the explicit analysis by the other law lords that if there is criminal liability, it arises regardless of whether the parent or the minor is the appropriate person to consent to a minor's medical treatment is preferable.

[93] Op. cit. at 429.

[94] One way in which it would be "contrary to public policy", according to Lord Brandon, is that to allow doctors to prescribe contraceptive to under age minors would "undermine or circumvent the criminal law ... The criminal law and civil law should ... march hand in hand" (at 431). Glanville Williams has pointed out that the criminal law and civil law often diverge. ("The Gillick Saga" (1985) 135 NLJ 1156 at 1158.)

Misprision

There have also been suggestions that doctors, at least in South Australia and New South Wales, may be liable for the common law offence of misprision of felony. Certainly it is an archaic offence, but is still seen as of possible modern relevance. For example, efforts have been made in recent legislation to exclude mediators and other staff in Community Justice Centres from liability for the offence.[95] The offence consists of a failure to report to the appropriate authorities knowledge of a felony that has been committed. The offence seems to extend to a failure to report a felony that has been committed.[96] The amount of knowledge one needs to have before one is required to disclose is difficult to assess: "[It] is a question of fact for a jury ... whether the knowledge that he has is so definite that it ought to be disclosed. A man is neither bound nor would he be wise to disclose rumours or mere gossip but if facts are within his knowledge that would materially assist in the detection or arrest of a felon he must disclose them as it is a duty that he owes to the State."[97] Furthermore, Woods argues[98] that the offence is a "dead letter" in relation to doctors providing contraception to women under the age of consent. Certainly Lord Denning suggested that doctors and patients have a confidential relationship, allowing the former not to disclose information they may have received within that relationship.[99] Woods also points out that the doctor would not necessarily know that an offence had been committed because of the various age-related defences. Although, as Woods also notes, there is no defence in New South Wales if the woman is under 14 years of age, the confidentiality of the doctor-patient relationship should still protect the doctor.

Misprision is no longer an offence in Victoria, as the distinction between felonies and misdemeanours was abolished in 1981 *(Crimes (Classification of Offences) Act)*. Section 326 of the *Crimes Act* 1958 (Vic) now provides an offence of concealing a serious offence for benefit. Health care workers, even assuming the requisite knowledge, presumably receive no benefit from concealing the information. A similar offence, specifically in relation to medical practitioners, has been created in Queensland by the *Medical Act* 1939–1981. Section 35 (ix) provides that if a doctor obtains information "which indicates an attempted or completed crime" he or she must report the matter to the nearest police station. Again, in most circumstances, the doctor would not have the requisite information.

Confidentiality

Assuming that the minor patient can consent to his or her own medical treatment, are doctor–patient communications, when the patient is a minor,

[95] See s.28(6), *Community Justice Centres (Pilot Project) Act 1980* (NSW); now repealed, and s.28(7) *Community Justice Centres Act* 1983.
[96] See *Sykes* v *DPP* [1962] AC 528.
[97] Id. at 569, per Lord Goddard.
[98] Op. cit. at 154.
[99] Per Lord Denning, *Sykes* v *DPP*, op. cit. at 564. See below as to whether a confidential relationship exists between a doctor and her minor client.

governed by the legal and ethical rules as to confidentiality which apply when the patient is an adult?[100]

It has been suggested above that a doctor could be protected from a prosecution from misprision if the information received concerning any felony was in the context of the doctor-patient relationship.[101] Would similar protections apply if the patient is a minor? Can doctors inform parents of the contraceptive and related treatment given to their minor patients? Under the *Venereal Diseases Act* 1958 (Vic)[101a] medical practitioners are required to notify parents or guardians if the minor is under 16 and has a sexually transmitted disease and, in New South Wales, may do so (*VD (Amendment) Act*, 1977). The fact that a statutory authorisation is required in this area may suggest that in other circumstances "normal" rules of confidentiality apply to minors. The Australian Law Reform Commission in its report on child welfare assumes confidentiality in doctor-minor consultations: ". . . the medical practitioner or other professional's confidential relationship is a relationship with the child, who is his (sic) patient, not with the parent".[102] The ALRC in its Privacy Report also argues that if a parent pays for her or his minor's medical treatment, although this creates a contractual relationship between the doctor and the parent, this does not necessarily override the duty of confidence the doctor owes to the minor patient.[103] Where the doctor actually has the requisite information to suggest that a felony has been committeed, he or she should be protected by the confidentiality of the transaction with the minor.

In their discussion paper on privacy[104] the ALRC raised the issue of the disclosure of children's medical (and educational) records. They suggested allowing parents full access when the minor was under 12. "Between 12 and 16 years a child should be entitled to object to disclosure of information to a parent. While the record-keeper should be left to decide whether to disclose the information to a parent, he should only override the child's objection where convincing reasons relating to the health, safety or well-being of the child justify that step." (They apparently assumed that a minor over 16 had the same rights as an adult.) This relatively mild suggestion was greeted with outrage by "the community": "Never has a tentative proposal of the Law

[100] Not that the ethical rules are clear. As the ALRC has pointed out, the AMA's Code of Ethics is contradictory. Clause 6.2.1 says doctors should not disclose information without the patient's consent "save with statutory sanction". Various reasons for disclosing information are then given, for example, court evidence (6.2.4) and statutory requirements (6.2.5). Clause 6.2.8 goes on to say, in contradiction to 6.2.1, that information should not be disclosed in these circumstances (6.2.2-6.2.7) "in the absence of the consent of the patient or the nearest relative" (Aust. Law Reform Commission, *Child Welfare*, Report No 18, AGPS, Canberra 1981 at 299, footnote 71).

[101] See text at footnote 98.

[101a] Section 12 of the *Health Legislation Amendment Act* 1985 repeals the *Venereal Diseases Act* 1958. The provision was not in force at the time of writing.

[102] Aust. Law Reform Commission, *Child Welfare*, Report No. 18, AGPS, Canberra, 1981 at 299.

[103] Aust. Law Reform Commission, *Privacy* (Vol 2), Report No. 22, AGPS, Canberra, 1983 at 123. cf. Hayes & Hayes, op. cit., at 288.

[104] Aust. Law Reform Commission, *Privacy & Personal Information*, Discussion Paper No. 14, AGPS, Canberra, 1980, at 64-65.

Reform Commission engendered so much bitter criticism. Hundreds of letters were received; petitions were signed in churches and tabled in Parliament; and personal representations were made."[105] The Commission resiled from its suggestion and recommended in its Privacy Report (1983) that the age of 18 be chosen as the age at which parental access to their child's records under Freedom of Information legislation should cease. At the same time, the Commission also notes that in many cases the minor would be protected by a legal duty of confidentiality that the doctor owes to his or her patient, and they recommend that this be a ground of exemption from the duty to disclose, though weighed against the guardian's legal responsibilities.[106]

Although any contractual relationship between the doctor and the minor's parents does not override the confidentiality between the doctor and the minor, the sending of medical bills to her parents, perhaps stating the nature of the treatment may create difficulties for the minor. There are obvious advantages for the minor patient if her medical practitioner bulk bills. The new Medicare scheme also provides that minors of 15 and over can apply for their own Medicare card, thus protecting their privacy.[107] This pamphlet also states "standard Benefit payment mechanisms do not compromise the confidential nature of the doctor/patient relationship".[108]

There has been little litigation on the duty of confidentiality. This writer is aware of only one case involving a minor, a disciplinary hearing before the UK General Medical Council.[109] A young woman of 16 who was unmarried and living at home visited a Brook Advisory Clinic (one of a group of clinics offering contraceptive advice and information, similar to the clinics run by the Family Planning Association in Australia) and was given a prescription for an oral contraceptive. The Brook Advisory Clinic stated that it gave advice in strictest confidence. The Clinic doctor, as was his normal practice, notified the client's family doctor, "expressly in confidence", that he had prescribed the pill, without asking for the client's permission to do so. The family doctor then informed the young woman's father, again without her consent. The Brook Advisory Clinic subsequently made a complaint to the General Medical Council. The committee apparently stated: "But in the particular circumstances of this case – and I would like to emphasise this – the committee do not regard your action in disclosing the information referred to in the charge as improper."[110] Speller[111] notes that the GMC did make it clear that, "in principle" such breaking of confidentiality was professional misconduct. The editorial in the New Law Journal asked, on the other hand, what was "particular" about the incident. Was it that the pill has potentially harmful side effects, a factor, the editorial suggests which does not make

[105] Kirby, M. "Law and Family Planning" *MJA*, 17 March 1984, 356 at 356.
[106] Aust. Law Reform Commission, op. cit. (1983), at 124.
[107] Health Insurance Commission Policy Statement, reproduced in Wootten, op. cit.
[108] Ibid.
[109] Speller, S. R., *Law of Doctor and Patient*, HK Lewis & Co London 1973 at 138; Anon., "Confidentiality and consent to treatment" (1971) 121 *New Law Journal* 214.
[110] Speller, op. cit. at 138.
[111] Ibid.

it particularly different from many other treatments. They further state that the age of the patient, at 16, could not make the circumstances particular "for she is in no different position if she had been 66".

Speller suggests that the GMC may have reached their decision because the action was brought by the clinic rather than the young woman – it was her right to confidentiality that was abbrogated not the clinic's – and because the young woman had in fact written to the Council, commending the doctor and saying that she was pleased that her doctor had told her parents, in effect, he suggests, giving retrospective consent. Parenthetically, one must question the Brook Clinic doctor's practice – surely he was also abrogating the client's confidentiality, though arguably in the "client's best interest". Speller's assessment that the case has little precedent value, is particularly apt in the Australian context. If, as has been argued, minors of sufficient capacity can, according to the common law, consent to their own medical treatment, they should have exactly the same right to confidentiality as an adult. A minor seeking contraceptive advice and treatment may, however, be better advised to approach a Family Planning Clinic where confidentiality is assured.[112]

SECTION II: MINORS' ABILITY TO CONSENT – THE PSYCHOLOGICAL EVIDENCE

In section one I suggested that the following attributes are essential to an informed consent:
(i) the patient has the ability to understand the nature and consequences, the risks and dangers, of the proposed treatment;
(ii) sufficient information is provided by the health care worker so that the patient understands the nature and consequences, including the risks and dangers of the proposed treatment; and,
(iii) consent is freely given.
Grisso and Vierling,[113] among others, have characterised these attributes as "intelligently", "knowingly" and "voluntarily" giving consent. Psychologists clearly have something to offer in deciding whether minors of a particular age have the ability to give a consent (with these attributes) to treatment.

"Intelligent Consent"

This is at the heart of the concept of an informed consent, and is perhaps the attribute most in contention in relation to minors. This requirement is sometimes referred to as "competent consent" or "capacity to consent".[114]

Roth, Meisel and Lidz[115] have suggested that there are five alternative

[112] See Wootten, op. cit.
[113] Grisso, T. and Vierling L., "Minors consent to treatment: a developmental perspective" [1978] *Professional Psychology* 412.
[114] Weithorn, L. A., "Developmental factors and competence to make informed treatment decisions" in Melton, G. B. *Legal Reforms Affecting Children and Youth Services*, Haworth Press, New York, 1982, [*Child and Youth Services*, Vol 5 No.s 1/2 at 88.
[115] Roth, L. H., Meisel, J. D. and Lidz, C. W., "Tests of competency to consent to treatment" (1977) 134 *American Journal of Psychiatry* 279.

tests of competency proposed or used in psychological or legal literature: (a) evidence of choice; (b) "reasonable" outcome of choice; (c) choice based on "rational" reasons; (d) the ability to understand and (e) actual understanding. The first three will be dealt with very cursorily since they are not readily applicable in the legal context.

(a) *Evidence of Choice*

Under this test a person is considered competent if he or she can indicate a preference in favour of or against the suggested treatment, including a decision to allow someone else to make that decision, for example, the doctor or a family member.[116]

Can minors exhibit the necessary preference? Weithorn suggests: "Most minors [of school age] with minimum verbal and social skills who are not suffering from severe intellectual or other impairment, should be able to demonstrate competence according to this standard."[117]

Is this an adequate test of the competency of minors to consent to their own medical treatment in relation to fertility control? Roth *et al*[118] argue that this test is the one that allows the patient the most autonomy. It is certainly the least paternalistic – it makes no judgment on the worth of the preference (see test (b) below) or whether the decision has been rationally made (see test (c) below). The test also has the advantage that competence can be reliably and objectively assessed: the decision, or lack of it, is easily observed.[119] However, it would seem that this test is unlikely to be considered adequate by judges, medical practictioners or parents as a test of the competency of minors to consent to medical treatment. At the very least something stronger would appear to be required to overcome the relatively common belief that minors cannot either legally or in fact consent to their own treatment. Some requirement of understanding would appear to be necessary (see tests (d) and (e) below). Furthermore, it would not appear to be an adequate implementation of the informed consent doctrine: the test tends to remove the onus from the medical practitioner to explain adequately the proposed treatment. And, while it may protect the patient's autonomy, it does little to promote self-determination.

(b) *"Reasonable" Outcome of Choice*

Under this test, a person has the competence to consent if they make the treatment choice a "reasonable" person would make in the circumstance.[120]

[116] See Roth et. al. op. cit. at 280 and Weithorn op. cit. at 89.

[117] Weithorn, op. cit. at 90. She cites in this context a study of Lewis, Lewis and Ifekwunigue (1978). They investigated the capacity of school children from six to nine years of age to give consent to participation in a flu vaccine trial. The children could decide not to participate, could select to have their parents make the decision for them or consent to be involved (parents' consent would also be sought in this circumstance). All the children indicated a preference: 21% agreed to participate, 46% refused to participate and 33% chose to have their parents make the decision.

[118] Op. cit. at 280.

[119] Ibid.

[120] Roth et al op. cit. at 280-281, Weithorn op. cit. at 90-91.

Arguably this test is the most disruptive of patient autonomy:[121] again it is not concerned with the process of decision making by the patient and it certainly gives the medical practitioner great power. It would appear that "consent" to treatment has little content if the patient is not conceded the right to refuse treatment on the single ground that most people, or the "reasonable" person, would accept that treatment. Furthermore, there may be real difficulties in deciding what is the "reasonable" treatment.[122]

(c) *Choice Based on "Rational" Reasons*

Roth *et al* describe this test as "whether the reasons for the patient's decision are 'rational' ... [or] whether the patient's decision is due to or is a product of mental illness ... the quality of the patient's thinking is what counts".[123] Roth *et al*'s particular concern with this test is that it too easily allows substitute consent to be given "on behalf of the mentally disordered patient". They point to the difficulty of deciding whether the reasons for treatment choices are rational or irrational, and state that, "even if the patient's reasons seem irrational, it is not possible to prove that the patient's actual decision making has been the product of such irrationality".[124]

The issues involved in determining minors' capacity to consent are somewhat different. Initially, my object is to establish whether any generalisations can be made about the ability of people of a particular age to provide an informed consent, rather than any particular individual's ability. Further, as Weithorn points out, what we are concerned with in relation to minors' capacity to consent is their (possible) "lack of cognitive sophistication rather than 'mental illness' ".[125] "Cognitive sophistication" is addressed in the next two tests.

(d) *Ability to Understand*

This test is "probably the most consistent with the law of informed consent".[126] Can the patient understand what she is being told about the various treatments? Roth *et al* argue that this test is not concerned with whether the patient weighs the information in the same way as the doctor, just that the information *can* be considered and weighed.

[121] See Meisel, A. "The 'exceptions' to the informed consent doctrine: Striking a balance between competing values in medical decision making" [1979] *Wisc. Law Review* 413 at 446.

[122] Weithorn op. cit. at 91. In the context of contemporary fertility control, we would expect that both adults and minors would be offered a choice of treatments by a health care worker, and it would be difficult to decide the "right" treatment (according to the reasonable person or the reasonable doctor). Some of the obvious dangers of assuming either competency or incompetency under this test are discussed in the section on "voluntariness".

[123] Op. cit. at 281.

[124] Ibid.

[125] Op. cit. at 93.

[126] Roth et al, op. cit. at 281.

(e) *Actual Understanding*

The health care worker here has a responsibility to ensure that the patient has understood the information. This is obviously the most difficult test to implement, but is probably the test that judges and doctors would apply to minors given the evident concern about minors' legal capacity and actual ability to consent. It may also be the only test that is truly consistent with the doctrine of informed consent.

These latter two tests will be discussed in some detail, as they both address the cognitive capacities of minors.

Ability to Understand and Actual Understanding

The psychological theorist likely to be of most assistance in elucidating minors' cognitive capacities – whether they have the ability to understand, and, to a lesser extent, actually do understand – is Piaget. Piaget, after intensive observation of children, postulated a four stage model of the development of cognitive abilities. The stages were: the sensorimotor phase evident in children from birth to approximately 18 months of age; the pre-operational phase from 18 months to 7 years of age; concrete operations from 7 to 11 or 12 years; and formal operations from 11 or 12 years on. Only the last two phases will be discussed in any detail, as there is little evidence that a child in the pre-operational or sensorimotor phase could give an informed consent to medical treatment, or indeed would have a need for fertility control treatment. (During the sensorimotor phase a child is limited to thinking about objects and incidents that can be directly observed. During the pre-operational period a child begins to use symbols or words to represent objects he or she cannot see but cannot yet, for example, reason about more than one dimension at a time. Hence a child at the pre-operational level will not recognize that two containers have the same amount of liquid in them, if the containers are of different shapes and thus display differing levels, even when he or she has been shown that the same amount of liquid has been poured into the containers.)

By the concrete operational period, the child attains the "principle of invariance", allowing the child to see that the shape of the container does not affect the equality of contents. He or she can reason about relationships between objects, which is bigger or smaller, and can reason deductively. Piaget suggests that the reasoning in this phase is limited to concrete things: a child at this stage of development can arrange sticks of differing lengths in order of size but cannot solve a verbal problem of a similar kind – if A is longer than B, and A is shorter than C, which is the longest? By contrast, at the formal operational level, usually reached at 11 or 12 years of age, according to Piaget, adolescents can think logically about abstract relationships, though this capacity may continue to develop until the age of 14.[127]

How is this relevant to a minor's capacity to consent? Weithorn suggests

[127] See Piaget, J. and Inhelder, B. *The Psychology of the Child, Basic Books,* New York, 1969 and Inhelder, B. and Piaget, J. *The Growth of Logical Thinking*, Routledge & Kegan Paul, New York, 1958.

that "the ability to reason competently in health care decisions may require the capacity to consider each of several treatment alternatives (i.e. potential benefits, risks, side effects and discomforts of treatment options, as well as the likelihood of each occurring."[128] Since abstract thinking is required here, it would appear that what Piaget describes as formal operational thought is necessary. Piaget's work suggests that minors of 11-14 years of age have these sorts of capacities and some experimental work has been undertaken, based on Piaget's theories, specifically in the treatment context.

Weithorn and Campbell[129] ran an experimental study with 7, 14, 18 and 21 year olds. They presented their subjects with four descriptions of illnesses – diabetes, epilepsy, depression and enuresis – and asked them to choose a treatment from a number of options. The subjects heard a tape of the treatment dilemmas and were asked to put themselves in the position of the hypothetical patient. The subjects were interviewed using a standard schedule of questions and scored for their competence to consent on each of Roth *et al*'s tests.

As regards *Evidence of Choice*, all subjects expressed a choice and none opted to have someone else make the decision. In other words, even 9-year-olds are capable of expressing a preference for one sort of treatment rather than another. Weithorn and Campbell assessed the *"Reasonableness" of Choice* for each group. (Each treatment possibility had been rated for appropriateness for each age group by experts in the relevant specialities. There was wide agreement on treatment for epilepsy and diabetes but greater variability for the two psychological problems.) There were differences between groups of subjects here, at least for some treatment dilemmas. All individuals chose insulin injections as the treatment for diabetes – the expertly assessed "reasonable" choice. In the case of epilepsy, the most "reasonable" outcome of choice was adjudged to be a trial on each of two medications. All subjects except three 14 year olds chose this alternative. Although this produced a statistically significant difference between the 14 year old group and the rest of the sample, it did not differentiate between the 14 year olds and the "adult" group (18 and 21 year olds combined). In relation to treatment of depression, 75% of 14, 18 and 21 year olds chose outpatient therapy, but 50% of the 9 year olds selected in-patient treatment. Age had no effect on treatment choice in the enuresis dilemma, with a great variation in choice of treatment for all groups. On the measurement of *Rational Reasons*, the 9 year olds differed significantly from the adult group on all dilemmas and the 14 year olds' reasons were significantly different from the adult group's on the epilepsy dilemma only.[130] Finally, Campbell and Weithorn measured subjects' *Understanding*. They tested their rote recall or factual understanding – asking questions whose correct answers were provided in the information presented – and "inferential understanding"

[128] Op. cit. at 93.

[129] Weithorn L. A. and Campbell, S. B., "The competency of children and adolescents to make informed treatment decisions" (1982) 53 *Child Development* 1589.

[130] Here subjects received a point for each specified response when asked what they had "considered" or "taken into account" when deciding on the appropriate treatment.

– asking questions whose answers had to be inferred from the information presented.[131] On both scales of understanding, the 9 year olds differed significantly from the adults and the 14 year olds on all dilemmas, but there were no significant differences between the 14 year olds and the adults.

In the discussion of their results, Campbell and Weithorn note that, although 9 year olds did not understand the treatment options as well as adults and did not consider all the factors relevant to each treatment option, they were perfectly capable of expressing a clear preference amongst treatment options which in most cases was the same as adults. Of course, my particular concern here is with the competence of adolescents, though it is important to note that even quite young children could, at least, be more involved in the decision as to what treatment their parents and doctor may choose for them. Fourteen year olds on the other hand, generally performed similarly to the adult group. Weithorn and Campbell comment that where they did differ – on the treatment of choice for epilepsy – the treatment they "refused" could, they were told, produce as possible side effects "peridontal problems and excessive growth of body hair".[132] They suggest that: "These findings may relate to the concerns of early adolescents about body image and physical attractiveness."[133] This seems to me a legitimate concern, and it would be unnecessarily paternalistic to suggest that it is not a "reasonable" concern for an adolescent deciding on her own treatment. So, for example, a young woman should be informed that one of the possible side effects of an oral contraceptive is weight gain. If she balanced this against other "positive" aspects of this treatment, for example, its low failure rate, and concluded that, on balance, she wished to use another method, her decision should not be considered unreasonable. She should not be declared incompetent to decide the issue even though a medical practitioner might consider her emphasis on weight gain an "unreasonable" consideration. Such a declaration would place too much emphasis on the "reasonable" outcome of choice test. As Weithorn and Campbell point out, on the test of understanding (which, like Roth *et al*, they argue is the test most consistent with the law of informed consent) there was no difference between 14 year olds and adults on the epilepsy (or any other) dilemma.[134]

[131] e.g. "If a person needs to take insulin injections every day for the rest of his/her life, how might this be a problem or get in the way of things?" (diabetes dilemma).

[132] Weithorn and Campbell op. cit. at 1596.

[133] Ibid.

[134] Studies of juveniles' comprehension of *Miranda* warnings are also relevant here. (Grisso, T. and Manoogian S. "Juveniles comprehension of *Miranda* warnings" in Lipsitt, P.D. and Sales, B. D. *New Directions in Psychological Research* Von Nostrand Reinhold Co., New York, 1981 and Grisso, T. "Juveniles consent in delinquency proceedings" in Melton, G. B., Koocher, G. P. and Saks, M. J. *Children's Competence to Consent* Plenum Press, New York, 1983). Grisso and Manoogian were concerned to test whether juveniles could give an intelligent waiver of their rights. They found that more than half the sample had a deficient understanding of their rights. They concluded that age alone was not a very good predictor of understanding, while the correlation between IQ and comprehension was much higher. It may also be true that adults of low measured IQ may be incapable of providing a fully informed waiver of *Miranda* rights or, for that matter, consent to medical treatment. Any legislation explicitly demanding the possession of a particular IQ before competency to consent could be found, would be objectionably discriminatory.

"Knowing consent"

Weithorn and Campbell's study suggests that minors' understanding (of treatment options, etc.) could vary depending on the way information is presented. Goldman and Goldman's work,[135] while not specifically exploring the consent issue, throws further light on minors' capacity to give a knowing consent. While the onus here is on the health care worker to provide adequate information, the minor's state of knowledge about sexuality and contraception is obviously relevant to this onus. Goldman and Goldman aimed to explore "children's sexual thinking": "the extent of children's sexual knowledge, their sexual understanding at various ages, and to identify what processes of thought they use in trying to explain biological functions and the phenomena of their own bodies as they grow and change".[136] To this end they interviewed 838 children in four countries – Britain, USA, Sweden and Australia.

One question they asked their subjects was "What do people do if they don't want to have/start a baby?" Responses were scored in the following way:[137]

SCORE	*LEVEL*	*CATEGORIES*
0	Nothing	*Unscorable:* Don't know, no answers
1		*Nothing can be done:* Except reverse of artificialisms, "God, Jesus, Doctor don't do it" Causal agents take no action.
2	Natural	*Abstention methods:* Avoidance of casual act, "Don't get married, don't swallow seed etc."
3		*No interference with nature methods:* Withdrawal or "safe periods" ... Masturbation or oral sex.
4	Surgical	*Surgical methods – one partner only:* Hysterectomy or vasectomy, castration ... sterilisation ...
5		*Surgical methods – both partners:* Both don't have to but either may.
6	Devices	*Use of device(s) – one sex only*
7		*Use of devices – both sexes*

Twenty three per cent of Australian five year olds thought that "nothing could be done", going down to 8% of 11 year olds and none of the older children.[138] No Australian children under 11 responded with the highest scored response indicating that they did not know that there were contraceptive devices available for use by both men and women. Five per cent of Australian 11 year olds had this knowledge, for thirteen year olds 40% of males and 5% of females, and at 15 years of age 75% of males and 50% of females were aware of contraceptive devices for both sexes.

Goldman and Goldman also assessed their subjects' knowledge of abor-

[135] Op. cit.
[136] Id. at 57-58.
[137] Id. Table 13.1 at 276.
[138] Id. Table 13.2 at 277.

tion – scoring 1 for mention of unspecified methods of abortion for example, "stop the baby growing"; 2 for mention of abortion by non-medical means, for example exercise, smoking or drinking; 3 for medical means, for example medicine, drug or injection and the top score of 4 for abortion by surgical means for example an operation, cutting or scraping.[139] At the age of 11, 20% of the Australian children scored 1, none 2, 20% scored 3 and 20% scored 4; 40% did not mention any method of abortion. At the age of 13, 88% had some knowledge: 38% scoring 1, 5% scoring 3 and 45% scoring 4. By the age of 15, all Australian children had some knowledge of abortion methods – 55% scoring 1, 3% scoring 2, 15% scoring 3 and 27% scoring four.

This sort of information does not necessarily tell us that large numbers of minors of 15 and under are incapable of understanding contraception and abortion, and making treatment choices about them, whem given the appropriate information by a health care worker, although it does appear to reduce the likelihood of a minor actually realising that she or he may need some information and advice. The effect of giving minors appropriate information can, to some extent, be adjudged by the response of Swedish children to the same questions as Swedish children are exposed to much more information about sexuality and contraception. Sweden has an extensive sex education programme in schools: sex education and personal relationship courses are compulsory for 7 to 16 year olds.[140] A comparison of their knowledge of contraception with those of Australian minors is illuminating. All Swedish children aged 9 or over had knowledge of contraception; 73% of boys and 40% of girls at 11 years of age knew of contraceptive devices for both sexes; 100% of males and 93% of females at age 13 and 100% of males and 97% of females at the age of 15 have this level of knowledge.[141]

The results of the Australian and Swedish samples viewed together seem to reflect not so much a lack of cognitive capacity of minors under 16, but the effect of a lack of basic information. Similar results are evident on the Goldmans' tests of sexual vocabulary. Though the consistently higher scores of Swedish children cannot necessarily be attritubed to their better sex education, the inference is attractive. The subjects are well matched on other criteria.[142] Similar differences are also observable between the Swedish group and subjects from the USA and Britain.[143]

Other results reported by Goldman and Goldman are also of interest. As well as the discussion of abortion methods in response to asking interviewees

[139] Id. Table 13.11 at 287.
[140] Id. at 54.
[141] Id. at 276; cf. figures on knowledge of abortion at 287.
[142] Id. at 80.
[143] Note also that the Goldmans suggest that the difference between the Swedish results and those of other English speaking countries may be greater than revealed in their study because the rate of refusal by parents to their children's participation in the survey was higher in the latter countries: 20% of English speaking parents refused, compared with only 5% of the Swedish parents. The English speaking group is therefore likely to come from more "open-minded families ... with a greater proportion of negative, inhibited and non-communicative families excluded than in Sweden." At 373.

about "not having babies" (reported above), abortion was also included in the test of sexual vocabulary.[144] When asked the meaning of the word abortion, only 5% of Australian 13 year olds and 20% of Swedish 13 year olds gave a fully appropriate definition, with 20% and 43% respectively at 15 years. (A fully appropriate answer required mention of termination of pregnancy before full term, leading to the death of the embryo, foetus or baby).[145] In comparing the results here with those on "knowledge of abortion" discussed above, the Goldmans state:[146] "It is at once apparent that children's awareness of the possibility and process of abortion is in advance of their understanding of the vocabulary of abortion ... children know about the abortion process at 11 years, whereas their knowledge of the meaning of the word itself was barely achieved by 15 years." In other words, minors' ability to give an *intelligent* consent is confirmed; their capacity to give a *knowing* consent if technical language is employed is more doubtful. The onus is squarely back on the health care worker (and parents and sex educators) to be sensitive to the limitations of their young patient's vocabulary and the corresponding limitations of their own sophisticated, medical vocabulary.

"Voluntary Consent"

This requirement of informed consent has been described as a requirement that the consent be obtained without "force, fraud, coercion, duress, undue influence, deceit, constraint, mistake or deception".[147] The presence of any of these, Somerville suggests, will vitiate the informed consent, for either an adult or minor. Concern has been expressed that, even without the presence of what we would normally describe as fraud, duress etc., minors, particularly adolescents, may still be unable to give a truly voluntary consent. Grisso and Vierling[148] argue that adolescents are inclined to defer to adults, especially those in authority, and therefore may defer to a health care worker in the treatment situation and be unable to give a voluntary consent.

Again, psychological researchers have attempted to explore minors' deferent behaviour. Patel and Gordon[149] attempted to assess how susceptible groups of minors were to "influence". Their subjects were 72 school students in grades 10, 11 and 12.[150] They found a general tendency of decreasing susceptibility

[144] At the age of 15, 87% of Swedish subjects can give a fully appropriate definition of pregnancy, compared to 38% of similarly aged Australians; for "conception", 40% of Australian 15 year old and 93% of Swedish 15 year olds give a fully appropriate response. Id at 344 & 346.

[145] Id. at 359.

[146] Id. at 361.

[147] Somerville, op. cit. at 46.

[148] Op. cit. at 422.

[149] Patel, A. S. and Gordon, J. E. "Some personal and situational determinants of yielding to influence" (1960) 61 *Journal of Abnormal and Social Psychology* 411.

[150] No ages were given but my assumption, based on other American research where grade and age are given, is that they were approximately 15, 16 and 17 years of age. The subjects had to complete a synonym vocabulary test – choosing from five responses to each stimulus word. The experiments provided "hints" to the students: various incorrect responses had been marked on the questionnaire which subjects were told were the marks of a previous class.

with age, with a significant difference between the scores of the grade twelve students and the other two groups. They also attempted to vary the "status" of the influence by telling subjects that the responses marked on their question papers were from a higher or lower grade of children and found that this made little difference to the acceptability of the suggestions to the lower grade children – implying, they suggest, "that when young children accept suggestions, it is without reference to or evaluation of the adequacy of the source of the suggestions".[151] Patel and Gordon also found that all subjects were more likely to accept "suggestions" when they found the item difficult (assessed by subjects some days after the test was administered). They concluded: "The ambiguity of the situation in which *S's* [subjects] must perform is a potent factor in producing dependence on suggestions."[152]

Costanzo and Shaw[153] explored a more complicated hypothesis. They reasoned, on the basis of Piaget's work, that "the relation between age and conformity to rules (norms) is curvilinear. That is, at an early age the child is uninfluenced by rules but gradually begins to follow them until at about age 11-12 the rules are internalised and utilised completely."[154] At that stage, the minor begins to develop her own rules and thus conformity behaviour decreases. They tested four groups of children – one aged 7-9, the second 11-13, the third 15-17 and the fourth 19-21 years. The task was to estimate the length of lines and, on the test trials, subjects were made to believe that three other subjects had estimated the length of the lines before them: that estimate was incorrect, though the subjects did not, of course, know this. The experimenters found their thesis confirmed. Conformity was least for the 7-9 year olds, greatest for the 11-13 year olds, with maximum conformity at age 12, and decreased for the 13 to 17 year olds and decreased again for the 19-21 year olds. Subjects were later asked about the reasons for discrepancies between their responses and those of the others, where they had not conformed. Those who had been found most likely to conform blamed themselves: "I must be going blind; I was wrong most of the time"; those least likely to conform suggested that the others were wrong.[155] They conclude: "From the preadolescent to the adolescent period of development the amount of conformity to external social pressure increases, whereas conformity decreases after adolescence and through early adulthood."[156]

Should results of this nature lead to concern about the voluntariness of a minor's consent to treatment? What proportion of minors do in fact "conform" to the suggestions provided? In Patel and Gordon's (1960) study, overall, "37% of the items on which misleading suggestions were provided were answered in the suggested direction";[157] that is, close to two thirds of "hints"

[151] Op. cit. at 416.
[152] Id. at 415.
[153] Costanzo, P. R. and Shaw, M. "Conformity as a function of age level" (1966) 37 *Child Development* 967.
[154] Id. at 967.
[155] Id. at 972.
[156] Ibid.
[157] Op. cit. at 415.

were ignored. However, for some groups acceptance was much higher: for example, for young women in grades 10 or 11, making decisions on words they found difficult with "hints" provided by higher grade students, an average of 68% of the "hints" was accepted. Arguably, this reveals sensible decision making rather than "involuntary" decisions. In the previous discussion of "intelligent consent", it was suggested that an intelligent decision could be evidenced by the making of a choice and that choice included a decision to allow the treatment decision to be made by another. This may be what was happening with Patel and Gordon's subjects. Costanzo and Shaw's study included a group of 19-21 year olds, that is, what we would call adults. It seems that they showed less conformity than the 15-17 year olds – their mean score was approximately 6.5 with 5.5 for the adult (19-21) group.[158] We are not told whether the difference between these two groups is statistically significant: we may be applying a test that is more severe than one we would insist on for adults.

There are further problems with the applicability of these experimental findings to the treatment consent situation. Patel and Gordon, the authors of the study using the synonym test, suggest that the "typical" tests of conformity (of which Costanzo and Shaw (1966) is an example) "provide little evidence that *S's* [subjects] do in fact change their ... overt behaviour outside of the experimental situation."[159] They postulate that what researchers call social influence – for example, the "responses" of the other "subjects" in Costanzo and Shaw's (1966) study – may be seen by subjects as guides for their responses and that subjects conform to "avoid censure" but would not necessarily perform in this way outside the experimental situation. Typically, the "suggestions" are not made explicit and, though the experiments may indicate a lot about verbal behaviour in response to cues, "it cannot be said that *S's* [subjects] are yielding to influence or accepting suggestions when, as far as *S* [the subject] is concerned, no suggestions have been offered".[160] Patel and Gordon suggest they have eliminated at least some of these experimental effects. Their synonym tests were administered by the students' English teachers and so would not have been seen as an experiment, and the possible social influence was made explicit: teachers told the subjects that marks may have been made in the question book by a previous class, and were told to ignore them. There was thus no pressure to accept the suggestion from the presumed "originator of the suggestion". For our purposes, it is still unclear how much their experiment tells us about minors' tendencies to conform to, say, a doctor's suggestion in the treatment situation: the fact that minors (and adults) accept hints in a test of synonyms may say more about their response to exams than their susceptibility to influence when making decisions about their fertility.

One study looked at decision making in the "real world". C.C. Lewis[161]

[158] Means are not given; these are approximated from a graph at 971. The maximum score was 16.
[159] Op. cit. at 411.
[160] Ibid.
[161] Lewis, C. C. "A comparison of minors' and adults' pregnancy decisions" (1980) 50 *American Journal of Orthopsychiatry* 446.

interviewed 42 women who were undergoing pregnancy tests and compared the decision making of minors (17 years and under, the youngest being 13 years old) and adults (the oldest was 25). Lewis was concerned to explore, among other things, the implications of the sort of research described above on the conformity of minors. She asked her interviewees whom they had consulted or would consult about their pregnancy decision. She found no "age related changes in the number of people consulted or expected to be consulted [or in] the tendency to consult the boyfriend, the parents or members of the peer group"[162], although adults were more likely to be planning to consult a doctor or counsellor, who were seen as "objective", than were minors. Subjects were also asked "why they chose abortion, motherhood or adoption over each other alternative".[163] (There was no difference between adults and minors on the actual decision made.) Lewis found that adults were more likely to refer to their capacity to care for the child, and minors more often considered the effect of their decision on their relationship with their parents or other members of their family and the possibility of the child being deformed.

Interestingly, Lewis also tried to assess minors' competency or "latent ability" to consider the consequences of pregnancy. She asked her subjects two hypothetical questions: "Tell me three ways you think having a child would change your life" and "Imagine someone your own age is asking you advice about what to do about her pregnancy. What things would you encourage her to think about in making her decision and why?" In the hypothetical situation minors, like adults, did mention child-rearing capabilities. When responses to their own situation and the hypothetical situation are combined, minors still reveal a greater concern with parents and the child's deformity. She suggests that, given minors were able to "imagine the various ramifications of the pregnancy decisions . . . [they] may perceive their *own* decisions as determined by external forces, not by their own abilities", and that subjects mentioning deformity or parents "were not saying they *wanted* to have an abortion, but they *had* to have an abortion".[164] Lewis quite rightly points out that it is not surprising that minors felt they were controlled by "external forces": 81% lived with their parents (50% of the adult group did so). "In addition, minors' greater difficulty finding work and supporting a child may render the decision less 'their' decision."[165] Minors' marked concern with the foetus' abnormality, presuming there was no medical reason for concern, is more difficult to explain. Such a view certainly reflects "external control": there is no choice to be made. It may be a function of lack of information and, at least in one case, it reflects misinformation; one of Lewis' 17 year old subjects said, "I've already freaked out a couple of times because of my mother telling me it's going to be retarded, like in 'It's Alive' or 'Rosemary's Baby'."[166] Or it may reflect guilt and, Lewis

[162] Id. at 448.
[163] Ibid.
[164] Id. at 449.
[165] Id. at 450.
[166] Id. at 449.

argues, will be more likely to induce guilt about the abortion decision later in life than reasoning based on either the quality of the woman's own life or that of the future child.

Do these results indicate that minors' consent to abortion is not fully voluntary? Financial dependence on parents seems to require that the minor takes the views of her parents into account in making her decision. But to deny a minor the right to make her own decision, albeit one affected by seemingly rational calculations of her financial position, can only exacerbate her dependence and her feeling of being subject to "external forces". If a belief in the deformity of the child is a widespread belief on the part of minors, it clearly needs to be addressed by health care workers and sex educators.

Lewis suggests that "the existence of a convenient external 'excuse' compelling abortion may 'short-circuit' the thinking of the younger adolescent, allowing her to avoid full consideration of the implications of immediate child bearing, both in terms of her own life and the quality of the child's life".[167] Again, more experimental research has been undertaken on the notion of "external control", a characteristic often referred to as "external locus of control" (with its obverse, "internal locus of control"). Grisso and Vierling[168] state that this characteristic "has been associated with passive acceptance of fate and external influences on one's life; a characteristic that might contribute to deference in consent situations". Milgram[169] attempted to measure internal locus of control – "the extent that the child comes to view his own personal efforts rather than events in the external environment . . . as responsible for his successes and failures" – in 50 children in four grades 1, 4, 7 and 10, with average ages of 6.9, 9.9, 13.2 and 15.7 years. He found significant differences on the internal locus of control measure[170] between grades 1 and 4 and grades 7 and 10, with "age related increments in internal locus of control". In general, this confirms Lewis' findings on minors' pregnancy decisions, though no adults were included in Milgram's (1971) investigation.

Yet the implications for the voluntariness of minors' treatment decisions are unclear. Grisso and Vierling (1978) conclude, on the basis of research by Milgram (1971), Patel and Gordon (1960), Costanzo and Shaw (1966) and others: "Below 15-17 years, then, there is reason to question whether minors in general can satisfy the voluntary element of consent."[171] Perhaps this conclusion is too pessimistic. Grisso's comments on his research on juveniles' waiver of *Miranda* rights is relevant here.[172] He cautions against research trying to improve the way police present the rights to minors, suggesting that it has little potential to enhance the protection of minors. He reminds us that an understanding of the rights is only one factor in a proper waiver and

[167] Id. at 450.
[168] Op. cit. at 422.
[169] Milgram, N. "Locus of control in negro and white children at four age levels" (1971) 29 *Psychology Reports* 459.
[170] Id. at 464.
[171] Grisso and Vierling, op. cit. at 423.
[172] Grisso op. cit. at 141.

the voluntariness of the waiver depends as much on the "social atmosphere of the situation" as on the understanding of the rights. And I would emphasise here the differences between the "social atmosphere" of police-juvenile interactions and doctor-minor interactions.

Police-juvenile interactions are inherently oppressive; relationships between minors and doctors are not or, at least, do not need to be similarly oppressive. At the most obvious level, minors voluntarily attend for contraceptive advice and treatment. Grisso and Vierling (1978) themselves point out that health care workers can affect the likelihood of deference to their views by their "manner of presentation".[173] Police, on the other hand, can do little to change the dynamics of their interaction with minors (or adults for that matter). Lewis' study indicates that minors were able to articulate concerns about the effect of having a child on their own lives but did not appear to apply this to their own decisions. Surely appropriate intervention by, for example, a counsellor could exploit this potential.[174] It is also important not to lose sight of decisions minors could make that may avert the need for terminating a pregnancy. Consulting a doctor or a clinic for contraceptive advice is a voluntary act by the minor, even though her belief in an "external locus of control" may inhibit her seeking out contraception. But, once she has done so, surely sensitive handling by a health care worker could enable her to make a voluntary, informed decision about choice of contraceptive measures prior to the need to make the more difficult decision to have an abortion.

It must also be remembered that to restrict minors' capacity to consent to their own treatment by mandating parental involvement, or parental or court decision making, can only increase the feeling of "externality of control":[175] Once again, Grisso's comments[176] are apposite. Rather than improving police presentation of *Miranda* rights, he suggests "improving our early socialisation of children to the concept of a right". And the same thing must apply in relation to the socialisation of children in their attitudes to decision making about their own medical treatment. C.E. Lewis[177] summarises a research project conducted by him and other colleagues to attempt to introduce an "adult-free" health care system for primary school children.[178] Lewis concludes: "Children *can* learn decision making and, when given the oppor-

[173] Op. cit. at 423.

[174] The indication from Lewis' study that minors are unlikely to consult a doctor or counsellor about their decision can be overcome by the practices of abortion clinics who can insist on counselling before an abortion is carried out.

[175] See Lewis' suggestion to this effect, op. cit. at 452.

[176] Op. cit. at 141.

[177] Lewis, C. E. "Decision making related to health: When could/should children act responsibly" in Melton et al (op. cit.) at 75.

[178] The children were given cards on which they wrote their names and placed them on the teaher's desk when they wanted to see the school nurse. The nurse examined them, told the children what she found and, provided no serious illness was found, asked the child to formulate treatment options and then to decide on the desired treatment. They found that "almost all [children] displayed ability to participate, and even non-users were aware of the changes in the nature of the transaction". The pattern of use of the health care service was very similar to that of adults (number of visits etc.) and, Lewis reports, the children saw themselves as much more responsible for their own health care.

tunity, make remarkably responsible decisions."[179] This sort of approach (or, at least, involving children to some extent in their health care decisions) is likely to increase the sense of "internal control" and indicates that minors have the capacity, even if it is not fully exploited, to make their own decisions.

CONCLUSION AND RECOMMENDATIONS

It is clear that minors, including those below the age of consent to sexual intercourse (generally 16), engage in sexual intercourse and are likely to continue to do so, whatever the law may provide. Many of these young people are unprotected by any contraception.

It has been argued here that the common law provides that a minor of sufficient maturity to understand the nature of the treatment is able to provide a valid consent to her own contraceptive treatment. While this view remains controversial, or little understood by medical practitioners, some legislative clarification is obviously required.

The recent Carney Report[180] dealt with some of these issues. It suggested:

> "Legislation should provide that minors may give a valid and sufficient consent to a medical procedure, provided that their maturity and understanding, bearing in mind the nature of the procedure, is such that they can form a sound and reasonable judgment of the issue."[181]

One difficulty with the recommendation relates to the phrase "sound and reasonable judgment". It could be argued that minors should be able to make "unsound" judgments if they are making an intelligent, knowing and voluntary consent.

In the Report's draft legislation, clause 21 protects a medical practitioner from criminal liability (arising from lack of parental consent) if he or she acts without the consent of the parent and in his or her opinion – "(a) the child was capable of understanding and consenting to the medical treatment". This form of wording does not introduce any proviso that the minor's judgment be sound, which is surely preferable. The draft legislation only purports to protect the medical practitioner from any criminal liability arising out of the lack of parental consent. To clarify once and for all the question of tortious liability, it would of course need to be expanded.

It may also be preferable to specify a fixed age above which minors are automatically deemed able to give an informed consent to medical treatment. In Section II, the question of whether any generalisations could be made about the age at which minors are able to give an informed consent was explored. It seems clear that by the age of 14, most minors have the capacity to understand doctors' communications and are able to exercise voluntary consent. The state of minors' knowledge about sexuality and contraception

[179] Id. at 91.
[180] *Child Welfare Practice and Legislation Review Report: Equity and Social Justice for Children, Families and Communities*, Victoria, 1984.
[181] Id. at 291.

is somewhat more problematic, but their capacity to understand does not seem to be in doubt. While there is a clear need for more extensive, relevant sex education, young Australian women's current lack of knowledge does not seem an adequate ground for withholding from them the right to consent to their own fertility control treatment – either independently of their parents or against their parents' wishes. The claim of capacity is justified for *most* 14-year olds. Piaget's theoretical work, and the empirical material exploring his theses, provide no guarantee that any *particular* 14 year old is capable of giving an informed consent. The empirical material also indicates that some adults will never reach the "formal operational" stage of cognitive operations which seems required for a person to give an informed consent. We do not refuse these adults medical treatment on these grounds, and we should not do so for women of fourteen.

There is obviously a possibility that some health care practitioners could take advantage of minors' assumed capacity to consent by rendering overbearing contraceptive advice. Although it has been argued here that minors are capable of giving a voluntary consent, it must be recognised that doctors can manipulate the health care decisions of adults – and, therefore, also of minors. Young women in institutions are particularly at risk. A 1982 Victorian Department of Criminology seminar revealed that minors in Winlaton were being given the controversial injectable contraceptive, *depo provera*. Feminist health care workers at this seminar were inclined to argue that these young women were incapable of giving an informed consent. We must be careful to differentiate between the minors' general capacity to give consent to their own treatment and their ability to give that consent in an inherently repressive environment. The New South Wales *Community Welfare Act* provides special protection for minors in custody against "special medical examinations", including vaginal examination; this legislation provides, among other things, the minor or her parent may insist that a second medical opinion be obtained before submitting to such a compulsory examination. Such a procedure could be adopted and extended for young women in institutions in Victoria.[182] In particular, guidelines could be developed which provide that young women must be offered a range of contraception together with adequate information on the associated risks.[183]

For women under 14, the situation is somewhat more complicated. It is clear that quite young children can participate in their own health care decisions. Whether they have all the capacities required to give an informed consent is less clear. Some of this lack of clarity is the product of lack of empirical information for the ages of 12 to 14. There seems to be room for an individuated approach for minors under 14. If such a minor is capable

[182] The Carney Report recommends that legislation along the lines of the NSW Act, be enacted in Victoria, at 292.

[183] The Carney Report also endorsed the reservations of the Office of Women's Affairs (expressed in a submission to the Inquiry) about the use of Depo Provera. The Report states: "At the least its use should be more tightly controlled, a young woman should also be provided with written advice on its benefits and risks. They should also be required to give their consent in writing before it is administered." (at 292).

of giving an informed consent and has the maturity to understand the nature of the treatment, she should be entitled to exercise her own choice independently of her parents. At the same time, if a minor does not quite reach the full capacity to consent to her own treatment, what is the purpose of denying her access to contraceptive advice and treatment? To some extent our views here depend on whether our attitude to children's rights is nurturant or self-determinative, that is, whether one "is essentially paternalistic (or maternalistic) in that what is good or desirable is determined for the child by the society or some subject of society, not by the child"; or stress "those potential rights which allow children to exercise control over their environments, to make decisions about what they want, to have autonomous control over facets of their lives".[184]

As Freeman stated: "This does not mean that in the exercise of such autonomy [in relation to contraception and abortion] they [adolescents] will not make mistakes: having rights entails developing the capacity to take personal responsibility. In the development of that capacity, mistakes will be made. Rights are not always exercised wisely, sometimes they are abused or misused, but this is not an argument for denying them."[185]

[184] Rogers, C. M. and Wrightsman, L. S., "Attitudes towards children's rights: Nurturance or self-determination?" (1978) 34 *Journal of Social Issues* 59 at 61.
[185] M.D.A. Freeman, *The Rights and Wrongs of Children*, Frances Pinter, London, 1983 at 265.

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