



Forward, *Gillick*: Are competent children autonomous medical decision makers? New developments in Australia

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ABSTRACT

Another chapter has opened in the tortured history of the status of *Gillick* competence. Never before has *Gillick* been extended to permit a mature child to make autonomous medical decisions over and above the curial '*parens patriae*' power. In 2013, two judicial decisions promulgated from different Australian courts are in conflict over this most fundamental of questions. This Article situates the law of the '*parens patriae*' power in Australia and, drawing on overseas conceptualizations of analogous doctrine, explores the bases for and potential consequences of this conflict.

KEYWORDS: *Gillick* competence, *parens patriae* power, children and medical decision-making

INTRODUCTION

The status of childhood decision-making about medical treatment is a contentious one and, despite its importance and complexity, subject to an opaque and poorly governed legal framework. Unlike adults,¹ children have historically been given little real autonomy to make medical decisions for themselves. In this Article, two recent cases from

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¹ See eg *Schloendorff v Society of New York Hospital*, 211 N.Y. 125, 129 (1914); *Re T (Adult: Refusal of Medical Treatment)* [1992] 4 All E.R. 649, 652–53; *Hunter and New England Area Health Service v A* (2009) 74 N.S.W.L.R. 88, [15].

Australia throw the controversy surrounding medical decision-making by children back into the spotlight, and not for the better.

In Part I, the bases for children's medical decision-making are explored. Across the common law world, the judicial power to deal with medical decisions about and for children comes in the form of the supposedly 'unlimited' '*parens patriae*' power, an inherent power courts possess to make or override decisions for incompetent persons, including children.² Although the genesis of this power differs between jurisdictions, its application is reasonably consistent. Part II engages with how Australian courts have recently muddied the waters by promulgating two facially inconsistent decisions. Importantly, it seeks to identify the rationale for why, for the first time, an Australian court has limited what was previously unlimited; the courts' *parens patriae* power to make medical decisions on behalf of incompetent and competent children.

I. CHILDREN'S MEDICAL DECISION-MAKING: THE MATURE MINOR

Self-determination is integral to any liberal society. But how far should society extend that right to children,³ to make decisions that could have significant long-term impacts, or cut short their lives? The answer to that question is clouded by competing legal and policy objectives. Courts have long held a distinction between medical decisions to be made against the wishes of parents and treating practitioners, and those to be made by courts acting *parens patriae*.

A. Decisions against parents, guardians and treating practitioners

Most decisions about medical treatment occur within the treatment environment. For young children, parents and guardians typically provide the necessary consent to protect practitioners from liability in performing treatment. There is no controversy where children lack the capacity to make medical decisions by themselves; parents can authorize, or override a child's refusal of, medical treatment.⁴ Some treatment is, however, beyond parental power to consent to and requires judicial approval, including sterilization⁵ and gender reassignment treatment.⁶

Parental power wanes once a child is deemed psychologically competent to make medical decisions, a concept known as the 'mature minor' principle.⁷ That principle was fashioned in the UK case of *Gillick*, where a parent sued a medical practitioner who had provided her daughter with contraceptive advice. The Law Lords held that where a child could '[achieve] a sufficient understanding and intelligence to enable him or her to understand fully what is proposed',⁸ a doctor was entitled to provide that advice in

² UK: *Re R (A Minor) (Wardship: Medical Treatment)* [1991] 4 All E.R. 177; Australia: *Re Thomas* [2009] N.S.W.S.C. 217, [29]; Secretary, Department of Health and Community Services (NT) v JWB and SMB [*Marion's Case*] (1992) 175 C.L.R. 218, 258; USA: *In re E.G., a Minor*, 549 N.E.2d 322, 327 (1989).

³ Child is defined herein as anyone under the age of 18 years.

⁴ *Marion's Case*, *supra* note 2, at 235-36. *Re R*, *supra* note 2, at 185-86; see Gillian Douglas, *The Retreat from Gillick*, 55 MOD. L. REV. 569, 575 (1992). For discussion regarding the US, see Robert Stenger, *Exclusive or Concurrent Competence to Make Medical Decisions for Adolescents in the United States and United Kingdom*, 14 J.L. & HEALTH 209, 211 (2000).

⁵ *Marion's Case*, *supra* note 2, at 253.

⁶ *Re Jamie* (No. 2) (2013) 278 F.L.R. 155, [127]-[139].

⁷ *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112; *Marion's Case*, *supra* note 2, at 237.

⁸ *Gillick*, *supra* note 7, at 189.

the absence of parental consent ('Gillick competence'). Since that time, the common law has recognized that 'mature minors' possess a higher legal status than minors generally.⁹ In Australia, *Gillick* is good law, meaning that children who demonstrate the requisite level of understanding can consent to medical treatment without their parents' consent.¹⁰ In the USA, the ability of mature minors to consent to medical treatment,¹¹ and to refuse it,¹² has been sporadically recognized, although treatment refusals have yet to receive SCOTUS consideration.¹³

B. The *parens patriae* power

In addition and supreme to parental powers, a court acting *parens patriae* can regulate a minor's decision-making by either displacing parental decision-making or acting *in loco parentis* where a guardian is unavailable.¹⁴ In Australia, the discretionary *parens patriae* power, an inherent equitable or statutory power,¹⁵ operates over a child's healthcare decisions in three broad circumstances: consent to treatment in the face of parental disagreement;¹⁶ refusing medical treatment;¹⁷ and 'special treatment' for an incapable child,¹⁸ or self-sought for a capable child.¹⁹

The *parens patriae* power can notionally only be exercised to protect 'incompetent' patients.²⁰ Once deemed incompetent, the power is characterized as 'limitless' when exercised in the patient's best interests.²¹ Thus, in order to bring children within the *parens patriae* power, they have been classed as 'incompetent' simply by reason of their childhood, and irrespective of any psychological competence they may possess.²² The past 50 years have seen a gradual decline in the strength of that view, with courts recognizing

⁹ This principle has also made its way into USA jurisprudence, although not based on *Gillick*: see eg *City of Akron v. Akron Center for Reproductive Health, Inc*, 462 U.S. 416 (1983).

¹⁰ *Marion's Case*, *supra* note 2, at 237.

¹¹ *Akron*, *supra* note 9, at 440.

¹² E.G., a *Minor*, *supra* note 2, at 326.

¹³ There has been an inconsistent application of the mature minor principle; see O. G., P. G., & M. G. v. The Hon. Robert Baum, 790 S.W.2d 839, 842 (1990) (Texas rejected the mature minor doctrine).

¹⁴ *Marion's Case*, *supra* note 2, at 243. A similar position has been adopted by the USA and UK: Stenger, *supra* note 4, at 240. For a comparison between the USA, Canada, and Australia, see Justice S. Strickland, *Address at Association of Family and Conciliation Courts 51st Annual Conference: To Treat or Not to Treat: Legal Responses to Transgender Young People* 60, May 28–31, 2014.

¹⁵ The Family Court's welfare jurisdiction is conceived as substantially identical to the State Supreme Court's *parens patriae* power: see *Marion's Case*, *supra* note 2, at 256; *Thomas*, *supra* note 2, at [27].

¹⁶ Eg *Gillick*, *supra* note 7, at 173–74; *K v Minister for Youth and Community Services* [1982] 1 N.S.W.L.R. 311, 323.

¹⁷ These cases are commonly (but not exclusively) characterized by refusals of blood transfusions by Jehovah's Witnesses: *X & Ors v The Sydney Children's Hospitals Network* (2013) 85 N.S.W.L.R. 294; *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 F.L.R. 386; *A. C. v. Manitoba (Director of Child and Family Services)* [2009] 2 S.C.R. 181.

¹⁸ *Marion's Case*, *supra* note 2, at 259.

¹⁹ Commonly, this manifests in children seeking court authorization for gender altering therapy; *Jamie*, *supra* note 6, at 158[11]; *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* (2004) 180 F.L.R. 89.

²⁰ *Re Frances & Benny* [2005] N.S.W.S.C. 1207, [17]; *Addington v. Texas*, 441 U.S. 418, 421 (1979).

²¹ *Re R*, *supra* note 2, at 186; *Thomas*, *supra* note 2, at [29]; *Marion's Case*, *supra* note 2, at 258. In the US, the *parens patriae* power has been defined as making the State the 'overseer' of the rights of children with an 'overriding' interest: 21 A.L.R.5th 248, 2a, 7a, and that children are 'under the control of the State', allowing courts to compel medical treatment in the patient's best interests: 4 A.L.R.5th 1000, 2a, 5a.

²² *Re Frances*, *supra* note 20, at [17]; 4 A.L.R.5th 1000, 2a ('dependent children, and incompetents' (emphasis added)).

that as minors age towards 18 years, or demonstrate their maturity,²³ the *parens patriae* power ‘fades... as the minor gets older and disappears upon ... reaching adulthood’.²⁴ The actions and decisions of mature minors are to be accorded greater weight and effect, increasing on a sliding scale until adulthood, that is, as children are perceived to increase in their ability to understand, their decisions are more likely to be accepted as correct binding.²⁵ What causes the ‘fading’ effect is not simply an increment of age, as courts (at least in Australia) are sufficiently empowered to override a decision up to the day before a minor’s 18th birthday.²⁶ Rather, competence is a discretionary factor that may be used to sway a court to accept the child’s decision or not. But, at least until the *Jamie* opinion, a child simply being deemed *Gillick* competent has never displaced the *parens patriae* power in its entirety.²⁷

There has been significant debate about whether *Gillick* could be applied beyond its own facts in order to fully emancipate children’s decision-making upon their attaining a threshold of competency.²⁸ Subsequent decisions had shown that this was not the case, at least as a matter of law. For example, *Re W*²⁹ holds that the *Gillick* competence doctrine does not preclude the *parens patriae* power for *refusals* of medical treatment.³⁰ For some time after *Gillick*, judges were at pains to deal with refusal cases as if *Gillick* competency was relevant, but otherwise dismiss the child’s ability to make a competent decision, sometimes in tortured fashions.³¹ More recently, courts have simply treated competency as irrelevant in refusal cases.³² The position in the USA is even more clouded, with decision-making capacity of children varying from state to state.³³

II. TERMINATING PARENS PATRIAE: THE AUSTRALIAN CONFLICT

A. New developments

The system of Federalism adopted by Australia makes conflict between state and federal courts almost impossible: the High Court of Australia is the ultimate arbiter of

²³ In *A.C.*, *supra* note 17, at 203[22], Abella J noted that:

‘It is a sliding scale of scrutiny, with the adolescent’s views becoming increasingly determinative depending on his or her ability to exercise mature, independent judgment. The more serious the nature of the decision, and the more severe its potential impact on the life or health of the child, the greater the degree of scrutiny that will be required’.

²⁴ *E.G.*, *a Minor*, *supra* note 2, at 327.

²⁵ See Nicholas Lennings, *Children and Refusal of Medical Treatment: In Urgent Need of Reform*, 21 *J.L. & MED.* 122, 138 (2013).

²⁶ See generally *X*, *supra* note 17, at 311[72].

²⁷ The USA position in this respect is unclear. *Dicta* in *In re AMB*, 640 N.W.2d 262, 292–93 (2001) suggests, quite rationally (and which is echoed in *Jamie*), that the *parens patriae* power is defeated by proof of maturity, as the incompetence feature that attracts the doctrine is gone. Cf. *Formire v. Nicoleau*, 75 N.Y.2d 218, 238 (1990) where maturity was listed only as a factor to be weighed, suggesting that the *parens patriae* power is not abrogated by maturity.

²⁸ See discussion in Lennings, *supra* note 25, at 130; Anne Morris, *Gillick, 20 Years On: Arrested Development or Growing Pains?*, 21 *PROF. NEGLIGENCE* 158 (2001); Douglas, *supra* note 4, at 572–73. [1992] 4 All E.R. 627.

²⁹ *Re W* is considered good law in Australia: *X*, *supra* note 17, at 302–03.

³¹ *Re E*, *supra* note 17, at 391 (14 year-old Jehovah’s Witness did not understand the procedure ‘enough’ to be *Gillick* competent).

³² *X*, *supra* note 17, at 368[50].

³³ See Stenger, *supra* note 4, at 211, 225.

federal and state common law,³⁴ and lower federal courts cannot adjudicate on state laws.³⁵ But the inconsistent way in which medical decisions are regulated within Australia has led to such a conflict. The State Supreme Courts inherently possess the *parens patriae* power.³⁶ The Federal Family Court's 'welfare' jurisdiction is, for present purposes, identical. In 2013, these two jurisdictions collided on the question of children's medical decision-making.

In the case of *X*, the New South Wales Court of Appeal refused,³⁷ consistently with established authority, to recognize the decision of a *Gillick* competent 17 year-old Jehovah's Witness to refuse a 'life-saving' blood transfusion. In so doing, the Court of Appeal held that the *parens patriae* power is immutable and cannot be abrogated by a determination of *Gillick* competence.³⁸ However, in the case of *Jamie*, the Full Court of the Family Court held that an 11 year-old *Gillick* competent child could consent to treatment for Gender Identity Disorder,³⁹ on the grounds that once a child was deemed *Gillick* competent, the court had no jurisdiction to approve or disapprove of the proposed treatment.⁴⁰ This decision is striking because even countries with federally enshrined human rights have not completely negated a court's ability to control children's decision-making in those circumstances where the child is deemed competent.⁴¹

B. Are the decisions reconcilable?

Essentially, what these two cases suggest is that if the Court agrees with the substance of a child's medical decision, competency is binding; if not, then it may be ignored. So while *Jamie* seemingly gives *Gillick* some real teeth,⁴² the power is more clouded than ever. In fact, *X* and *Jamie* appear to be in diametric conflict. *Jamie* suggests that *Gillick* competence provides an inalienable right for a competent child to consent to medical treatment against parents and courts whereas *X* asserts that *Gillick* competency may be taken into account, but cannot abrogate the *parens patriae* power.⁴³ What follows evaluates the reasons for the inconsistency between these decisions.

1. 'Absent Controversy'

In part, the decision in *Jamie* is grounded in a finding from an earlier decision in *Marion's Case* that a child may have the capacity to give informed consent once *Gillick* competent.⁴⁴ But *Gillick* and *Marion's Case* are dubious bases for *Jamie's* validity. First, the plurality's reasoning in *Marion's Case* was directed towards accepting *Gillick*; that is, a minor is capable of consenting to medical treatment in the absence of their parents,

³⁴ *Kirk v Industrial Court (NSW)* (2010) 239 C.L.R. 531, [98]–[99].

³⁵ *Re Wakim, Ex parte McNally* (1999) 198 C.L.R. 511.

³⁶ In Australia, the *parens patriae* power is typically referred to as a 'jurisdiction'.

³⁷ The N.S.W. Court of Appeal is the highest court in the State of N.S.W., but subject to the federal High Court's ultimate authority.

³⁸ *X*, *supra* note 17, at 305, 306–10.

³⁹ See *Jamie*, *supra* note 6, at 184[136]–[137].

⁴⁰ *Id.* at 182[129], 192[186]–[188], 193[195]–[196].

⁴¹ Eg US: *E.G.*, *supra* note 2, at 326, but cf. *AMB*, *supra* note 27, at 292, 293; Canada: *A.C.*, *supra* note 17, at 218[56] (court may override a decision where a child's life is threatened).

⁴² See Michael Williams, John Chesterman & Phil Grano, *Re Jamie (No 2): A Positive Development for Transgender Young People*, 22 J.L. & MED. 90, 99 (2014).

⁴³ *X*, *supra* note 17, at 305[43].

⁴⁴ *Jamie*, *supra* note 6, at 183[134].

not courts, and this has commonly been held to distinguish *Gillick* from *parens patriae* cases.⁴⁵ As such, *Jamie* stands alone as authority usurping the *parens patriae* power. Second, and more important, is the concept of ‘controversy’. In *Jamie*, the Court attempted to limit its reasons to requests for gender-altering therapy ‘absent some controversy’.⁴⁶ That is, a child would be able to consent to the gender-altering treatment where all parties agreed. However, such limitation has no grounding in the language employed in *Jamie*, which ultimately relies only on *Gillick* competency.⁴⁷

There has been some confusion as to how much weight should be placed on the controversy criterion. Justice Strickland, writing extra-judicially, has attempted to distance the Court from the position that *Jamie* stands for independent decision-making, stating that the *parens patriae* power is returned when there is disagreement between the parties.⁴⁸ But this nuance has been missed both in a subsequent first-instance decision of the Family Court⁴⁹ and academic commentary,⁵⁰ and it does not appear plausible to suggest that controversy moderates the Court’s exclusion of the *parens patriae* power. A criterion like controversy is a matter that falls *under* the discretionary *parens patriae* power and has no bearing on the ability of a child to understand medical treatment. It cannot be controversy that activates the *parens patriae* power, as that would still undermine a child’s ability to express her will vis-à-vis medical treatment, contrary to the United Nations *Convention on the Rights of the Child* (‘CROC’).⁵¹ This approach would also undermine the holding that expressly rejected the application of discretionary factors once *Gillick* competency was established.⁵² Unless controversy operates as some ephemeral predicate to a finding of *Gillick* competence, which finds little support in *Jamie*’s express language, it seems *non sequitur* to suggest that controversy itself can limit a *Gillick* competent decision.

2. Consent versus Refusal

Another possible distinction could be the factual difference between *X* (addressing refusal of treatment) and *Jamie* (addressing consent to special treatment). Although the law has long considered refusal and consent opposite ends of one decision-making spectrum and identical in terms of the *information* to be understood, how they have been treated as a matter of discretion has differed markedly.⁵³ *Gillick* has consistently been held to apply only to decisions of *consent* to treatment, not refusals, a position echoed in Australian jurisprudence and affirmed in *X*. Unquestionably, the unfortunate

⁴⁵ *X*, *supra* note 17, at 301[25].

⁴⁶ *Jamie*, *supra* note 6, at 184[139].

⁴⁷ *Id.* at 182[129].

⁴⁸ Strickland, *supra* note 14, at 77.

⁴⁹ *Re Spencer* [2014] Fam. C.A 310, [36].

⁵⁰ Williams, Chesterman & Grano, *supra* note 42, at 98.

⁵¹ Nov. 20, 1989, 1577 U.N.T.S 3. As *infra* section II.B.3.b makes clear, the CROC is integral to the Family Court’s reasoning in *Jamie*.

⁵² *Jamie*, *supra* note 6, at 180, 181[120]–[121], 182[129] (‘if the child is *Gillick* competent... there remains [no] role for the court at all’).

⁵³ Cf. Stephen Gilmore and Jonathan Herring, ‘No’ is the Hardest Word: Consent and Children’s Autonomy, 23 CHILD & FAM. L. Q. 3 (2011) (a distinction may lie depending on whether all treatment has been refused or specific treatment. Only the latter should be considered the polar opposite of consent); see also Emma Cave & Julie Wallbank, *Minors’ Capacity to Refuse Treatment: A Reply to Gilmore and Herring*, 20 MED. L. REV. 423, 435–37 (2012).

distinction between consent and refusal decisions is at the heart of the conflict between *Jamie* and *X*. But two questions flow from this: first, is it normatively correct to maintain that distinction, and second, is the language in *Jamie* broad enough to obviate it in any event?

The *X* opinion accepted that there was no logical difference between consenting to and refusing medical treatment.⁵⁴ And yet, the Court did impliedly reinforce this distinction by acknowledging differing factual and legal consequences of consenting to and refusing medical treatment.⁵⁵ Such consequentialism⁵⁶ has long been, lamentably, a driving force behind refusal judgments, nullifying any real weight or purpose to a finding of *Gillick* competence in refusal cases.⁵⁷ On this view, where a child *refuses* treatment, *Gillick* cannot prevent or override the *parens patriae* power. But, at least facially, this is an incorrect categorization of how the *parens patriae* power is to operate. In the UK, doubt has been cast for some time over the continuing validity of the distinction between consent and refusal.⁵⁸

If the *parens patriae* power protects the vulnerable, the decision's mere nature cannot control its exercise. What should guide the power is the child's 'best interests', irrespective of whether consent or refusal is involved.⁵⁹ To assert otherwise presupposes (falsely) that consent decisions are beneficial and refusal decisions not. For example, a child may seek orders to consent to a radical new procedure that has a high death rate and horrific side effects. It would be absurd to allow that decision to be made so long as a child is deemed competent, but to deny a request to refuse treatment. Indeed, maintaining this distinction has been rejected in Australian law reform proposals.⁶⁰ That does not mean that greater rigor cannot be exercised in determining whether a child is *competent* to make a refusal decision, although that formulation too is fraught with danger.⁶¹

But even if the consent/refusal dichotomy is maintained, *X* and *Jamie* cannot be reconciled. Although the *Jamie* opinion carefully avoids the subject of refusal of treatment, terminating the *parens patriae* power on the finding of *Gillick* competence arguably extends the Court's reasoning beyond consent to medical decisions generally.⁶² Distinguishing between transgender therapy and refusal of a blood transfusion has no 'logical distinction' when competency to make a medical decision is in issue.⁶³ The consent/refusal distinction can only come into play under the *parens patriae* discretion

⁵⁴ *X*, *supra* note 17, at 309[66] (quoting Balcombe LJ in *Re W*, *supra* note 29, at 642).

⁵⁵ *Id.*

⁵⁶ Eg judges often look to the decision's outcome rather than the competency of children (or even adults) to make that decision; see John Devereux, David Jones & Donna Dickenson, *Can Children Withhold Consent to Treatment?*, 306 BRIT. MED. J. 1459, 1460 (1993).

⁵⁷ See Lennings, *supra* note 25, at 139-41.

⁵⁸ Emma Cave, *Competence and authority: Adolescent treatment refusals for physical and mental health conditions*, 8 CONTEM. SOC. SCI. 92, 93 (2013).

⁵⁹ *A.C.*, *supra* note 17, at 218[57] which, despite maintaining the consent/refusal dichotomy, discusses the importance of the best interest test. The best interest standard was explicitly adopted in *Gillick*, *supra* note 7, at 174 and is the primary impediment to *Gillick* competency actually conferring an enforceable right; see Lennings, *supra* note 25, at 129.

⁶⁰ See New South Wales Law Reform Commission, *Young People and Consent to Health Care*, Report No 119 (2008) 128.

⁶¹ See Lennings, *supra* note 25, at 138-39.

⁶² Williams, Chesterman & Grano, *supra* note 42, at 99 (*Jamie* precludes a best interests override).

⁶³ Strickland, *supra* note 14, at 77.

after *Gillick* competence has been assessed and applied.⁶⁴ By saying that competency is the terminus of the court's role, the ability to distinguish between consent and refusal, traditionally the province of judicial discretion, has been lost.

Both *X* and *Jamie* cannot be right. Either *Jamie's* hammer blow to the *parens patriae* power is correct, causing *X* to be wrongly decided and *Gillick* to presumptively obviate the *parens patriae* power, or it is not. If the latter is correct, at best, *Jamie* is an aberration that applies only to cases of consent in the Family Court, and *Gillick* remains trammelled. Irrespective of the adopted interpretation, the power is more clouded than ever. To illustrate, a doctor is shielded from liability by *X* if treatment is given in the face of a child's refusal, but is left wide open by *Jamie* to both civil and, albeit highly unlikely, criminal liability. And which is the higher authority? Both are intermediate courts of appeal. Only the High Court can decide which, so far, it has been unable to do.⁶⁵

3. The Logic behind the *parens patriae* power

The *parens patriae* power is often framed as protective, empowering courts to assist those who are *incapable* of assisting themselves, such as infants.⁶⁶ Where mature children fall into this vulnerability category is unclear. In *X*, the Court of Appeal referred to children's vulnerability stemming from their need to rely upon others (their parents) 'to satisfy their needs, whether physical, emotional, or experiential'.⁶⁷ But this logic is circuitous, for if 'vulnerability lies at the heart of the disability identified by legal incapacity',⁶⁸ such incapacity is brought about by a child's vulnerability, and yet children are vulnerable because they are legally incapacitated. Perhaps a better characterization is simply that the power is enlivened simply by virtue of childhood; certainly, the language in *Re Frances* supports such a notion that the power applies to those 'who are children or otherwise incapable of looking after themselves'.⁶⁹

Little comfort can be drawn from *Gillick* itself to establish a contrary proposition. In that case, any grant of autonomy was caveated by requiring the treatment to be in the child's best interests.⁷⁰ Subsequent interpretations of *Gillick* further limited its scope to little more than its bare facts.⁷¹ Arguably, if the Family Court relied on *Gillick* as authority to extinguish the *parens patriae* power over children per se, that would conflict with how the power has long been understood. Again, the confusion mounts; which is correct? This is not a conundrum that can be explained away. It is a direct conflict with no easy jurisprudential resolution. At best, one can say that children can be exempted in the Family Court, but not in the Australian States. But, normatively, which is correct?

a. Competent in fact Holding children incompetent simply by virtue of their childhood conflicts with contemporary psychological literature. In *Marion's Case*, the High Court

⁶⁴ Eg *X*, *supra* note 17, at 302[32].

⁶⁵ *X & Ors v Sydney Children's Hospitals Network* [2014] H.C.A.S.L 97. The High Court noted that the plaintiff had reached the age of majority, making the outcome on appeal moot.

⁶⁶ *Marion's Case*, *supra* note 2, at 259.

⁶⁷ *X*, *supra* note 17, at 308[61].

⁶⁸ *Id.* at 308[60].

⁶⁹ *Re Frances and Benny*, *supra* note 20, at [17] (emphasis added).

⁷⁰ *Gillick*, *supra* note 7, at 174.

⁷¹ That is, to prevent one's parents from restraining a child's access to basic medical treatment; Douglas, *supra* note 4, at 573.

referred to the eminent, but somewhat dated, theories proffered by Piaget.⁷² The question of what comprises competence as a factual question has been canvassed elsewhere.⁷³ For present purposes, it is sufficient to note that if the jurisdiction's object is to protect those who cannot protect themselves, by definition, *Gillick* competency meets that threshold. To be *Gillick* competent is to understand the decision and its consequences. Vulnerability in terms of medical decisions is manifested by a failure to understand the treatment, not its risks and effects per se. To be receiving medical treatment is already to be at risk. If it is accepted that the decision can be understood, legal vulnerability falls away, leaving only the 'public interest' in preserving the 'sanctity of life'.⁷⁴ The question that then arises is whether that residuary interest is sufficient to justify the discretionary override of a competent minor's decision?

b. Competent in law Attaching the *parens patriae* power to childhood absent any other factor does bring the power in conflict with *Jamie*. Whereas in *X* the power was characterized as an unlimited flexible discretion,⁷⁵ *Jamie* displaced the power entirely on *Gillick* competence. In the Canadian decision of *A.C.*, referred to at length and relied upon in *X*, Justice Abella noted that 'courts will inevitably be so convinced of a child's maturity that the principles of welfare and autonomy will collapse altogether and the child's wishes will become the controlling factor'.⁷⁶ What distinguishes *Jamie* and *X* is the nature of that collapse. In *X*, the collapse can occur after *Gillick* competence and all policy factors are considered (meaning that the court retains ultimate control); in *Jamie*, the collapse occurs on the finding of *Gillick* competence. The driving force behind this distinction is the weight given to the CROC in *Jamie*.⁷⁷ While the impact of conventions on Australian common law is limited, the CROC has been given significant weight in the past and can be used to guide the common law in circumstances of ambiguity.⁷⁸ That ambiguity exists in these cases is without question; the High Court has not yet ruled on whether the *parens patriae* power can be abrogated in this fashion and nor has the legislature seen fit to act. Accordingly, if the CROC does apply to limit discretionary decisions against children that would not otherwise be applied to adults (in the absence of clear contrary authority), then the conclusion that *Gillick* competent minors are subject to the *parens patriae* power generally is in doubt.

Moreover, the continued acceptance of the authority that undermines *Gillick*, *Re R* and *Re W*, is troublesome.⁷⁹ In both those decisions, the finding that *Gillick* did not apply was dicta—the applicants both failed to establish that they were competent, and both were made in the absence of any human rights legislation or the CROC.⁸⁰ Most importantly, if the *raison d'être* of the power, protection of the vulnerable, is no longer

⁷² *Marion's Case*, *supra* note 2, at 238-39.

⁷³ See Lennings, *supra* note 25, at 132, 137.

⁷⁴ See *X*, *supra* note 17, at 308[57].

⁷⁵ *Id.* at 305-06.

⁷⁶ *A.C.*, *supra* note 17, at 232[87].

⁷⁷ *Jamie*, *supra* note 6, at 180, 181[120]-[121], 182[129].

⁷⁸ See *B & B & Minister for Immigration & Multicultural & Indigenous Affairs* (2003) 173 F.L.R. 360, 383; *Thomas*, *supra* note 2, at [36]-[37]; see Jamie Potter, *Rewriting the Competency Rules for Children: Full Recognition of the Young Person as Rights-Bearer*, 14 J.L. & MED. 64 (2006).

⁷⁹ See *Cave*, *supra* note 58, at 94 (the decisions '[offend] the principle that negative autonomy rights (rights to refuse intervention) are stronger than positive autonomy rights'); see also Rachel Taylor, *Reversing the Retreat from Gillick?* R (Axon) v. Secretary of State for Health, 19 CHILD & FAM. L.Q. 81 (2007).

⁸⁰ *Cave*, *supra* note 58, at 99-100.

established in fact,⁸¹ then any law that targets children solely by reason of their childhood is *prima facie* in conflict with the CROC and exceeds the common law formulation of the power, suggesting that the exclusion of *Gillick* is illogical.

If this is accepted, then *X* is wrongly decided, and the language in *Jamie* operates across the spectrum of decision-making. That would mean that courts lose control over children's decision making on a finding of *Gillick* competence. Such an unprecedented radical shift in jurisprudence is unlikely to be met kindly. Ousting the *parens patriae* power entirely prevents the courts from using the child's best interests to restrain a decision.⁸² One can imagine recourse to past practices of stipulating that children had not understood 'enough' the relevant evidence in order to avoid *Gillick* competence, further denigrating their decision-making integrity with the added insult of being labeled 'incompetent' to decide their own fate.⁸³

CONCLUSION

What these two decisions have done is further cloud an already opaque jurisprudence at one of the most emotionally, physically, and spiritually difficult junctures in a person's life. The complexity of challenging a medical decision already required significant and expensive input by doctors, hospitals, lawyers and courts, delaying the treatment process and imposing unnecessary burdens on decision-makers. Now, on one view, it is worse. Until something is done to resolve the conflicts in this area, these problems will continue to abide unchecked. Nor is it fair for judges to be left with this task—where refusals of treatment are concerned, judicial officers have little time to formulate reasons or hear evidence of competency that might sway them to an alternate view, if such a view is socially desirable. What is needed is a legislative response that deals, finally, with questions of consent and refusal and the place of *Gillick* competency in the decision-making framework.

⁸¹ See Williams, Chesterman & Grano, *supra* note 42, at 99.

⁸² In support *Jamie's* holding; see *id.* (courts should bow to a competent child's decision).

⁸³ See Lennings, *supra* note 25, at 139.

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