**MEDICAL LAW – LAWS3152**

***Parens Patriae* Jurisdiction**: Court's power to protect

- **children**,
    - Courts can order treatment against parent's wishes, provided it is in **child's best interest**
- **mentally ill** and
- **disabled/incompetent persons**.

- ~~*IssacMessiha v South East Health*: Court ordered for life support plug to be pulled. (i.e. the court decided it was not appropriate for the court to intervene the doctor's decision to pull the plug.)~~
- ~~*Schiavo Case*: Bush – in US– signed legislation to allow Federal courts to review applications in removing feeding tube. (here, the Federal court refused to recommence feeding tube)~~
- ~~*Krommydas v Sydney West Area Health Services*: Court gave order for respiratory device to be discontinued. (in this case, the patient was legally dead according to Human Tissue Act – 'whole brain death'. Yet the family resisted to apply medical help because they believe he was alive)~~

- Note:
    - If you go to the Guardianship Tribunal (NSW), they will apply under the Guardianship Act.
        - *Guardianship Act* s35(1)(c) recognises that Supreme Court retains it's parens patriae jurisdiction.
    - If you go to the Family Court, they will apply s67ZC.
        - Parents go to Family Court for approval if child is under 18.
        - Thee welfare jurisdiction in the Family Court under s67ZC is only limited to a child of the marriage
    - If you go to the Supreme Court, they will apply the parens patriae jurisdiction.
        - If child is over 18, but mentally incapable, you'd go to the Supreme Court for the parens patriae jurisdiction. (you cannot go to SC for those over 18 and mentally capable)
        - A child outside of the marriage has to depend on the Supreme Court's parens patriae jurisdiction.

**Conflicts between clinicians and parents**:

- Director Clinical Services, Child & Adolescent Health Services and Kiszko [2016] FCWA 75, [92].
    - Fact: parent refusing the child being treated with radioactive treatment or chemo after brain surgery.
    - Held: "The **best interests approach**" offers no hierarchy of values which might guide the exercise of a discretionary power…much less any general legal principle that might direct the difficult decisions to be made". The Court's task is to recognize that the facts in individual cases "may vary almost infinitely, that the enquiry is a positive one tailored to the best interests of the particular child and not children in general, and that [it] is required to take into account all factors which it perceives to be of importance in determining that issue".

**Note about unborn child legal rights:**

- traditionally, unborn child has no legal personality to seek legal protection in medical law. This is **still the case but** there is Crimes Amendment Grievous Bodily Harm Act 2005. It extended the definition of grievous bodily harm to fetal destruction (this was in response to men hurting pregnant women, resulting in harming the fetus).
- Two Bills introduced into upper and lower house:

- Zoe's law 1
- Zoe's law 2: recgonsied fetus of 20weeks or 400g is a living person. Then the **GBH claim** can be brought on in relation to the fetus being the victim (without this bill it means only GBH to the women and not the fetus). But note this bill was not to affect Abortion law or medical procedure. Yet it is controversial in medical law in recognizing fetus with personhood.

**Note case study**: when a white couple was accidently pregnant with black couple's embryo donation.

- *Status of Children Act 1996* s14: Birth mother (the genetic mother does not matter) is presumed to be the legal mother of the child. This **presumption is irrebuttable**. Will not be forced to give up baby regardless of genetic heritage of baby.

s14 Presumptions of parentage arising out of use of fertilisation procedures

- (1) When a married woman has undergone a fertilisation procedure as a result of which she becomes pregnant:
  - (a) her husband is presumed to be the father of any child born as a result of the pregnancy even if he did not provide any or all of the sperm used in the procedure, but only if he consented to the procedure, and
  - (b) the woman is presumed to be the mother of any child born as a result of the pregnancy even if she did not provide the ovum used in the procedure.
- (1A) When a woman who is the de facto partner of another woman has undergone a fertilisation procedure as a result of which she becomes pregnant:
  - (a) the other woman is presumed to be a parent of any child born as a result of the pregnancy, but only if the other woman consented to the procedure, and
  - (b) the woman who has become pregnant is presumed to be the mother of any child born as a result of the pregnancy even if she did not provide the ovum used in the procedure.
- (2) If a woman (whether married or unmarried) becomes pregnant by means of a fertilisation procedure using any sperm obtained from a man who is not her husband, that man is **presumed not** to be the father of any child born as a result of the pregnancy.
- (3) If a woman (whether married or unmarried) becomes pregnant by means of a fertilisation procedure using an ovum obtained from another woman, that other woman is **presumed not** to be the mother of any child born as a result of the pregnancy. This subsection does not affect the presumption arising under subsection (1A) (a).
- (4) Any presumption arising under subsections (1)-(3) is **irrebuttable**.
- (5) In any proceedings in which the operation of subsection (1) is relevant, a husband's consent to the carrying out of the fertilisation procedure is presumed. **(see s15 to rebut presumption)**
- (5A) In any proceedings in which the operation of subsection (1A) is relevant, the consent of a woman to the carrying out of a fertilisation procedure that results in the pregnancy of her de facto partner is presumed. **(see s15 to rebut presumption)**

**15 Rebuttal of parentage presumptions**

(1) A presumption arising under this Division, or a parentage presumption arising under any other Act or rule of law, that is rebuttable, is rebuttable by proof on the balance of probabilities.
(2) Every presumption arising under this Division (except for a presumption arising under section 12 (1) or 14 (1)-(3)) is a rebuttable presumption.

## PROFESSIONAL REGULATION & PROFESSIONAL ETHICS

**Australian Medical Association, *Code of Ethics* (2006)**

- The AMA Code of Ethics articulates and promotes a body of ethical principles to guide doctors' conduct in their relationships with patients, colleagues and society.
- This Code has grown out of other similar ethical codes stretching back into history including the Hippocratic Oath.
- Because of their special knowledge and expertise, doctors have a responsibility to improve and maintain the health of their patients who, either in a vulnerable state of illness or for the maintenance of their health, entrust themselves to medical care.
- The doctor-patient relationship is itself a partnership based on mutual respect and collaboration. Within the partnership, both the doctor and the patient have rights as well as responsibilities.
- Changes in society, science and the law constantly raise new ethical issues and may challenge existing ethical perspectives.
- The AMA accepts the responsibility for setting the standards of ethical behavior expected of doctors.

**Professional regulation of the medical profession**

- National scheme that applies to NSW.
- Along with Acts in other states establishes Australian Health Practitioner Regulation Agency
    - Investigative function - into registration, performance and suitability of practitioners
    - However, in **NSW** this function carried out by **state-based councils and health care commission**
- **Health Practitioner Regulation National Law (NSW) No. 86a:**

- S3: Objective is to establish a national registration and accreditation scheme for **doctors** and medical **students**; to facilitate mobility within Australia and to protect the public with suitable and qualified practitioners; the ethical and professional standards.
- S31: establishment of National Boards for the health professions
    - (e.g. Medical Board of Australia regulates the medical profession, Dental Board of Australia)
    - (**there are also State versions** of these Boards such as NSW Board of Medical Board of Australia)
- S35: Functions of National Boards: register competent persons, decide the requirements for registration or endorsement of registration in the health profession, develop standards/codes/guidelines, approve accredited programs of studies, oversee assessment of knowledge and clinical skills of overseas trained applicants for registration in the health profession whose qualifications are not approved qualifications for the profession.
- S38: National Board must develop registration standards

> (1) A National Board must develop and recommend to the Ministerial Council one or more registration standards about the following matters for the health profession for which the Board is established—
>
> > (a) requirements for professional indemnity insurance arrangements for registered health practitioners registered in the profession;

(b) matters about the criminal history of applicants for registration in the profession, and registered health practitioners and students registered by the Board, including, the matters to be considered in deciding whether an individual's criminal history is relevant to the practice of the profession;

(c) requirements for continuing professional development for registered health practitioners registered in the profession;

(d) requirements about the English language skills necessary for an applicant for registration in the profession to be suitable for registration in the profession;

(e) requirements in relation to the nature, extent, period and recency of any previous practice of the profession by applicants for registration in the profession.

(2) Subject to subsection (3), a National Board may also develop, and recommend to the Ministerial Council, one or more registration standards about the following—

(a) the physical and mental health of—

(i) applicants for registration in the profession; and

(ii) registered health practitioners and students;

(b) the scope of practice of health practitioners registered in the profession;

(c) any other issue relevant to the eligibility of individuals for registration in the profession or the suitability of individuals to competently and safely practise the profession.

- s39 A National Board may develop and approve codes and guidelines-
  (a) to provide guidance to the health practitioners it registers; and
  (b) about other matters relevant to the exercise of its functions.

  **Example:** Good medical practice: a code of conduct for doctors in Australia – made by Medical Boards.

  **Example:** A National Board may develop guidelines about the advertising of regulated health services by health practitioners registered by the Board or other persons for the purposes of section 133.
- S41:an approved registration standard for a health profession, or a Code or guideline approved by National Board, is admissible to show what constitutes appropriate behavior for medical profession.
- S41B: NSW State based function: state based councils **can hear complaints** to health practitioners and notifications.
  - In NSW, the NSW Medical Council (not Board) is established under s41B, and the Healthcare Complains Commission.
- s144B **Who can make complaint**
  - (1) Any person can make a complaint (i.e. including director general of health, state based councils)
  - (2) A complaint may also be made by a Council or the Secretary
- S144 **Grounds for complaint** about registered health practitioner [NSW]
  - This is not a medical negligence, which is for monetary compensation.

        - This is professional disciplinary complaint, which is to protect the society from rogue doctors
    - The following complaints may be made about a registered health practitioner-
        - (a) A complaint the practitioner has, either in this jurisdiction or elsewhere, been convicted of or made the subject of a criminal finding for an offence.
        - (b) A complaint the practitioner has been guilty of
            - unsatisfactory professional conduct
                - s139B(1),
                    - (a) Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience. – this could also take the form of a law suit
                    - (b) A contravention by the practitioner (whether by act or omission) of a provision of this Law, or the regulations under this Law or under the NSW regulations, whether or not the practitioner has been prosecuted for or convicted of an offence in respect of the contravention
                    - (j) Engaging in over servicing
                    - (l) Any other improper or unethical conduct relating to the practice or purported practice of the practitioner's profession
                - s139C(b) – assisting or enabling non-qualified person to engage in surgery/medical practice
                - s139C(c) –Refusing or failing, without reasonable cause, to attend (within a reasonable time after being requested to do so) on a person for the purpose of rendering professional services in the capacity of a medical practitioner if the practitioner has reasonable cause to believe the person is in need of urgent attention by a medical practitioner, unless the practitioner has taken all reasonable steps to ensure that another medical practitioner attends instead within a reasonable time –
                    - **i.e.** ethical obligation on doctors to render assistance in an emergency failing or refusing without reasonable care in emergency – this relates to Module 3 as well for medical **negligence claim, here it is regulatory claim.**
            - professional misconduct
                - s139E:
                - (a) it means unsatisfactory professional conduct that is sufficiently serious, and result in suspension/de-registration of doctor's licence.
                - (b) more than one instance of unsatisfactory professional conduct that, when the instances are considered together, amount to conduct of a sufficiently serious nature to justify suspension or cancellation of the practitioner's registration

**c.f.** s140~s143A: **notifiable conduct**: in Module 3:
refers to statutory obligations of health professionals to notify the suspicions of notifiable conduct. This is a **positive obligation (s141)** and thus it is different to professional misconduct/unsatisfactory conduct which are merely complaints

- (a) practised the practitioner's profession while intoxicated by alcohol or drugs
- (b) engaged in sexual misconduct in connection with the practice of the practitioner's profession
- (c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment
- (d) placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards
- (c) A complaint the practitioner is **not competent (s139)** to practice the practitioner's profession.
    - S139: A person is "competent" to practice a health profession only if the person
        - a) has sufficient physical capacity, mental capacity, knowledge and skill to practise the profession; and
        - b) has sufficient communication skills for the practice of the profession, including an adequate command of the English language.
- (d) A complaint the practitioner has an impairment.
- (e) A complaint the practitioner is otherwise not a suitable person to hold registration in the practitioner's profession.

- S145B&145C: actions that **Health Care Complaint Commission** and N**SW Medical Council** can take. Serious matters that are grounds for de-registration are referred to tribunal under s145D.

**145C Courses of action available to the Commission on complaint [NSW]**
(1) The following courses of action are available to the Commission in respect of a complaint made to the Commission, or that the Commission has decided to make, about a registered health practitioner or student-

(a) the Commission may refer the complaint to the Council for the health profession in which the practitioner or student is registered or, after consultation with a Council, to a Committee or the Tribunal;
(b) the Commission may refer the complaint for conciliation or deal with the complaint under Division 9 of Part 2 of the Health Care Complaints Act 1993 ;
(c) the Commission may refer the complaint to another entity, including, for example, a National Board;
(d) the Commission may determine that no further action should be taken in respect of the complaint;
(e) the Commission may take any other action that it can take under the Health Care Complaints Act 1993 .

(2) If the Commission refers a complaint to a Committee or the Tribunal, the Commission must inform the Council accordingly

**145B Courses of action available to Council on complaint [NSW]**
(1) The following courses of action are available to a Council in respect of a complaint-
(a) the Council may make any inquiries about the complaint the Council thinks appropriate; (b) the Council may refer the complaint to the Commission for investigation;
(c) the Council may refer the complaint to the Tribunal;
(d) the Council may refer the complaint to a Committee;
(e) for a complaint about a health practitioner or student who is registered in a health profession other than the medical or nursing and midwifery profession, the Council may deal with the complaint by inquiry at a meeting of the Council;
(f) the Council may-

(i) refer the practitioner or student for a health assessment; or

(ii) refer the matter to an Impaired Registrants Panel; or

(iii) refer the professional performance of the practitioner concerned for a performance assessment; (g) the Council may direct the practitioner or student concerned to attend counselling;
(h) the Council may refer the complaint to the Commission for conciliation or to be dealt with under Division 9 of Part 2 of the *Health Care Complaints Act 1993* ;
(i) the Council may refer the complaint to another entity, including, for example, a National Board;
(j) the Council may determine that no further action should be taken in respect of the complaint.
(2) The Commission must, on receipt of a complaint referred by a Council for investigation, investigate the complaint or cause it to be investigated.
(3) If a Council makes a referral under subsection (1)(f), the matter ceases to be a complaint for the purposes of this Law and the *Health Care Complaints Act 1993* .
(4) Subsection (3) ceases to apply in respect of any matter that a Council subsequently deals with as a complaint

**145D Serious complaints must be referred to Tribunal [NSW]**
(1) Both a Council for a health profession and the Commission are under a duty to refer a complaint to the Tribunal if, at any time, either forms the opinion that it may, if substantiated, provide grounds for the suspension or cancellation of a registered health practitioner's or student's registration.
(2) However, either the Council or the Commission may decide not to refer the complaint to the Tribunal if of the opinion the allegations on which the complaint is founded (and on which any other pending complaint against the registered
health practitioner or student is founded) relate solely or principally to-

(a) for a practitioner, the physical or mental capacity of the practitioner to practise the practitioner's profession;
or

(b) for a student, the physical or mental capacity of the student to undertake clinical training in the health profession in which the student is registered.
(3) If the Council decides not to refer the complaint to the Tribunal, the Council must instead refer the complaint to a
Committee or Impaired Registrants Panel.
(4) If the Commission decides not to refer the complaint to the Tribunal, the Commission must instead refer the complaint to the Council.
(5) This section does not require the Council or the Commission to refer a complaint the Council or Commission thinks is frivolous or vexatious

**Case Study:** Problem with cosmetic surgery: all GPs can do surgery even though they do not have the skills or has been adequately trained.

- Patients are recommended to check if the surgeon is a member of the Plastic Surgery Associations.
- Government response: Five pillars for improving regulation of cosmetic procedures
  - Regulation of practitioner registration;
  - Licensing of private health facilities where cosmetic procedures take place;
  - Implementation of infection control measures;
  - Regulation of some of the devices and substances used in cosmetic procedures;
  - And consumer legislation, including specific legislative protections for children.
- Good Medical Practice Code supplemented by the Medical Boards per above s39 to make additional regulations for young people cosmetic surgeries.
  - Eg. 3 months cooling off period (i.e. time to think about the surgery) for cosmetically surgery on children and they need advice from independent psychiatrist.
  - 7 day cooling off for minor procedures like laser clinic.
  - If sedation is required, the medical practitioner must ensure there are trained staff or equipment for the purpose of resuscitation.

## Module 2: CONSENT TO MEDICAL TREATMENT

### Introduction

- Medical Treatment in the Absence of Consent – why is this topic difficult?

(1) difficulty in keeping **separate the different categories of case** where medical treatment decisions need to be made on behalf of an incompetent person:
- children
- intellectually handicapped children
- intellectually handicapped adults
- temporarily incompetent, but normally competent adults
- now permanently incompetent, but once competent adults;

(2) because there are **different sources of law** involved:
- federal law eg Family Law Act 1975 (Cth)
- state law eg Guardianship Act 1987 (NSW)
- common law;

(3) each "source" of law may be relevant to considering different questions:
- who can decide re medical treatment?
- according to what standards/principles?
- what is the role of the Courts?

- **Secretary, Department of Health and Community Services v JWB and SMB (1992) 175 CLR 218 ("Marion's case")**

- **General principle:** Medical treatment involves the intentional infliction of physical force upon the body. Medical treatment is therefore, prima facie, an assault, absent a valid consent to that treatment.
- **Exceptions to the general principle**
  - **Unlawful contact despite consent**
    - AG reference (No 6 of 1980): unregulated fights (consent to fight does not help if you intend to cause bodily harm) (public interest justifies boxing sport)
    - Euthanasia: illegal despite consent (*Rights of Terminally Ill Act 1995*)
    - R v Brown 1993: Sado-masochism – the court said that it was not in the public interest to allow such consent as defence of bodily harm.
    - Certain surgeries: e.g. transgender surgery
  - **Lawful contact despite absence of consent**
    - Lawful arrests
    - Self-defence
    - Physical contact from exigencies of everyday life (jostling)
    - Certain medical treatment (necessity)
    - surgical intervention may be **authorised without incompetent patient (adult/child) consent**.
      - 1 Temporary Incapacity
        - eg emergency situations
      - 2 Children (ie patients who are "developing" capacity)
        - the **starting point** is the parent/guardians to get parental consents – **subject to best interest of the child.**
        - It not just because they are parent but because they are 'guardians' of the child.
        - children can sometimes give consent for simple procedures
      - 3 Permanently Incompetent Patients (mentally handicapped):
        - **Re Marion** falls into this category.
      - 4 Patients Who Were Once Competent But are No Longer:
        - relevant to end-of-life decision-making.
    - Note any medical treatment of an **adult with full mental capacity does not come into any of the exceptions.**

- **Re B case**: court upheld the right of a women, oxygen supply dependent quadriplegic women, to have the ventilation removed which would cause her to die from suffocation. The patient had full mental capacity/competence to **refuse** the treatment. The doctors should not confuse with the question of mental capacity with the nature of the decision made by the patient however grave the consequence because there is difference is value rather than absence of competence.

**Consent to medical treatment involving minors/children**

- ***Family Law Act 1975* (Cth) s61B-61C**:
  - the **parent's power to consent** to medical treatment on behalf of the child **ceases at 18**.
- ***Common law***
  - **General principle**: The rights of **parents as guardians** are "dwindling rights" which "exists only so long as they are needed for the protection of the person and property of the child" – **Deane J, *Re Marion case 1992*.**
    - *Gillick v West Norfolk AHA 1986*: A **minor is capable of giving informed consent** if he has sufficient understanding and intelligence to enable him/her to understand fully what is proposed.
      - This means a doctor doing all it can such as cooling-off period etc, but then the court disapproves of the doctor's practice and then the doctor can be held liable for trespass.
      - Note the other side of the coin: **If a child is old enough** to consent to a treatment, then would it be a **breach of confidentiality** to involve parent at all.
        - Example: if the child has come alone to the doctor (e.g catholic parents seeking declaration from the court that their daughters will not be given contraceptive advices without parent knowing). This is an **unanswered question**.
    - **HCA approves** of this view.
  - Under common law, **if the child is not competent** to decide matters themselves, the court applies the **best interest test** to determine whether medical treatment on child is lawful.
    - **General Principle**: where a child is incapable of giving valid consent to medical treatment, parents, as guardians, may consent to medical treatment performed on the child in a wide range of circumstances. However, in exercising their rights as guardians over children, **parents must act in the best interests of the child** (But should be a step of last resort – all alternative and less invasive methods must have failed; certain that no other procedure will work)

➢ **Consent to medical treatment upon Intellectually Handicapped Children**

- **General principle**: **Re Marion**
  - it should not be presumed that they are incapable of consent to medical treatment. It depends on their competence, age, maturity and capability.
    - i.e. not presumed to be not Gilick competent
    - i.e. it will depend upon the rate of development of each individual
  - E.g. **Re C** for 'refusal' of mentally ill **adult**
- ***Re Marion case 1992*: leading case on medical consent in AU.**
  - Fact: Marion was a 14-year-old, suffered from mental retardation, behaviour problem. Parents apply an order **from court** for **sterilisation** of mentally incapable patient.
  - Issues:
    - Could Marion's parents as joined guardians lawfully authorise the surgery **without court order**? No

- If no, does Family Court have jurisdiction to order it? Yes
  - Parens patriae-for Supreme Court,
  - Welfare Jurisdcition s67ZC-for Family Court

- Held: **court approval rather than parental approval** is required for **sterilisation** of a **child for non-therapeutic (i.e. non-incidental to treatment) purposes**.
  - **Majority** (Deane J and McHugh J) favoured the best interest principle to determine if the medical treatment would be lawful for the child applied for the parent's application
    - If it was a **therapeutic (i**.e. incidental result of another surgery to cure disease) sterilisation – then the parent would have the authority (i.e. without court order) to require such sterilisation, but only if it is in the best interest of the child.
    - Here it was for cosmetic purposes i.e. **non-therapeutic**, then the parents do not have the authority to consent on behalf of the child and **must** get court approval.
      - i.e. the decision to sterilize an intellectually disabled minor falls outside the ordinary scope of parental powers/guardian ~~under s 63E~~
  - **Majority**: There are features of a sterilisation procedure which indicate in order to ensure the best protection of the interests of the child, a decision should not come within the ordinary scope of medical treatment. Court authorization is a procedural safeguard
  - **Brennan J rejected** the best interest test – as it fails to identify the factors of 'best interest'. This means depending on the values of the decision-maker (i.e. the judge), the best interest can be shaped differently. Brennan J proposes a new test by distinguishing treatments in terms of: 1. What is the purpose of the treatment? 2. Is the treatment proportionate?
    - Therapeutic treatments: Administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition, or a psychiatric disorder, provided the treatment is appropriate for and proportionate to the purpose for which it is administered
    - Non-therapeutic treatment: Treatment which is (a) disproportionate to the cosmetic deformity or (b) when administered chiefly for other purposes.
  - Brennan J: does the **Family court** have **jurisdiction** to authorise sterilisation?
    - Court's role is limited to declaring parents are exercising their powers in a lawful way
      - Where there is a doubt about the therapeutic character of a proposed procedure, those who would be involved in the procedure may be at risk if they act merely upon a purported authorization given by the parent or other guardian
      - Necessary in a doubtful case to obtain an affirmative declaration from a court in order to safeguard those involved
      - Exercise of parent's power to authorise therapeutic sterilisation is subject to supervision by court in pp jurisdiction. Court exercising pp has no wider power than parents or guardians possess
    - For non-therapeutic
      - Courts have no further power than parents to authorise non-therapeutic sterilization

- In particular, ss. 63(1) and 64(1) of the Family Law Act do not suggest that the Court has been invested with a power to authorize an invasion of the personal integrity of a child greater than the power possessed by the child's custodians or guardians

- **X v Sydney Children's hospitals Network [2013]**
  - Principle: Even if a child is competent, a parent/guardian or other interest parties may nevertheless apply to the court to overturn the minor's decision.
  - Jehovah's minor refusing for blood transfusion. They were old/competent (but below age of 18) enough to understand the nature of effect and consequence of the treatment. The court using the **Parens Patriae Jurisdiction** then **overturn** the mature minor's decision.
  - **But if they are over 18 and competent**, they can make their own mind up.

- ***Legislation that regulates medical decision making involving minors***

Legislation regulates a minor's capacity to consent to medical treatment (and may displace the common law, subject to a possible right in a guardian to obtain an injunction restraining a minor from exercising statutory rights to consent). However, where legislation doesn't exist, or otherwise apply, the general principle applies.

- ***Minors (Property and Contracts) Act 1970***
  - S49(1): Where medical/dental treatment of a minor aged **less than 16 years** is carried out with the **prior consent of a parent/guardian** of the minor, the consent **has effect** in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, the minor was aged 21 years or upwards and had authorized the giving of the consent.
    - **i.e.** parental or guardian consent for medical or dental treatment of a minor less than 16 is a good consent that defeats any claim of battery by the minor later on.
    - Effect of this section: giving certainty for doctors in who has the right to consent.
  - S49(2): **prior consent of a child** aged **14 and above** for medical/dental procedure can be taken to have effect as consent were given when the child was 21 or upwards in relation to claim for assault or battery. (this also gives certainty to the doctors)
- ***Children and Young Persons (Care and Protection) Act 1998 (NSW):*** Deals with children (define under **s3** under this Act) **15 years or less (i.e under 16)**:
  - S173: **Director General** or police officer may serve a notice requiring a child to be presented to medical practitioner if believes on reasonable ground that the child requires care or protection.
  - S174:
    - (1) Medical practitioner may carry out medical treatment on child without consent if of opinion that **it is necessary, as a matter of urgency/emergency**, to carry out treatment in order to **save his/her life** or to **prevent serious damage** to his/her health.
    - (3) Medical or dental treatment carried out on a child or young person under this section is taken, for all purposes, to have been carried out with the consent of
      - (a) in the case of a child-a parent of the child, or
      - (b) in the case of a young person-the young person
    - (4) Nothing in this section relieves a medical practitioner or registered dentist from liability in respect of the carrying out of medical or dental treatment on a child or young person, being a liability to which the

medical practitioner or dentist would have been subject had the treatment been carried out with the consent

- S175(1): must not carry out special medical treatment otherwise than in accordance with provision.
  - special medical treatment defined under s175(5)
    - e.g. treatment intended or reasonably likely to make the child permanently infertile=**sterilization**.
    - E.g. administration of drug addiction, experimental procedures not following the ethical guideline, vasectomy or tubal occlusion
- S175(2): May carry out special medical treatment if:
  - (a) Medical practitioner is of the opinion that it is **necessary, as a matter of urgency**, to carry out treatment in order to save his/her life or to prevent serious damage to his/her health; or
  - (b) Civil and Administrative Tribunal gives authorization over certain special medical treatment. Tribunal shall not authorize unless it is necessary to save child's life or prevent serious damage to the child's psychological or physical health (s175ss3).
  - (c) Consent is granted in accordance with the regulations
- Note: **Conflict between common law and legislation:**
  - under common law this case did not allow parent's consent for non-therapeutic sterilization but you can go to the Family court where it can give consent in its Welfare jurisdiction – Family Law Act s67ZC.
  - But, with this Children and Young Persons Act 1998 s175, there are exceptions given under s175(2).

- **Guardianship Act 1987**
  - S34: This part applies to a patient who is **of or above the age of 16 and incapable** of giving consent.
  - S44(1) If, after conducting a hearing into an application for consent to the carrying out of medical or dental treatment on a patient to whom this Part applies, the Tribunal is satisfied that it is appropriate for the treatment to be carried out, it may consent to the carrying out of the treatment.
  - S45 (1) The Tribunal must not give consent to the carrying out of medical or dental treatment on a patient to whom this Part applies unless the Tribunal is satisfied that the treatment is the most appropriate form of treatment for promoting and maintaining the patient's health and well-being.
  - S45 (2): Also restricts special medical/dental procedures (defined under s33 – includes **sterilization**) upon unless you get authority from Civil and Admin Tribunal.
    - The Tribunal will not give consent unless it is necessary to carry out the procedure in order to save life or prevent serious harm.

- Note:
  - If you go to the Guardianship Tribunal (NSW), they will apply under the Guardianship Act.
    - *Guardianship Act* s35(1)(c) recognises that Supreme Court retains it's parens patriae jurisdiction.
  - If you go to the Family Court, they will apply s67ZC.
    - Parents go to Family Court for approval if child is under 18.
    - Thee welfare jurisdiction in the Family Court under s67ZC is only limited to a child of the marriage
  - If you go to the Supreme Court, they will apply the parens patriae jurisdiction.
    - If child is over 18, but mentally incapable, you'd go to the Supreme Court for the parens patriae jurisdiction.
      - (you cannot go to SC for those over 18 and mentally capable)

- A child outside of the marriage has to depend on the Supreme Court's parens patriae jurisdiction.

## ➢ **Sterilisation**

- **Is this a special case?** So that sterlisation is outside the scope of a parent to consent to on behalf of the child? Yes, for non-therapeutic sterilization – i.e. to simply render someone infertile.
  - c.f. therapeutic sterilization: which are **byproduct of surgery** which are appropriately carried out to treat some disease)
- **Justification for court's approval is required** for non-therapeutic sterlisation:
  - Court authorisation is a necessary, procedural safeguard to ensuring that sterilisation is really in the child's best interests
    - Sterilisation requires invasive, irreversible and major surgery.
    - Significant risk that the wrong decision will be made about the child's present or future capacity to consent;
    - Significant risk that the wrong decision will be made about what are the best interests of the child;
    - The consequences of a wrong decision are particularly grave.
- **Common Law**:
  - ***Re Marion case 1992*****:** Parents consent, (subject to the presumably child's best interest? My idea), only extends to **incidental/therapeutic (i.e. meaning given by the majority, NOT Brennan J)** treatments. **Non-incidental sterilsation** is **outside** the parent's scope of consent and **court consent is required**
    - The HC concluded that the **Family Court has jurisdiction to authorize sterilization** under s64(1)(c) of the ***Family Law Act*** which gave the Ct power to make such orders as it considers proper in proceedings with respect to the custody, guardianship or welfare of or access to a child. **S64 has now been repealed**. Power exists under **welfare jurisdiction in s67ZC**.
      - Family Court's welfare jurisdiction similar to parens patriae jurisdiction.
    - **Majority view**: It is to decide whether, in the circumstances of the case, that is in the best interest of the child. The court's approval or refusal is contained in a declaration which can be supported by injunction if necessary
    - **Dissenting view**: because it is not always that you need court's approval depending on some factors:
      - **Brennan** J: Court only has a role in declaring that the parents are exercising their power in a lawful way - ie whether that sterilisation was **therapeutic** in the circumstances
        - Ct role limited to considering PURPOSE and PROPORTIONALITY, then there is no need of court' s approval.
        - He doubted parents or courts had authority to authorise a **non therapeutic** sterilization itself.
      - **Deane** J: Parents have power to consent to sterilisation without Court approval where sterilisation is, according to general community standards, obviously necessary for the welfare of the child.
        - Parental power can only validly be exercised after **due inquiry** about what truly represents the **welfare of the child** - this requires a Ct hearing. Ct can grant declaratory relief assuring parents they are acting legally.
        - The Ct can intervene to override a parental refusal to authorise surgery in appropriate cases.
        - Note: sterilisation can never be for the welfare of the child merely to avoid pregnancy. Although if the child has no understanding of sexual relationship and no other way of contraceptive method that

is reasonably foreseeable, sterilisation might be justified with welfare, without such welfare jurisdiction court cannot intervene.

- **McHugh** J: Parents have the right to consent to sterilisation where the child's welfare justifies this.
    - Necessary for protection of the physical or mental health of the child, or to alleviate pain, fear or discomfort of such severity, duration and regularity that is not reasonable for a child to bear.
    - Required to eliminate a real risk of a child become pregnant if she does not/never will understand sexual relationship or pregnancy.
    - Analogous purposes.
    - Cannot authorise if procedure can be avoided by means less drastic than sterilisation
    - Where for reasons of conflict of interest the parents can't decide, the Court, with PP jurisdiction, can decide in substitution for the parents, and may declare the lawfulness of the parents' decision

- ***Re Angela (Special Medical Procedure) [2010]*:** 12 years old who had Rett syndrome (neurology disease that cause severe intellectual and physical impairment of epilepsy. The girl can't talk or use sign language and her level of development is like 3 months old baby (can't feed herself…).
    - Best interest of the child (also it is a Therapeutic sterilization): Procedure to stop bleeding and susceptibility to seizures from Rett Syndrome leading to sterilization.
    - Family Court (welfare jurisdiction) - Crennan J approved it on basis of that it affected quality of life.

- **Legislation**:
    - s175 Children and Young Persons (Care and Protection) Act. i.*e.* **Tribunal consent is required** – see above.,