



Medico-Legal Journal of Ireland 2015, 21(2), 65-75

## Medico-Legal Journal of Ireland

2015

### \*65 Time for Legislative Clarity on Consent to Medical Treatment: Children, Young People and the “Mature Minor”

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Subject: Health

Keywords: Children; Consent; Gillick competence; Ireland; Medical treatment; Minors;

#### Introduction

Despite recent calls for legislative change in the area, the law in relation to consent to medical treatment for those under the age of 18 in Ireland remains unfortunately, and perhaps dangerously, murky. This article proposes to analyse the law in relation to three categories of “children”, looking first at proxy consent for young children, secondly at consent for those aged 16 and 17, and finally at the possibility of a Gillick-type consent process in this jurisdiction, that is, consent for sufficiently mature under-16s. We will ultimately argue that, rather than addressing this issue on a piecemeal basis through various pieces of legislation, the time has come for a single Act which definitively provides for statutory clarity in this area.

#### General Principles

For the purposes of clarity, it is important to note at the outset that it is generally accepted that the constitutional rights which are afforded to parents in respect of their children under Arts 41 and 42 of the Constitution apply until children reach the age of majority—that is, 18 years of age.<sup>1</sup> However, as the Law Reform Commission observes, “at various points, in particular through the teenage years, children and young people develop increasingly sophisticated cognitive capacity and related decision-making judgement”.<sup>2</sup> Simply put, the rules and policies in relation to medical decision-making for two-year-old infants cannot apply to 17-year-olds on the cusp of adulthood.

Similarly, in considering medical decision-making, we cannot but refer to statutory principles which are tangentially, but no less importantly, linked to medical law. So, for example, when looking at proxy decision-making, we must consider principles of family law, and in particular the rights and responsibilities of parents who, for whatever reason, may not necessarily agree on what course of treatment is appropriate. Similarly, in the context of older minors, we cannot but consider medical decision-making in relation to, for example, contraception, without keeping in mind the fact that the age of consent to sexual intercourse is 17 under the Criminal Law (Sexual Offences) Act 2006.<sup>3</sup> Equally too we have to be mindful of the provisions of the Mental Health Act 2001 in so far as they concern the involuntary admission of children.<sup>4</sup> Legal principles aside, we must also understand that “medical treatment” refers to everything from administering low doses of pain relief to seriously invasive treatments, as well as the refusal of such treatments. In short, in this area of law, perhaps more than most, we cannot assume that one principle can apply across all age groups, or across all types of medical practice. In this context, art.12 of the United Nations Convention on the Rights of the Child states:

States Parties shall assure to the child who is capable of forming his or her own view the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Kaplan argues forcefully that this article establishes that, in the context of medical treatment, “children must be imparted with rights in accordance with their varying stages of development, and hence, the legal weight attached to their opinions will be related to an objective factor, their age, and a subjective factor, their intellectual maturity”.<sup>5</sup>

These concerns accepted, there are a number of general guidelines and principles which guide medical practitioners when they are treating anyone under the age of 18. The HSE's National Consent Policy<sup>6</sup> states at the outset that in any matter relating to children, the child's best interests are of paramount importance, and advocates for an approach which “involves putting the interests and wellbeing of the child at the centre of all decisions and ensuring that the child's own voice is heard and respected as far as possible”.<sup>7</sup> Developing on this, the Policy recognises that there is a crucial difference between involving a child in the decision-making process on the one hand, and the child consenting to medical treatment on the other:

“[E]ven where children are unable to give a valid consent for themselves, they should nonetheless be as involved as possible in decision-making as even young children may have opinions about their healthcare and have the right to have their views taken into consideration by giving their assent to the proposed treatment or service.”<sup>8</sup>

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This position is reflected in the Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners, which states:

“Children and young people should be involved as much as possible in discussions about their healthcare. When you are talking to a child or young person, it is important to give them information in an age-appropriate manner, listen to their views and treat them with respect.”<sup>9</sup>

Generally speaking, then, while it is acknowledged that children and young people may not have the legal capacity to consent to treatment in all circumstances, they should nonetheless be involved in the decision-making process in so far as is possible.<sup>10</sup> In this regard, Kilkelly and Donnelly's work on the child's right to be heard in the healthcare setting is of fundamental importance.<sup>11</sup> Here we will assess decision-making capacity in three contexts: the young child and proxy consent; young adults (16 and 17-year-olds); and the “mature minor” under 16.

## The Young Child and Proxy Consent

As the Law Reform Commission notes in its recent Report, *Children and the Law: Medical Treatment*,<sup>12</sup> in respect of very young children, as parents and guardians are generally accountable for their safety and welfare, they make all major decisions on behalf of those children.<sup>13</sup> In the context of medical decision-making, these decisions will, in general, be upheld, “even if this is in conflict with the views of professional persons”.<sup>14</sup>

No such position is, however, absolute, and this proxy power is not unlimited. As was argued in *Department of Health and Community Services v JWB and SMB*,<sup>15</sup> “the power [of parents to consent to the medical treatment of a child] does not extend to, for example, the right to have a child's foot cut off so that he or she could earn money begging”.<sup>16</sup> Closer to home, this position is evidenced in the seminal case of *North Western Health Board v W*.<sup>17</sup> Here, the parents of a young child refused consent for the performance of a PKU test.<sup>18</sup> While the performance of the test, according to the Supreme Court, was “unquestionably in the best interests of the infant”,<sup>19</sup> the court upheld the parents' refusal, stating that the Constitution protected the institution of the family to the extent that parents were constitutionally permitted to make what might be considered unwise medical decisions in relation to their child. According to Murphy J., before the State could intervene, a situation would have to arise

“where either the general conduct or circumstances of the parent is such as to constitute a virtual abdication of their responsibility or alternatively, the disastrous consequences of a particular parental decision are so immediate and inevitable as to demand intervention and

perhaps call into question either the basic competence or devotion of the parents”.<sup>20</sup>

Thus, it would seem according to this decision that parental autonomy in this regard is almost sacrosanct, with Hardiman J. indicating that parents' proxy decision-making capabilities could only be overturned where there were “countervailing constitutional considerations, or perhaps in the case of an immediate threat to the life of the child”. The case has, however, been criticised for “attaching no weight to the autonomous right of the child to have his health, life and welfare protected”.<sup>21</sup> Indeed, Keane C.J. (dissenting) took the view that the parents had refused to protect the child's constitutional right “to be guarded against unnecessary and avoidable dangers” to his health, and that the court should intervene in the child's best interests.<sup>22</sup>

An example of a case in which parental refusal to treat was overturned is *Re Baby B: Temple Street v D*.<sup>23</sup> This case concerned a baby who was very unwell and required a blood transfusion. The parents, as Jehovah's Witnesses, refused to consent to this transfusion and the hospital sought an order to override the refusal of consent. Referring to Arts 41 and 42 of the Constitution, and in particular Art.42.5, Hogan J., while clearly acknowledging that the parents had not “failed” in their duty to their child in any real sense of the term, stated that, from a constitutional perspective, the test of whether parents have “failed” is “an objective one judged by the secular standards of society in general and of the Constitution in particular, irrespective of their own subjective religious views”.<sup>24</sup> Based on the jurisdiction of the court under Art.40.3.2°, the court granted a declaration that it was lawful to administer the blood transfusion in the case.

An interesting case in this regard is *HSE v F*.<sup>25</sup> Here, a woman living with the HIV virus refused to take antiretroviral medications during the course of her pregnancy, and stated that she did not intend to consent to the administration of such medications on behalf of the child following its birth. Importantly, the administration of such medications was not sought in an effort to protect the life of the child, but rather to protect his or her health. Broughton reports that Birmingham J. ruled that the child was to receive “such medical treatment as may in [his/her] treating doctors' opinion be necessary”, including, “but not limited to”, medical treatments which would reduce the risk of the transmission of the HIV virus from the woman to her child.<sup>26</sup> Broughton observes:

“Birmingham J. expressed the view that if there was a substantial body of opinion amongst medical professionals voicing concerns about the drugs, even if it were a minority, he would have \*67 come down in favour of the mother. However, on balance, the judge, who spoke of the significant and superior position of the family under the Irish Constitution, believed that the risk of the child not being treated was greater than the risks posed by the drugs, and ruled accordingly.”<sup>27</sup>

Broughton quite rightly points out that this case lies between the *W* case and the *Baby B* case: “The risk of the death of the child without the treatment is not as remote as in the *PKU* case, yet it is not nearly as imminent and serious as it would be in the case of the need for an immediate blood transfusion.”<sup>28</sup> She refers to an exception mentioned in the *W* case by Hardiman J. in the context of the control of infectious and/or communicable diseases, but these exceptions are statutory ones, and indeed ones which have not yet been legislated for.<sup>29</sup> It would appear that this case marks a new departure in law: deferring to the views of the medical profession as to what constitutes the best interests of a child over those of a parent.

## When Parents/Guardians Disagree

Where parents agree, the situation seems to be that, unless the refusal of treatment would place the life or health of the child at immediate and serious risk, such a refusal will be respected by medical practitioners. However, the established case law deals with the general position which assumes that parents and guardians will always agree on what constitutes the appropriate medical care for their child. This, of course, is not always the case. This question has been obliquely referred to in cases of joint guardianship under s.11 of the Guardianship of Infants Act 1964 (the “1964 Act”) where, for example, it has been held that while day-to-day matters can be decided unilaterally by the custodial parent, the non-custodial parent has a right to be consulted in relation to “welfare matters of importance”.<sup>30</sup> Where parents disagree, it may be necessary to apply to the court under s.11(1) of the 1964 Act.<sup>31</sup>

At the Heads of Bill stage of the Children and Family Relationships Act 2015 (the “2015 Act”),

Head 36 sought to clarify this position, and provided that, in general, when exercising any duties, powers, rights or responsibilities in relation to a child, any guardian should “act jointly (in particular by consulting wherever practicable with the aim of securing agreement) with any other guardian of the child”. Head 36(5)(b) continued by stating that each guardian has the responsibility to “ensure the child is properly maintained and supported and is provided with necessary medical care...”. In this context, each guardian was given the power to “consent to medical, dental and other health related treatment for the child”, a power they must exercise, according to Head 36(7), “in a manner consistent with the age and maturity and evolving capacity of the child”. An application for a review of any “significant decision” by a guardian could be made to a court under Head 45(1) by a guardian “or any person”. A “significant decision” means a decision which:

- (a) (a) could seriously damage or cause a serious risk to the health or safety of a child, or
- (b) (b) is likely to have serious long-term consequences for the child.<sup>32</sup>

Additionally, any guardian of a child could apply to the court under Head 45(3) “for its direction on any question affecting the welfare of the child and the court may make such order as it thinks proper”, a procedure similar to that found in the current s.11 of the 1964 Act.

It seems, then, that the Heads of the new Bill<sup>33</sup> provided for a more consultative and engaged decision-making process in the context of child welfare, and, particularly, medical decision-making. There was an obligation on guardians to act jointly in exercising their duties under Head 36(1), and the non-custodial guardian continued to exercise the same rights as the custodial guardian.

However, these provisions did not form part of the Bill as initiated. At Committee Stage, Deputy Alan Shatter pointed out that Head 36 and its subheads had been “based on best practice in other jurisdictions” and that they “helped to create an ethos in which the courts would encourage co-operation between estranged parents in the interests of children”.<sup>34</sup>

The Minister for Justice and Equality, Deputy Frances Fitzgerald, indicated to Deputy Shatter that the reason Head 36 was not included was because the legal advice the Government received was that if they drafted the legislation in a “stronger way”, it would “cast into doubt the right of the guardian to make any decision unilaterally”.<sup>35</sup>

It remains the case, therefore, and somewhat unsatisfactorily, that a guardian still applies under s.11 of the 1964 Act for direction in the event of a disagreement with another guardian in relation to medical treatment. What is interesting in this regard is that, under s.3(1) of the current 1964 Act, in making a decision under s.11(1) of that Act, the court must consider the “welfare” of the child. Section 45 of the 2015 Act changes this test, bringing the legislative position into line with the Constitution following its amendment,<sup>36</sup> and states, in amending s.3 of the 1964 Act, that:

Where, in any proceedings before any court, the—

- (a) (a) guardianship, custody or upbringing of, or access to, a child ...

is in question, the court, in deciding that question, \*68 shall regard the best interests of the child as the paramount consideration.<sup>37</sup>

However, this decision will not be made solely on what is considered the best medical interests of the child, or what the court subjectively believes is in the best interests of the child. Schweppe argues elsewhere that in making decisions such as this, “the court should adopt a test ... which takes parental views and best medical practice into account, but also considers questions such as the religious background of the child ... the extent of the parental opposition, the wishes of the child, where relevant, and the experience of siblings”.<sup>38</sup> This broad approach is reflected in the 2015 Act which, under s.63, inserts a new Part into the 1964 Act—Pt V, entitled “Best Interests of

the Child”—which requires the court to take a multiplicity of factors into account when determining what is in the best interests of the child, including in this context:

- the benefit for the child of having a meaningful relationship with both of the child's parents;
- the ascertainable views of the child concerned, giving due weight to such views having regard to the age and maturity of the child;
- the physical, psychological and emotional needs of the child;
- the history of the child's upbringing and care; and
- the child's religious, spiritual, cultural and linguistic upbringing and needs.

The primacy afforded to a broader best interests test in the 2015 Act is to be welcomed. However, the 2015 Act leaves unanswered the question of whether joint medical decision-making is required in the case of joint guardianship. The HSE's Quality and Patient Safety Division and the HSE's National Immunisation Office both recommended that the “default position in relation to medical consent be one parent/legal guardian consent in line with the HSE National Consent Policy to safeguard the best interests of children”.<sup>39</sup>

This Policy<sup>40</sup> discusses the requirement for joint consent in the context of proxy decision-making concerning a child under the age of 16. The general principle is that parents or guardians can consent to the treatment of such a child, and that such consent can be provided by telephone. On the question of whether joint or individual consent is required, the Policy states that this is a matter of some controversy. The Policy is worth quoting in some length on this issue:

“On the one hand, it may be argued that the consent of both parents/legal guardians is required prior to the treatment of the child on the basis of the rights of the parents/legal guardians in keeping with Article 41 of the Constitution ... and the Guardianship of Infants Act 1964. However, seeking joint parental consent may cause delays in children receiving services and potential logistical difficulties in ensuring that all forms are co-signed ... In addition the requirement for joint consent may be perceived by those parents/legal guardians not in dispute to be bureaucratic.”<sup>41</sup>

There are three points to make on this statement. First, if consent can be given by telephone, any “logistical difficulties” can be overcome without any real difficulty. Secondly, there is absolutely no way for a medical practitioner to determine if parents or guardians are or are not “in dispute”—if they are in such a dispute, it is unlikely that the presenting parent will highlight this fact to the treating physician. Indeed, at a later point in the Policy, it suggests that “[w]here both parents/legal guardians have indicated a wish and willingness to participate fully in decision making for their child, this must be accommodated as far as possible by the service provider”.<sup>42</sup> However, in the absence of any advance directive or signed (and adequately witnessed) statement to this effect, it seems next to impossible to see how this could be put into effect. Finally, and perhaps most importantly, it seems unusual and indeed unwise to suggest that any rights of parents, guardians or indeed children themselves under legislation or the Constitution should be brushed aside for “bureaucratic” reasons.

The reasoning behind this position becomes more clear when we see that the Policy goes on to essentially view any proposal of treatment by a medical practitioner as being in the best interests of the child:

“The acceptance of consent of one parent/legal guardian assumes that the child's welfare is paramount, which is in line with the Child Care Acts 1991 and 2001, and that the Health and Social Care professional is proposing a treatment or intervention in the child's best interests. It also assumes that both of the parents/legal guardians are concerned with the child's

welfare.”<sup>43</sup>

However, if we view best medical interests as but one factor (albeit an important one) in the medical decision-making process, again, this view is untenable. The presumption that the best interests of a child will be that action which is proposed by a medical practitioner fails to take into account the multiplicity of factors outlined in s.63 of the 2015 Act. As we clearly saw in the case of *North Western Health Board v W*, medical best interests may not necessarily equate to the overall best interests of a child. Further, if we view consent as encompassing a right to consent to, but also a right to refuse, medical treatment, the issue becomes even less clear. If the presenting parent/guardian refuses medical treatment, should (or can) a doctor seek consent from \*69 the non-presenting parent in order to ensure that the best interests of the child are secured? As McMahon and Binchy observe, “[i]t will be interesting to see if the recent Children's Right amendment to the Constitution has strengthened the rights of children to be protected from injury or death through the exercise of parental autonomy”.<sup>44</sup>

All that said, the argument made at the Bill stage of the 2015 Act, essentially seeing any general principle which would require joint decision-making for all medical decisions as being unworkable, and potentially causing delays, has merit. If a general practitioner, for example, had to telephone the non-presenting parent or guardian for consent every time he or she examined a child, this would indeed be unworkable and cause unacceptable delays. We would argue that, in the same way that capacity to consent is viewed on a continuum,<sup>45</sup> we could look at medical decision-making processes in a similar manner, which would allow both parental/ guardianship rights, as well as the rights of the child, to be considered commensurate with the age and maturity of the child.

## Consent to Treatment and the Young Person

On its face, the legal situation in relation to 16 and 17-year-olds is less problematic. Section 23 of the Non-Fatal Offences against the Person Act 1997 (the “1997 Act”) governs the law concerning the medical treatment of young people<sup>46</sup> and provides:

- (1) (1) The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as it would be if he or she were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent or guardian.
- (2) (2) In this section, ‘surgical, medical or dental treatment’ includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure (including, in particular, the administration of an anaesthetic) which is ancillary to any treatment as it applies to that treatment.
- (3) (3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

The question is whether s.23 confers an absolute right to consent on 16 and 17-year-olds in the absence of parental consent or knowledge. The Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners<sup>47</sup> simply states that “[p]atients aged 16 years and over are entitled by law to give their own consent to surgical, medical or dental treatment. This entitlement does not apply to other areas such as organ or tissue donation or participation in medical research”.<sup>48</sup>

However, the law in this area is not as clear-cut as the Medical Council outlines. The Law Reform Commission in its Report, *Children and the Law: Medical Treatment*,<sup>49</sup> outlined the issues succinctly:

“[W]hile the decisions in the *McK* case and the *D* case are at least consistent with the view that 16 and 17 year olds often have the capacity to make significant health care decisions,

and that the concept of a 'mature minor' is also consistent with this approach, there is no definitive legal framework that clarifies the respective rights and responsibilities of those under 18, their parents and guardians, still less the health care professionals who come into contact with them."<sup>50</sup>

Discussing s.23 of the 1997 Act, McMahon and Binchy <sup>51</sup> detail the nature of the consent required:

"The section throws no light on what is necessary to constitute such a consent. The reference in sub-s (1) to 'an effective consent' does not refer to the quality of the consent; it merely relates back to the earlier part of the sentence where legal effectiveness is conferred on the consent by reason of the fact of its being provided by the minor. The courts may be disposed to treat the question of the minor's consent as 'one of fact', dependent on the circumstances of the case, including the particular minor's age and maturity (or lack of it) as well as the nature of the medical treatment. It can be predicted that the courts will closely scrutinise elective interventions of a cosmetic nature."<sup>52</sup>

They also note, as we have already observed in relation to proxy consent for young children, that any legislative or policy position in relation to consent to medical treatment cannot be observed without reference to the Constitution: "Articles 41 and 42 of the Constitution recognise the trusteeship role of parents in the upbringing and protection of their children", noting that legislation cannot "subtract" from this constitutional provision, though it can offer clarification on the issue.<sup>53</sup> Another consideration is the recent amendment to the Constitution, Art.42A, in which the State "recognises and affirms the natural and imprescriptible rights of all children". As Walsh J. in the Supreme Court summarised in *G v An Bord Uchtála* <sup>54</sup>:

"The child's natural rights spring primarily from the natural right of every individual to life, to be reared and educated, to liberty, to work, to rest and recreation, to the practice of religion, and to follow his or her conscience ... The child's natural \*70 right to life and all that flows from that right are independent of any right of the parent as such."<sup>55</sup>

Where the constitutional rights of the child and the constitutional rights of the parents/guardians come into conflict, this serves to further underlie the need for legislative clarity in this area. Again, the question of a continuum of treatment arises here. McMahon and Binchy postulate that while a 17-year-old could lawfully consent to, for example, an operation on her broken finger in the absence of parental consent or knowledge, in the case of "serious" medical intervention, where there may be a case that intervention is "not truly for the minor's welfare", the legal position becomes less clear.<sup>56</sup>

The question as to whether proceedings could be brought in relation to treatment in the absence of medical consent remains unclear. On one reading, as McMahon and Binchy note, the section disentitles parents or guardians from taking any steps in relation to the medical treatment of their child. On another reading, however:

"[W]hat s 23 does is to render the consent lawful to the extent that it cannot be regarded as unlawful by reasons merely of the failure to obtain the consent of the parents or guardians. On this latter view, the trusteeship function is not disturbed and parents or guardians remain entitled (to the uncertain extent that they have such an entitlement) to take proceedings in respect of the treatment in the same way as they can with respect to any other lawful activity ... in which their minor child engages."<sup>57</sup>

Quill argues that the position is even muddier—s.23, he observes, certainly provides that the consent of a minor aged 16 or over to medical or dental treatment will provide a defence against a criminal assault charge, but it is not clear whether the 1997 Act also applies to a civil claim; though he admits that one would expect the courts to take some guidance from this in respect of such a claim.<sup>58</sup> Thus, it could be argued that s.23 is not in fact a facilitative section at all; rather, it simply provides a defence for a doctor to a criminal action post-treatment.

In terms of other legislation on the issue of validity of consent, s.4(1)(a) of the Health (Family Planning) (Amendment) Act 1992 further provides that contraceptives may only lawfully be sold to persons over the age of 17 or someone under the age of 17 who has a prescription for contraceptives. Thus, it would appear that a minor over the age of 16 can receive contraceptives

without the need for involvement of his or her parents. Donnelly, however, has argued that it would be contrary to the authority of the family under the Constitution to provide contraceptive treatment to a child aged under 17 without the consent of her parents.<sup>59</sup> On this line of reasoning, there should be no distinction between 16 and 17-year-olds, though Mills makes the point that it is questionable whether the provision of contraceptives amounts to “medical treatment” under the 1997 Act, it “not being a treatment or procedure in the commonly understood sense of the word”.<sup>60</sup> Further, to add to the confusion, the Children First policy issued by the Department of Children and Youth Affairs<sup>61</sup> provides:

“The cooperation of parents/carers should be sought for any examinations and assessment considered necessary. If cooperation is not forthcoming, the possibility of legal action should be considered and conveyed to parents/carers.”<sup>62</sup>

As a child is defined as “a person under the age of 18 years”, this seems to be potentially problematic in the context of 16 and 17-year-olds, though it is unclear as to how the key principle that the age of the child should be taken account of “in all matters and decisions that may affect their lives”<sup>63</sup> interacts with this requirement.

Despite these questions, and the strong constitutional position afforded to the family, in *D v Brennan* (the “Miss D” case),<sup>64</sup> it would appear that the question never arose as to her capacity to consent to medical treatment.<sup>65</sup> The Miss D case was a case in which a 17-year-old in the care of the health board, whose baby had a fatal foetal abnormality, sought permission to travel for the purpose of a termination. From an examination of the newspaper reports, it appears that the only reference to her ability to consent was made by counsel for the unborn, who stated that because Miss D was over 16, she could make her own decisions about medical procedures.<sup>66</sup> However, there were numerous statements by McKechnie J. where he was clearly impressed by Miss D's “courage, integrity and maturity”; perhaps he was applying the common law position<sup>67</sup> in interpreting s.23, i.e. where the minor is mature enough to understand the nature and purpose of the treatment, she can be deemed competent to consent to that treatment. This would follow on from the Supreme Court's statement in *McK v Information Commissioner*,<sup>68</sup> in which an estranged father sought access to his daughter's medical records, that the views of a minor of nearly 18 years of age are “very relevant”.

Because the question seemed moot in the Miss D case—that is, that it was always assumed that Miss D could consent to medical treatment—the question as to the capacity of young people to consent to medical treatment was not advanced any by this judgment. As has been discussed, prior to the decision, it was suspected that were a young person to seek medical treatment, specifically a termination of pregnancy, parental consent (or the consent of the health board) would have to be obtained. In the Miss D case, it<sup>\*71</sup> seemed that she had full capacity to make the decision to terminate her pregnancy without the consent of her mother, and certainly without the consent of the health board.

## Consent to Treatment and the Mature Minor

The question then arises in relation to a young woman under the age of 16, and whether it is lawful to treat or give abortion information to her in the absence of parental consent or knowledge.

The Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners<sup>69</sup> states:

“43.4 Where the patient is under the age of 16 years, it is usual that the parents will be asked to give their consent to medical treatment on the patient's behalf.

43.5 In exceptional circumstances, a patient under 16 might seek to make a healthcare decision on their own without the knowledge or consent of their parents. In such cases you should encourage the patient to involve their parents in the decision, bearing in mind your paramount responsibility to act in the patient's best interests.”

As we have seen, according to s.23 of the 1997 Act, where a young person over the age of 16 is in the care of her parents, a doctor cannot be held criminally liable for providing medical



treatment to her in the absence of parental knowledge or consent. For those under the age of 16, as the Law Reform Commission notes,

“the ‘usual’ position is that parents should be asked for their consent, but ... in ‘exceptional circumstances’ the doctor would ‘encourage’ the under 16 year old to involve their parents, bearing in mind the doctor’s ‘paramount responsibility’ to act in the patient’s best interests”.<sup>70</sup>

The case of *Gillick v West Norfolk and Wisbech Area Health Authority*<sup>71</sup> concerned a mother who sought assurances that her daughters, who were under the age of 16, would not be provided with contraceptive treatment in the absence of her knowledge or consent. Lord Fraser of Tullybelton first considered the contention of Mrs Gillick that, as a result of s.8(1) of the Family Law Reform Act 1969, consent by a minor to medical treatment would be ineffective. He disagreed, being of the opinion that subs.(3) of the same section leaves open the question of whether consent by a minor under the age of 16 would have been effective if the section had not been enacted.<sup>72</sup>

The court then went on to consider whether giving such advice and treatment to a minor under 16 without her parents' consent infringes the parents' rights. Lord Fraser stated that: “Once the rule of the parents' absolute authority over minor children is abandoned, the solution to the problem ... cannot be found by reference to rigid parental rights of what is best for the welfare of the child.”<sup>73</sup> While it would be “most unusual” for a doctor to give contraceptive advice without the knowledge of the girl's parents, Lord Fraser was of the attitude that there would be circumstances where it would be necessary for the doctor to give advice and treatment without the knowledge of the parents. The doctor would have to be satisfied of the following matters before proceeding:

1. 1. that the girl (although under 16 years of age) will understand his advice;
2. 2. that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice;
3. 3. that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment;
4. 4. that unless she receives contraceptive advice or treatment, her physical or mental health or both are likely to suffer;
5. 5. that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.

Lord Scarman stated that parental rights would yield when the child had reached an age where she was capable of understanding, based on her level of knowledge and intelligence.<sup>74</sup>

The question now remains as to whether McKechnie J.'s statements in the *Miss D* case, coupled with the common law and statutory positions, open up an avenue for a *Gillick*-type case in this jurisdiction. Donnelly notes that there are two options open in the interpretation of s.23 of the 1997 Act: the first is facilitative, giving an automatic power to consent to those over 16 but not preventing those under 16 from consenting; and the second is preventative, which prevents all young people aged less than 16 from giving a valid consent.<sup>75</sup>

McMahon and Binchy question whether an Irish court would take the same approach as *Gillick*, and note that it would be difficult for an Irish court to take Donnelly's first facilitative option, cautioning that one should not overlook “the constitutional dimensions of the question”.<sup>76</sup> Tomkin and Hanafin,<sup>77</sup> having discussed *Gillick*, also note that “the presence in the Constitution of Articles 41 and 42 may constitute a barrier to a decision similar to that in the *Gillick* case being arrived at”.<sup>78</sup> Quill agrees that it is “almost inconceivable that any litigation on this topic in Ireland would proceed without resort to constitutional arguments”.<sup>79</sup>

However, Irish legislation outside the context of medical treatment recognises the concept of developing <sup>72</sup> competence,<sup>80</sup> and Mills argues that this, coupled with judicial recognition of personal rights inhering in the child,<sup>81</sup> lends “at least some credence to the argument that decision-making authority wielded by under 16s is consistent with Irish constitutional principles”.<sup>82</sup> Madden notes that the language used in the 1997 Act does not seem to be prohibitive of the under-16 consenting to medical treatment.<sup>83</sup> Duncan also argues that a child has a right to self-determination under the Constitution, as a corollary of his or her right to privacy and bodily integrity—now further strengthened by the express constitutional amendment—and that this may justify the acceptance of the Gillick “mature minor” approach in Irish law.<sup>84</sup> Madden agrees that as a child has the right to privacy and bodily integrity, an argument could be made that the child has the right to consent to, or refuse, medical treatment.<sup>85</sup>

While some writers are in agreement that Gillick could be accepted in Ireland, they question whether contraceptive treatment could ever be provided in the absence of parental consent. Madden, with whom Mills<sup>86</sup> concurs, for example, states:

“It is unclear whether young people under the age of sixteen are ... permitted to give consent, and whether the Irish courts would adopt a principle of individualised assessment of competence similar to Gillick. Whether the courts would distinguish between contraceptive treatment/advice and other medical treatment is open to question<sup>87</sup> given the moral and social connotations involved in this issue in the Irish context.”<sup>88</sup>

Donnelly<sup>89</sup> agrees that it is “at least arguable” that Art.42 of the Constitution would prevent an interpretation of the 1997 Act that would interfere with parental rights to control their children's right to contraceptive treatment. This is an issue which must face doctors on a regular basis, and Donnelly observes that while each doctor's decision will be based on the individual circumstances of the case, “he is hampered in reaching this decision by the absence of clarity in relation to the legal framework that binds him”.<sup>90</sup> The only guidance given to doctors is equally lacking in clarity. The Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners states:

“43.5 In exceptional circumstances, a patient under 16 might seek to make a healthcare decision on their own without the knowledge or consent of their parents. In such cases you should encourage the patient to involve their parents in the decision, bearing in mind your paramount responsibility to act in the patient's best interests.”

Two recent studies which appear in the *Medico-Legal Journal of Ireland*<sup>91</sup> show that there is widespread uncertainty amongst GPs as to what is currently legal in this area. 31.6 per cent of the GP respondents in Dublin in the first study believed that it is currently legal for a girl aged under 16 to be prescribed emergency contraception without parental consent; 38.5 per cent said that it is not legal; and a further 29.9 per cent were uncertain. The majority of those GPs felt legally exposed when dealing with the area of contraception and emergency contraception. In the second study in Cork County and City, 18.3 per cent of GPs surveyed who routinely prescribe contraception to patients would not do so for minors without parental consent; another one-fifth (18.3 per cent) would not require parental consent; and just under two-thirds (63.4 per cent) of GPs stated that it would depend on the individual case. Over two-thirds of GPs felt that 16-17 is the age at which minors are best able to give an informed consent to all forms of medical treatment, including contraception.<sup>92</sup>

## Refusal of Medical Treatment for the Young Person, and the Mature Minor

The Law Reform Commission also considers whether a young person (16 and 17) or a person under 16 has the capacity to refuse medical treatment generally, and more particularly, life-saving medical treatment.<sup>93</sup> This has most commonly arisen either in respect of the refusal of treatment for a mental illness or the refusal of a life-saving blood transfusion on religious grounds. The consequences of a refusal have the potential to be more serious, and are, by definition, at variance with the medical opinion of a patient's best interests.<sup>94</sup>

While Lord Scarman suggested obiter in *Gillick* that the minor assumes both the power to consent and to refuse treatment,<sup>95</sup> subsequent English case law does not lend support to that position. In *Re R*,<sup>96</sup> a case which involved a 15-year-old suffering from increasingly paranoid and

disturbed behaviour, and threatening suicide, Lord Donaldson M.R. was of the opinion that while a Gillick-competent child could consent to treatment, in the case of a refusal of treatment, someone with parental rights could consent to treatment. In *Re W*,<sup>97</sup> the court authorised the compulsory treatment of a 16-year-old in care who was in a dangerously anorexic state, and in so doing, confirmed *Re R* in finding that Gillick did not confer a power of veto on medical treatment to a minor. In *Re M*,<sup>98</sup> the court overrode a 15-year-old's objection to a heart transplant on the basis that it was in her best interests.<sup>99</sup> The young woman sought to refuse the treatment on the basis that she did not want to have somebody else's heart in her body, and also did not want to take medication for the rest of her life. The court found that while her wishes on these issues were certainly important, they were not decisive; death was a certainty, the court found, if the transplant did not go ahead, and thus her refusal to consent was overridden.

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Although the courts have suggested that more weight be attached to the decision of the minor, there are no English cases in which a minor has been permitted to refuse medical treatment to save his or her life. It would seem likely, given the significant constitutional protection of the right to life in this jurisdiction, that this would be true even more so here.

The Law Reform Commission suggests that, in general, a person under 18 should have the ability to refuse medical treatment in the same way that an adult can, and where life-saving treatment is refused, it recommends that an application should be made to the High Court to adjudicate on the refusal.<sup>100</sup> It is worth pausing for a moment to examine the adult jurisprudence on treatment refusal in this regard. In the seminal English case of *Re T* in 1992, in which the pregnant Miss T refused a blood transfusion on religious grounds, Lord Donaldson M.R. observed: "An adult who, like Miss T, suffers from no mental incapacity, has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered."<sup>101</sup> Notwithstanding this, the court found that Miss T's consent was not fully informed and not entirely voluntary.

In an Irish context, in *JM v Board of Management of St Vincent's Hospital*,<sup>102</sup> Finnegan P., whilst recognising the right of autonomy pursuant to Art.40.3.1° of the Constitution, as set out in the landmark case of *Re a Ward of Court*,<sup>103</sup> ruled that a blood transfusion could go ahead, notwithstanding the patient's prior refusal. In *Fitzpatrick v K*,<sup>104</sup> again concerning a blood transfusion on religious grounds, Laffoy J. suggested that the consequences of the refusal were potentially so extreme that the consent must "reach a particularly high threshold before it can be considered a valid refusal".<sup>105</sup> Thus, we see that the court sets a particularly high threshold for the refusal of life-saving treatment for adults, and it is against this that we are bound to judge our proposals for reform of the law in relation to children.

## When Children have Children: Pregnancy in Young Women

It remains unclear whether it is legally and constitutionally permissible for a medical practitioner to treat a pregnant young woman or minor in the absence of parental knowledge or consent, and particularly, whether it is possible for such a medical practitioner to terminate her pregnancy without the knowledge or consent of her parent or guardian. When the young woman gives birth to her child, this leaves her in a most paradoxical situation, medico-legally speaking: while she, as the parent of the child, has the full panoply of rights in relation to that child and can fully consent to, or refuse medical treatment on behalf of the child,<sup>106</sup> on a strict interpretation of the law, she cannot consent to even a basic medical examination without the consent of her parents or guardian.

Aside from the question of prenatal care, which presumably falls within the remit of the general legislative position, this issue comes into most sharp relief for any young woman under the age of 18 when we consider the question of termination of pregnancy. Section 2 of the Protection of Life During Pregnancy Act 2013 defines "woman" as "a female person of any age". The question is whether this has the effect of permitting a doctor to treat any pregnant teenager, regardless of age, in the absence of parental/guardian consent or knowledge. In examining this question, again, we must consider the application of Arts 41 and 42 of the Constitution. The issue arose in *Re Article 26 and the Regulation of Information (Services Outside the State for the Termination of Pregnancies) Bill 1995*.<sup>107</sup> Here, it was argued that because the term "woman" was not defined in the Act, a young person could seek abortion information without the knowledge or consent of her

parents, thus rendering the Act unconstitutional as a violation of Arts 41 and 42. Hamilton C.J. stated in response to this argument that:

“[I]t must be presumed that in the giving of such information, counselling and advice, the person giving same will have regard to and give advice in accordance with the principles of Constitutional justice and if there is any departure from these principles, such departure would be restrained and corrected by the Courts.”<sup>108</sup>

These principles of constitutional justice were not defined or described, but it is presumed that the Chief Justice had Arts 41 and 42 in mind. Whether the Medical Council's Guidelines and the Law Reform Commission's interpretation of s.23 of the 1997 Act amount to a protection of these principles is also unclear.

## Young People and Minors in the Care of the State

Depending on the type of care order made under the Child Care Act 1991, either the District Judge (in the case of emergency care orders, interim care orders and interim special care orders) or the Child and Family Agency (in the case of care orders and special care orders) can consent on behalf of the young person or minor, or give directions in relation to their treatment. Generally speaking, these provisions will apply where the medical treatment in question is a life-saving termination of pregnancy.

A and B v C (the “C case”)<sup>109</sup> concerned a young woman in the care of the health board whose parents \*74 opposed the decision to terminate her pregnancy. Geoghegan J. was of the opinion that, rather than conferring a right of abortion outside of the jurisdiction, the travel amendment “merely prevents injunctions against travelling for that purpose”.<sup>110</sup> This case did not involve an injunction; rather, the case concerned the question of whether the health board could facilitate this girl travelling under the terms of the Child Care Act 1991. Geoghegan J. was of the opinion that the court could not permit the young woman to travel if the termination proposed was one which was not allowed under Irish law.<sup>111</sup>

On the basis of this ruling, it was thought that while parents could lawfully bring their child to another jurisdiction to terminate the pregnancy of that child, where the child was not in the care of her parents, the situation was different. In these circumstances, such as children in the care of a health board, wards of court and certain children detained under the Mental Health Act 2001, where consent of the court was required in order to medically treat a child, or for them to travel, unless the termination was a constitutionally permissible one, the court could not sanction the treatment and the young person would be forced to bring her pregnancy to term.<sup>112</sup>

However, the situation was again interpreted differently in the “Miss D” case, in which the 17-year-old girl seeking a termination was in the care of the HSE. The HSE refused to give her permission to travel, and attempted to prevent her from obtaining a passport. Miss D took an action seeking to prevent the HSE from restraining her from travelling to the UK for the abortion. Considering the question of whether the HSE was correct in seeking District Court approval for Miss D to travel to the UK to terminate her pregnancy, McKechnie J. stated:

“... there was no law or provision of the Child Care Act which restrained a child in care from travelling for an abortion or which would support the HSE's claim that District Court permission was required for travel. Miss D's right to travel for an abortion was unaffected by Article 40.3.3° of the Constitution.”<sup>113</sup>

Due to her “courage, integrity and maturity”, McKechnie J. held that there was “no impediment to the applicant exercising her right to travel to England”.<sup>114</sup>

Thus, McKechnie J. held that Miss D's right to travel took precedence over the right to life of the unborn. There was a shift from Geoghegan J.'s position—where he believed that the State, and the courts, were under an obligation to protect the right to life of the unborn to the point that the court could not positively sanction travel for an unconstitutional abortion—to McKechnie J.'s decision, where the right to travel was paramount, trumping the right to life of the unborn. It could be argued that the Miss D case was decided on the basis of her capacity to consent to treatment, rather than Art.40.3.3°, but this issue requires resolution.

## Best Interests or Best Medical Interests?

Throughout this article, one theme has emerged, namely the question of how the best interests of a person under the age of 18 in the context of medical decision-making are to be determined. Where parents or guardians agree, particularly in the context of the administration of treatment (though not in the context of refusal of all forms of treatment, and certainly not in the context of life-saving treatment), it seems that there is little question as to whether the State can interfere. Where parents disagree, or where a young person disagrees with his or her parents or guardians and/or the medical practitioners on the question of treatment, the question becomes much less clear. When we seek to determine the best interests of a child, it would appear that courts have in the past deferred to the advice of medical practitioners: that is, that the best interests of the child are equated with the best medical interests of the child.

The European Convention on Human Rights, and emerging jurisprudence from the European Court of Human Rights, would suggest that a broader formulation of “best interests” is necessary. The College of Psychiatry, in its submission on the Assisted Decision-Making Bill 2013, acknowledged that “while the concept of ‘best interests’ may have been misused in the past it can, when used correctly, be an important and empowering concept”.<sup>115</sup> The interpretation by the courts of “best interests” in the Mental Health Act 2001 has revealed that best interests are being equated with best medical interests,<sup>116</sup> and for this reason, under the review of the Mental Health Act 2001 it has been recommended that s.4, which deals with “best interests”, needs to be amended to reflect an understanding that gives prominence to the “dignity, bodily integrity, privacy and autonomy” of the individual. In England, for example, under the Mental Capacity Act Code of Practice, there is a best interests checklist.<sup>117</sup> This broader thinking tallies with the more engaged and consultative process we saw earlier in the Children and Family Relationships Act 2015. We would suggest that in the context of medical decision-making, a broad definition of best interests should be adopted.

## Law Reform Commission Recommendations for Reform

Rather than dealing with the issues raised in this article on a piecemeal basis, we would argue that the preferable option is to legislate in accordance with the proposals of the Law Reform Commission in its 2011 Report,<sup>118</sup> which set out clearly the circumstances in which medical treatment can be given to, and refused<sup>\*75</sup> by, young people and minors. The Commission's proposals place the best interests of the young person at the heart of any consideration,<sup>119</sup> and the Commission states that due weight be given to the views of the child given his or her age and maturity.<sup>120</sup> In relation to those aged 16 and 17, the Commission's proposed Bill states quite simply: “The capacity of a person who is 16 or 17 years of age is as effective as it would be if he or she were of full age, that is, 18 years of age”, though this is a rebuttable presumption, “subject to contrary evidence that the person lacks capacity”.<sup>121</sup>

Section 8 of the proposed Bill provides that where a person under the age of 18 refuses life-sustaining medical treatment, “an application may be made to the High Court to determine the validity of the refusal”. The High Court may order that such life-saving treatment be administered where it is in the best interests of the person involved.

In the context of minors (i.e. those under the age of 16), the Commission proposes that while there is no presumption of capacity, where the minor proves sufficiently mature and has the understanding to appreciate the nature and consequences of the treatment in question, that minor may consent to or refuse medical treatment.<sup>122</sup> In these circumstances, it shall also be presumed that parents or guardians are involved in the decision-making process, although in exceptional circumstances, treatment may be administered in the absence of parental knowledge or consent.<sup>123</sup>

## Conclusion

We cannot ignore the influence of Gillick nor the Convention on the Rights of the Child nor the recent children's rights constitutional amendment in terms of giving children more rights and acknowledging that they are advancing in their decision-making capabilities and maturity. It is important that those advances in terms of children's rights are not just “tick box” exercises, which they are in danger of being if we do not allow children to refuse as well as consent to treatment.

We have seen that in adult cases, where the consequences of a refusal of treatment are severe, the law will step in and override that refusal, as in the Mental Health Act 2001 and in cases relating to life-saving blood transfusions. We are suggesting, therefore, that the Law Reform Commission's formulation of allowing children to refuse as well as consent to medical treatment, with the provision for an application to the High Court if the outcome were potentially sufficiently grave, is the correct approach. That said, a code of practice as to a more nuanced definition of "best interests" is required. The current system of legislative uncertainty is unacceptable for practitioners treating young people and requires urgent reform.

This journal may be cited as e.g. (2005) 11, 2 M.L.J.I. 1 [(year) (Volume number) (Issue number) M.L.J.I. (page number)]

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\*. The authors would like to thank Dr Susan Leahy and Dr John Lombard who were kind enough to offer advice on earlier drafts of this article. All errors remain our own.

1. Law Reform Commission, Children and the Law: Medical Treatment (LRC 103-2011), p.11.

2. Law Reform Commission, Children and the Law: Medical Treatment (LRC 103-2011), p.15.

3. For a detailed examination of the implications of this Act, see C. O'Sullivan, "Protecting Young People From Themselves: Reform of the Age of Consent Law in Ireland" (2009) 31 Dublin University Law Journal 386.

4. Mental Health Act 2001 s.25.

5. Kaplan, "The Right of a Minor in Israel to Participate in the Decision-Making Process Concerning His or Her Medical Treatment" (2002) 25(5) Fordham International Law Journal 1085.

6. Health Service Executive Quality and Patient Safety Division, National Consent Policy (QPSD-D-026-1.1. V.1.1), available at: [http://www.hse.ie/eng/about/Who/qualityandpatientsafety/National\\_Consent\\_Policy/consenttrainerresource/trainerfiles/NationalConsentPolicyM2014.pdf](http://www.hse.ie/eng/about/Who/qualityandpatientsafety/National_Consent_Policy/consenttrainerresource/trainerfiles/NationalConsentPolicyM2014.pdf) [last accessed 2 April 2015].

7. National Consent Policy, fn.6 above, p.48.

8. National Consent Policy, fn.6 above, p.48.

9. Medical Council, Guide to Professional Conduct and Ethics for Registered Medical Practitioners, 7th edn (Dublin: Medical Council, 2009), available at: <https://www.medicalcouncil.ie/News-and-Publications/Publications/Information-for-Doctors/Guide-to-Professional-Conduct-and-Ethics-for-Registered-Medical-Practitioners> [last accessed 17 July 2014].

10. Support for this view is found in the recent jurisprudence from the European Court of Human Rights in respect of vulnerable adults: *Storck v Germany*, App. no. 61603/00,

[2005] ECHR 406 (16 June 2005); *Shtukaturov v Russia*, App. no. 44009/05,

[2008] ECHR 223.

11. U. Kilkelly and M. Donnelly, *The Child's Right to be Heard in the Healthcare Setting: Perspectives of Children, Parents and Health Professionals* (Dublin: Office of the Minister for Children, 2006).

12. Law Reform Commission, *Children and the Law: Medical Treatment* (LRC 103-2011).

13. Law Reform Commission, Children and the Law: Medical Treatment (LRC 103-2011), p.16.
14. Law Reform Commission, Children and the Law: Medical Treatment (LRC 103-2011), p.16.
15. (1992) 175 C.L.R. 218.
16. (1992) 175 C.L.R. 218 at para.26 per Mason C.J.
17. [2001] 3 I.R. 622.
18. Refusal of the test is rare but an average of six or seven sets of parents annually do refuse their consent. See M. Donnelly, Consent: Bridging the Gap Between Doctor and Patient (Cork: Cork University Press, 2002), p.54.
19. [2001] 3 I.R. 622 at 729.
20. [2001] 3 I.R. 622 at 733.
21. See U. Kilkelly and C. O'Mahony, "The Proposed Children's Rights Amendment: Running to Stand Still?" (2007) 10(2) Irish Journal of Family Law 19.
22. [2001] 3 I.R. 622 at 707.
23. In the Matter of Baby AB: Children's University Hospital, Temple Street v CD and EF [2011] IEHC 1.
24. [2011] IEHC 1 at para.37.
25. Health Service Executive v F, unreported, High Court, Birmingham J., ex tempore, 20 November 2010. No written judgment is available for the case, and we have relied on Broughton's analysis here. See F. Broughton, "An Invisible Judgment for Invisible Children? What the High Court Decision in HSE v F (2010) says about Health Care Rights for Pre-Natal Children" (2012) 18(2) Medico-Legal Journal of Ireland 76.
26. (2012) 18(2) Medico-Legal Journal of Ireland 76 at 79.
27. (2012) 18(2) Medico-Legal Journal of Ireland 76 at 79.
28. (2012) 18(2) Medico-Legal Journal of Ireland 76 at 80.
29. See s.32 of the Health Act 1947, as discussed in J. Schweppe, "Best to Agree to Disagree? Parental Discord, Children's Rights and the Question of Immunization" (2008) 37(2) Common Law World Review 147 at 149-151: "II: Compulsory Immunization".
30. In the matter of EO and MO: FN v CO, unreported, High Court, Finlay Geoghegan J., 26 March 2004. See also, McK v Information Commissioner [2006] 1 I.R. 260 in relation to the right of the non-custodial parent to information regarding the medical treatment of his or her child.
31. See, for example, B v B [1975] I.R. 54.
32. Head 45(2) of the Children and Family Relationships Bill 2014.
33. General Scheme of a Children and Family Relationships Bill 2014.
34. Select Committee on Justice, Defence and Equality Debate (Vol. 2 No. 43), Children and Family Relationships Bill 2015: Committee Stage, Section 41 (5 March 2015).
35. Select Committee on Justice, Defence and Equality Debate (Vol. 2 No.43),Children and Family Relationships Bill 2015: Committee

Stage, Section 41 (5 March 2015).

[36.](#) Thirty-first Amendment of the Constitution (Children) Act 2012 (signed on 28 April 2015).

[37.](#) Emphasis added.

[38.](#) J. Scheppe, "Best to Agree to Disagree? Parental Discord, Children's Rights and the Question of Immunization" (2008) 27(2) *Common Law World Review* 147 at 174.

[39.](#) Committee on Justice, Defence and Equality, Report on hearings in relation to the Scheme of the Children and Family Relationships Bill (May 2014), available at: [http://www.oireachtas.ie/parliament/media/committees/justice/CFRB-Bill-REPORT\\_Final.docx](http://www.oireachtas.ie/parliament/media/committees/justice/CFRB-Bill-REPORT_Final.docx) [last accessed 17 July 2014].

[40.](#) Footnote 6 above.

[41.](#) Footnote 6 above, p.50.

[42.](#) Footnote 6 above, p.51.

[43.](#) Footnote 6 above, p.51.

[44.](#) B. McMahon and W. Binchy, *Law of Torts*, 4th edn (Dublin: Bloomsbury Professional, 2013), p.925.

[45.](#) See above, "General Principles".

[46.](#) Although as Nic Suibhne observes: "This provision provides a medical practitioner with a defence to a charge of assault and was clearly not enacted to deal with wider issues of capacity, autonomy and self-determination": Nic Suibhne on Children's Rights and Health Care (20 June 2010), available at: <http://humanrights.ie/children-and-the-law/nic-suibhne-on-childrens-rights-and-health-care/> [last accessed 2 April 2015].

[47.](#) Footnote 9 above, p.41.

[48.](#) Rooney questions whether the Act extends to the treatment of young people in the context of drug addiction: S. Rooney, "The Medico-Legal Impact of Consent to Treatment of Under-aged Drug Users" (1998) 4(2) *Medico-Legal Journal of Ireland* 74.

[49.](#) LRC 103-2011.

[50.](#) Law Reform Commission, *Children and the Law: Medical Treatment* (LRC 103-2011), p.51. The cases of McK and D are discussed at a later point in this article.

[51.](#) B. McMahon and W. Binchy, *Law of Torts*, 4th edn (Dublin: Bloomsbury Professional, 2013).

[52.](#) B. McMahon and W. Binchy, *Law of Torts*, 4th edn (Dublin: Bloomsbury Professional, 2013), p.930.

[53.](#) B. McMahon and W. Binchy, *Law of Torts*, 4th edn (Dublin: Bloomsbury Professional, 2013), p.930.

[54.](#) [1980] I.R. 32 at 69.

[55.](#) Emphasis added.

[56.](#) B. McMahon and W. Binchy, *Law of Torts*, 4th edn (Dublin: Bloomsbury Professional, 2013), p.930.

[57.](#) B. McMahon and W. Binchy, *Law of Torts*, 4th edn (Dublin: Bloomsbury Professional, 2013), p.931.

[58.](#) E. Quill, *Torts in Ireland*, 4th edn (Dublin: Gill & Macmillan, 2014), p.186.



- [59.](#) M. Donnelly, "Capacity of Minors to Consent to Medical and Contraceptive Treatment" (1995) 1(1) *Medico-Legal Journal of Ireland* 21.
- [60.](#) S. Mills, *Clinical Practice and the Law* (Dublin: Butterworths, 2007), p.81.
- [61.](#) Department of Children and Youth Affairs, *Children First: National Guidance for the Protection and Welfare of Children* (2011). This document has the aim of promoting safety and well-being of children, and provides particular guidance on how professionals dealing with children and young people should act in the context of child abuse or neglect.
- [62.](#) *Children First*, fn.61 above, para.4.10.6.
- [63.](#) *Children First*, fn.61 above, para.1.1.1(iv).
- [64.](#) Unreported, High Court, McKechnie J., 9 May 2007.
- [65.](#) The issue of the capacity of Miss D to consent in the context of the Child Care Act 1991 is discussed at a later point in this article.
- [66.](#) "Right to life 'continues until death'", *Irish Times*, 8 May 2007.
- [67.](#) *Hewer v Bryant*  
[1969] 3 All E.R. 578 at 582.
- [68.](#) [2006] IESC 2.
- [69.](#) Footnote 9 above.
- [70.](#) Law Reform Commission, *Children and the Law: Medical Treatment* (LRC 103-2011), p.54.
- [71.](#) [1986] A.C. 112.
- [72.](#) [1986] A.C. 112 at 167.
- [73.](#) [1986] A.C. 112 at 173.
- [74.](#) Support for this view is found in the dissenting judgment of Binnie J. in the Canadian case of *AC v Manitoba (Director of Child and Family Services)*  
[2009] SCC 30.
- [75.](#) M. Donnelly, *Consent: Bridging the Gap Between Doctor and Patient* (Cork: Cork University Press, 2002), p.48.
- [76.](#) B. McMahon and W. Binchy, *Law of Torts*, 4th edn (Dublin: Bloomsbury Professional, 2013), p.928.
- [77.](#) D. Tomkin and P. Hanafin, *Irish Medical Law* (Dublin: Round Hall Press, 1995).
- [78.](#) D. Tomkin and P. Hanafin, *Irish Medical Law* (Dublin: Round Hall Press, 1995), p.40.
- [79.](#) E. Quill, *Torts in Ireland*, 4th edn (Dublin: Gill & Macmillan, 2014), p.187.
- [80.](#) Mills refers to the Criminal Justice (Forensic Evidence) Act 1990, whereby in the case of young people aged between 14 and 17, consent must be given by both the parents and the young person involved: S. Mills, *Clinical Practice and the Law* (Dublin: Butterworths, 2007), p.83. The Criminal Justice (Forensic Evidence and DNA Database System) Act 2014, which repeals the 1990 Act, provides, under s.54, that in the case of a child who has attained the age of 16, consent is given by the child; in the case of a child who has attained the age of 14, the consent of the parents and the young person are required; and in the case of a child under 14, consent will be given by a parent or guardian.
- [81.](#) See, for example, *G v An Bord Uchtála*

[1980] I.R. 32 at 69, where Walsh J. stated, as set out earlier: "The child's natural rights spring primarily from the natural right of every individual to be reared and educated, to liberty, to work, to rest and recreation, to the practice of religion, and to follow his or her conscience."

[82.](#) S. Mills, *Clinical Practice and the Law* (Dublin: Butterworths, 2007), p.83.

[83.](#) D. Madden, *Medicine, Ethics and the Law*, 2nd edn (Dublin: Bloomsbury Professional, 2011), p.497.

[84.](#) W. Duncan, "The Child, the Parent and the State: the Balance of Power" in W. Duncan (ed.), *Law and Social Policy: Some Current Problems in Irish Law* (Dublin: Dublin University Law Journal, 1987), p.23.

[85.](#) D. Madden, *Medicine, Ethics and the Law*, 2nd edn (Dublin: Bloomsbury Professional, 2011), p.513.

[86.](#) S. Mills, *Clinical Practice and the Law* (Dublin: Butterworths, 2007).

[87.](#) It is worth noting that the Law Reform Commission does not distinguish between contraceptive and other health care and medical treatment: LRC 103-2011, p.24.

[88.](#) D. Madden, *Medicine, Ethics and the Law*, 2nd edn (Dublin: Bloomsbury Professional, 2011), p.513.

[89.](#) M. Donnelly, *Consent: Bridging the Gap Between Doctor and Patient* (Cork: Cork University Press, 2002).

[90.](#) M. Donnelly, *Consent: Bridging the Gap Between Doctor and Patient* (Cork: Cork University Press, 2002), p.50.

[91.](#) D. McMahon et al, "The Prescribing of Contraception and Emergency Contraception to Girls Aged Less than 16" (2010) 16(2) *Medico-Legal Journal of Ireland* 91; H. Cronin et al, "Attitudes of General Practitioners to Prescribing Contraception to Minors—A Medico-Legal Review" (2013) 19(1) *Medico-Legal Journal of Ireland* 28.

[92.](#) H. Cronin et al, "Attitudes of General Practitioners to Prescribing Contraception to Minors—A Medico-Legal Review" (2013) 19(1) *Medico-Legal Journal of Ireland* 28.

[93.](#) Law Reform Commission, *Children and the Law: Medical Treatment* (LRC 103-2011).

[94.](#) D. Madden, *Medicine, Law and Ethics*, 2nd edn (Dublin: Bloomsbury Professional, 2011), p.502.

[95.](#) D. Madden, *Medicine, Law and Ethics*, 2nd edn (Dublin: Bloomsbury Professional, 2011), p.502.

[96.](#) *Re R (A Minor) (Wardship: Consent to Treatment)*

[1992] Fam. 11.

[97.](#) *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)*

[1993] Fam. 64.

[98.](#) *Re M (A Minor) (Medical Treatment: Consent)*

[1999] 2 F.L.R. 1097.

[99.](#) For further discussion, see Lady Hale, "Who's Afraid of Children's Rights?" (Welsh Observatory on the Human Rights of Children and Young People, 14 June 2013), available at: <https://www.supremecourt.uk/docs/speech-130614.pdf> [last accessed 4 March 2015]; D. Madden, *Medicine, Law and Ethics*, 2nd edn (Dublin: Bloomsbury Professional, 2011), pp.499-512.

[100.](#) Law Reform Commission, *Children and the Law: Medical Treatment* (LRC 103-2011), p.153.

[101.](#) *Re T (adult: refusal of medical treatment)*

[1992] 4 All E.R. 782 at 786.

[102.](#) [2003] 1 I.R. 321.

[103.](#) [1996] 2 I.R. 79.

[104.](#) [2008] IEHC 104.

[105.](#) [2008] IEHC 104 at p.19.

[106.](#) See National Consent Policy, fn.6 above, which states: "Parent(s)/legal guardians are presumed to be the best decision-makers for their children and to act in their best interests. This presumption holds even if the parent/legal guardian is under 16 years."

[107.](#) [1995] 1 I.R. 1.

[108.](#) [1995] 1 I.R. 1 at 115.

[109.](#) A and B v Eastern Health Board and C

[1998] 1 I.L.R.M. 460.

[110.](#) [1998] 1 I.L.R.M. 460 at 478.

[111.](#) He stated that "the fact that there may be different views as to the importance of the constitutional right to travel does not in my view affect the issue of whether the District Court under the Child Care Act 1991 can actually exercise a jurisdiction authorising travel for a particular purpose, namely, for an abortion in circumstances where the proposed abortion would not be allowed under Irish law. I think that the court would be prevented from doing so by the terms of the right to life of the unborn expressed in the Constitution": [1998] 1 I.L.R.M. 460 at 479 (emphasis added).

[112.](#) Arguably, the same position could apply where the father of the unborn sought an injunction preventing his wife from travelling to terminate her pregnancy.

[113.](#) "High Court rules that girl can travel for abortion", Irish Times, 10 May 2007.

[114.](#) Law Reform Commission, Children and the Law: Medical Treatment (LRC 103-2011), p.49.

[115.](#) B. Kelly, "Progressive Bill on assisted decision-making offers real hope for families and carers", Irish Times, 11 March 2013.

[116.](#) C. Murray, "Moving Towards Rights-based Mental Health Law: The Limits of Legislative Reform" (2013) 48(1) Irish Jurist 161-181.

[117.](#) Available at: <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice> [last accessed 2 April 2015].

[118.](#) Law Reform Commission, Children and the Law: Medical Treatment (LRC 103-2011).

[119.](#) Section 4 of the Commission's Draft Health (Children and Consent to Health Care Treatment) Bill 2011.

[120.](#) Section 5 of the Commission's Draft Health (Children and Consent to Health Care Treatment) Bill 2011.

[121.](#) Section 7 of the Commission's Draft Health (Children and Consent to Health Care Treatment) Bill 2011.

[122.](#) Section 10 of the Commission's Draft Health (Children and Consent to Health Care Treatment) Bill 2011.

[123.](#) Section 10 of the Commission's Draft Health (Children and Consent to Health Care Treatment) Bill 2011.