

**RIGHTING A CHILD'S RIGHT TO REFUSE
MEDICAL TREATMENT**
**Section 11 of the New Zealand Bill of Rights Act
and the *Gillick* competent child**

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I INTRODUCTION

Section 11 of the New Zealand Bill of Rights Act 1990, which provides that "[e]veryone has the right to refuse to undergo any medical treatment", is without precedent in human rights documents.¹ Already, the High Court has held that "everyone" does not include a committed psychiatric patient.² The subject of this article is how section 11 might apply if a child who fully understands the significance of the decision refuses medical treatment. Since the House of Lords held in *Gillick v West Norfolk and Wisbech AHA*³ that some children are legally competent to *consent* to some medical treatment, children who fully understand the significance of such decisions have become known as "*Gillick* competent" children. A recent English Court of Appeal decision, *Re R*,⁴ adopted a considerably more restrictive attitude and held that no child has the right to refuse medical treatment if a parent consents to the treatment. Even the refusal of a *Gillick* competent child would not be legally valid, according to the Court of Appeal, because a consent provided by a parent would override the child's refusal.⁵ On its face, section 11 of the New Zealand Bill of Rights Act 1990 suggests that New Zealand courts should not follow the English lead. Part II of this article discusses the statutory provisions dealing with decisions about children's medical treatment and the relevant provisions of the Bill of Rights Act that might impact on their interpretation. This provides the context for an analysis in Part III of *Re R* and its possible impact on New Zealand law, particularly on the issues of the rights of parents and children and the powers of a court exercising its wardship jurisdiction.

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1 This was noted in the New Zealand Government White Paper accompanying the draft of the 1985 version of the Bill, *A Bill of Rights for New Zealand* (Government Print, Wellington, 1985), 109. The 1985 Bill was merely articulating what is widely recognised as a basic human right, whatever its source might be. The classic statement on the issue is that of Cardozo J in *Schloendorff v Society of New York Hospital* (1914) 105 NE 92, 93: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."

2 *Re S* [1992] 1 NZLR 363, 374-375.

3 [1986] AC 112.

4 [1992] Fam 11.

5 See Part III, below.

Though the English court was unnecessarily restrictive, this article suggests that untrammelled permissiveness would be equally unfortunate. The application of section 11 to children must properly account for the reality that most children exercise their autonomy and individuality within family relationships.⁶ Part IV of this article suggests that *Gillick* should provide New Zealand courts with a useful source of principles for establishing limits that may be imposed on the application of section 11 in cases concerning children that would pay proper regard to the specific factual contexts in which such problems might arise.

II THE NEW ZEALAND RIGHTS PERSPECTIVE

In a recent New Zealand High Court case, *Cairns v James*,⁷ which concerned a putative father's application for a blood test to be administered on a child he alleged to be his, Temm J suggested that the blood test might amount to medical treatment. Though the judge did not have to decide the question, he suggested that a court ordered blood test on the child might be inconsistent with section 11.⁸ Temm J apparently saw few problems with the application of section 11 to children. However, he did not have to face the more general issue of the application of section 11 to a child who expressly refuses medical treatment. To determine whether *Re R* might now represent the law in New Zealand on this issue, it is necessary to consider the specific statutory provisions dealing with a child's ability to consent to medical treatment. They are contained in section 25 of the Guardianship Act 1968. Section 25(1) and (2) provide, respectively, that all people of or over the age of 16⁹ and all married people can give valid consents. Where these special categories do not apply, the relevant provisions are found in subsections (3) and (5):

25 Consents to operations —

- (3) Where the consent of any other person to any medical, surgical, or dental procedure (including a blood transfusion) to be carried out on a child is necessary or sufficient, consent may be given —
- (a) By a guardian of the child; or
 - (b) If there is no guardian in New Zealand or no such guardian can be found with reasonable diligence or is capable of giving consent, by a person in New Zealand who has been acting in the place of a parent;

6 This is reflected in the Children, Young Persons, and Their Families Act 1989, which insists that a child's welfare be considered in the context of a child's family, whanau, hapu, iwi and family group.

7 [1992] NZFLR 353.

8 *Ibid*, 356.

9 Though section 25(1) empowers children of or over the age of 16 years to consent to treatment, the section does not deal specifically with a parent's right to override the refusal of a child of or over the age of 16. The Guardianship Act 1968, s14, provides that a child of or over the age of 16 "who is affected by a decision or by a refusal of consent by a parent or guardian in an important matter may . . . apply to a Family Court Judge who may, if he thinks it reasonable in all the circumstances to do so, review the decision or refusal and make such an order in respect thereto as he thinks fit". Arguably, "decision", in this section, is broad enough to encompass a consent that would purport to override a child's refusal.

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 (5) Nothing in this section shall limit or affect any enactment or rule of law whereby in any circumstances –
 (a) No consent or no express consent is necessary; or
 (b) The consent of the child in addition to that of any other person is necessary; or
 (c) . . . the consent of any other person instead of the consent of the child is sufficient.

The section does not specify the cases in which consents might be “necessary” or “sufficient” and leaves it to judges to develop applicable principles. Following from this, it is possible to interpret section 25 both consistently and inconsistently with *Re R*. Arguably, section 25(3)(a) validates the consent of a guardian, usually a parent,¹⁰ to treatment of children under the guardian’s care. Even if the child has a right to consent, the section recognises another valid consent, one that could override a child’s refusal. At a pinch, section 25(5)(a) also accommodates the *Re R* approach. A case in which a parent had consented might be construed as a case where no consent by the child was necessary. On the other hand, because sections 25(3)(a) and (b) validate consents by guardians and people who have been acting as parents only where the consent of persons other than children are “necessary or sufficient”, it may be possible to argue that a consent by someone other than the child itself would be *insufficient* if the child had refused treatment. Furthermore, section 25(5)(b) acknowledges that there will be cases in which a child’s consent “in addition to that” of any other person, such as a parent, would be necessary. To make sense of this provision, there must be some circumstances at least where a parent’s consent would be insufficient.

Some support for an interpretation that is consistent with *Re R* may be found in the leading New Zealand case on section 25, *Re X (sterilisation: parental consent)*.¹¹ As it concerned parents’ right to consent to medical treatment on behalf of a severely handicapped child, however, it is only of limited assistance to the more general issue of children’s right to refuse treatment. Parents of a 15-year-old girl sought the court’s consent for her sterilisation. The child had the mental age of about 3 to 8 months. Experts consulted and the family agreed that the operation would be in the child’s best interests. In a particularly sensitive judgment, Hillyer J ordered that the operation could go ahead. He also held that section 25(3) would give parents the right to consent to operations on behalf of a handicapped child. Referring to the specific wording of the section, he said that “where a child is under the age of 16 or is intellectually handicapped, such a consent is necessary.”¹² Though this statement may suggest that parental consent is required for both handicapped children and other children under 16, the case only dealt with the former. As *Re X* did not concern a child of a normal mental capacity, Hillyer J’s statement need not be understood as validating a parent’s consent to override such a child’s refusal of treatment. Though consent on behalf of a mentally incapacitated child may be necessary, it does not follow that a parental consent to an operation

10 See Guardianship Act 1968, s6.

11 [1991] NZFLR 49.

12 *Ibid*, 57.

that a child of normal mental capacity had refused is either "necessary" or "sufficient".

Until a New Zealand case arises directly on point it needs to be assumed for present purposes that the Bill of Rights Act applies to the relationship between doctors and patients and other relationships controlled by section 25 of the Guardianship Act 1968.¹³ Where two or more interpretations of an enactment are viable, the New Zealand Bill of Rights Act has greatest purchase. Though section 4 of the 1990 Act states that other enactments are not affected by the Bill of Rights Act, section 6 provides that a construction that is consistent with the rights and freedoms contained in the Bill shall be preferred to any others. In the present context, notwithstanding the decision in *Re R*, section 6 would instruct a court to interpret section 25 of the Guardianship Act consistently with section 11 of the Bill of Rights Act 1990 – unless, of course, deviation from the right amounted to a justified limitation. Rights affirmed in the Bill of Rights Act 1990 are subject to the justified limitation clause contained in section 5. The rights may be subject "only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." The 1985 version of the Bill, which would have entrenched the rights contained within it, included an equivalent provision. The White Paper accompanying the Bill suggested that the justified limitations clause would only permit enforced treatment of adults where "necessary to protect the health and safety of other persons, and not simply where their refusal of treatment will detrimentally affect their own health."¹⁴ More recently, Ron Paterson has suggested that section 11 would "[c]learly . . . cover the case of a competent patient who refuses to consent to life saving treatment."¹⁵ Cases involving children are perhaps not so clear. In-

13 This is a difficult issue that is well beyond the scope of this article. The difficulty is due to the wording of section 3 of the Bill of Rights Act:

This Bill of Rights applies only to acts done –

- (a) By the legislative, executive, or judicial branches of the government of New Zealand; or
- (b) By any person or body in the performance of any public function, power or duty conferred or imposed on that person or body by or pursuant to law.

In *Report of an Inquiry into the Strip Searching of Students at Hastings Boys' High School on the 19th of June 1991*, at 18, the Commissioner for Children distinguished the actions of parents from the actions of the school and concluded that "the Act would appear not to be applicable to the exercise of authority by a parent which may be presumed to come into the category of a transaction between private citizens but to be applicable under s3 (b) to actions taken by teachers under the authority of the Education Act 1989."

In *Gieringer v Police* (23 December 1991) unreported AP125/91, at 5, however, Holland J opined: "The wording of the section creates substantial difficulty in interpreting precisely what is meant. There are rights stated in the Act which are unlikely ever to arise in situations between a citizen and a branch of government or an official exercising functions, powers or duties conferred by the official by or pursuant to law. I have difficulty in seeing how a purposive interpretation of the section can be applied if the words used are held literally to mean what they say." The right to refuse medical treatment would often arise in the category of cases to which Holland J refers.

14 *Supra* n 1, 109.

15 R Paterson, "The Right of Patients to Refuse Medical Treatment", *NZ Doctor*, 19 August 1991, 33.

deed, assumptions about the legal capacity of children led the authors of the White Paper to different conclusions for cases concerning children and adults. Acknowledging that the freedom to refuse to undergo any medical treatment "raises the question of consents to medical treatment on minors and others who are incapable of consenting to medical treatment on themselves",¹⁶ the White Paper suggested that it was "reasonably clear" that a different approach should apply to children and that existing restrictions on their ability to decide about medical treatment for themselves would be permissible as justified limits. The further conclusion in the White Paper, that a parent's ability to consent on behalf of minors would also be permissible, is consistent with this view.

In general terms, the White Paper's approach is preferable to the analysis in the High Court decision of *Re S*, which held that a committed psychiatric patient was outside the ambit of section 11.¹⁷ S was subject to a reception order under the Mental Health Act 1969. He was granted leave subject to the condition, permitted by the Act, that he would be visited by hospital personnel who would continue to administer medical treatment. S objected to the medication but was found to be unable to understand his decision fully. Barker J avoided analysis of the significance of section 5 of the Bill of Rights Act by concluding that "everyone" in section 11 did not apply to a committed patient. In the judge's view, "everyone" meant "every person who is competent to consent".¹⁸ With respect, if followed, the approach in *Re S* would be a disastrous slope for analysis of domestic protection of human rights to slide down. It is certainly possible to mount an argument that people ought to be excluded from the ambit of rights because of their inability to make certain cognitive connections. However, concern for the vulnerability of such people might lead to the opposite conclusion — that the most vulnerable members of society need greatest rights protection.¹⁹ With respect, it would have been more useful if Barker J had analysed the application of the justified limitations clause to the particular issue before the court. At least the White Paper's approach to limits that might be placed on children's right to refuse medical treatment begins from the proposition that children were included in the ambit of the right. This approach would require the weight of any competing interests supporting the conclusion that a patient ought not to be protected by section 11 to be articulated, and then scrutinised carefully.²⁰

Though children should be accorded the protection of section 11 because they are people, notwithstanding the White Paper's analysis, a New Zealand court might be asked to articulate principles that would justify limiting the application of the right to children because they are children.

16 *Supra* n 1, 109.

17 *Supra* n 2, 374-375.

18 *Ibid*, 374.

19 See the discussion of *Re B (a minor) (wardship; sterilisation)* [1988] AC 199 by J Montgomery, "Rhetoric and Welfare" (1989) 9 OJLS 395, 400.

20 In *Re S*, n 2, at 375, Barker J did call for "clear legislative intent as to when and by whom the rights and freedoms in the Bill as regards the mentally disordered may be restricted."

If this question arises, the experience of other courts faced with a child's refusal of medical treatment will be of considerable interest. The following section details the recent attempt by the English Court of Appeal to address the issue, and assesses the significance of the case for New Zealand. Due to the enactment of section 11 of the New Zealand Bill of Rights Act, *Re R*²¹ cannot provide the complete answer to the issue for a New Zealand court. Indeed, there are many unfortunate aspects of the case that should prompt a New Zealand court not to follow it. Nevertheless, detailed consideration of the case is warranted, as the English Court of Appeal made a number of important points concerning the respective rights of parents and children and the ambit of a court's powers over its wards that may be relevant to any attempt by a New Zealand court to deal with the issue.

III CHILDREN'S RIGHT TO REFUSE MEDICAL TREATMENT IN THE ENGLISH COURT OF APPEAL

Re R concerned a child who was severely mentally disturbed. Though the child had lucid intervals during which she refused anti-psychotic medication, her mental condition would fluctuate, sometimes producing a "florid" psychotic state. The Court of Appeal considered that the child's overall mental state rendered her refusal invalid.²² The case is of significance to the present context, however, because the court was asked by the Official Solicitor to provide more general guidance on the issue of the weight to be given to a child's refusal of medical treatment. This required the court to consider two questions. First, what are the rights of parents if a *Gillick* competent child refused treatment? Secondly, could a court dictate that treatment be administered to such a child if the child had been made a ward of the court?

Parents' Rights to Consent and Children's Right to Refuse

Though *Gillick* concerned children's ability to receive contraceptive treatment and advice independently of parents, its relevance to the consent of a child to all medical treatment is widely recognised.²³ In England, as

21 [1992] Fam 11.

22 "The case is, therefore, authority for the view that competence to consent is not to be assessed on a day-to-day basis with a person competent on one day and incompetent the next", G Douglas, "Comment" (1992) 22 Family Law 68-69. More recently, the Court of Appeal (Lord Donaldson MR, Balcombe and Nolan LJJ) has held that a 16-year-old girl could be treated for anorexia against her wishes. Lord Donaldson MR considered that the child's views were of "no weight in the context of deciding whether to consent to particular medical treatment"; *Re J* (July 1 1992) *The Times*, 3. The case will be appealed to the House of Lords.

23 In a compelling analysis of the case, Les Moran outlines the rhetorical techniques deployed in the majority *Gillick* speeches to expose the significance of the contraception issue to more general medical treatment: "A Reading in Sexual Politics and Law: *Gillick v West Norfolk and Wisbech Area Health Authority and Another*" (1986) 7 Liverpool LR 83, 87.

in New Zealand²⁴ and Australia,²⁵ before a doctor may act on the consent of a child without consent of the parents, the doctor must be satisfied that the child fully understands all that the treatment entails. At common law, doctors who operate without a valid consent may be held liable for trespass to the person. Tort law is a jealous protector of the inviolability of the body. It yields only in rare cases of necessity, even where the treatment is therapeutic.²⁶ Doctors who operate on children who are not *Gillick* competent expose themselves to liability in tort even if the child expressly consents.²⁷

Potentially, the right of a child to refuse medical treatment might also impact on a doctor's civil liability. If a child's refusal were treated in the same way as an adult's, and no statutory or common law defence were available, a doctor who operated against the child's wishes would face a claim for damages. In *Re R* Lord Donaldson MR concluded, however, that in such cases a child's refusal did not have the same legal significance as an adult's, following from his view that parents held an independent power to consent on behalf of their children.²⁸ According to Lord Donaldson MR, one valid consent would be sufficient to render the treatment lawful. He held that if a doctor operated with a parent's consent, the doctor would avoid liability despite the child's refusal.²⁹ Lord Donaldson MR was prepared to distinguish *Gillick* on the ground that it concerned only a child's independent right to consent, and did not negative a parents' right

24 Though the Guardianship Act 1968 purports to be a code (see s 33), there remain many gaps and uncertainties in the legislation to be given meaning through judicial rulings. Difficulties in the interpretation of s 25(3) and (5) have already been noted. For analysis of other provisions of the Act and the more general relevance of *Gillick* to New Zealand law, see W R Atkin, "A Blow for the Rights of the Child; Mrs Gillick in the House of Lords" (1985) 1 FLB 35; reprinted as "Parents and Children: Mrs Gillick in the House of Lords" [1986] NZLJ 90. D Collins, in *Medical Law in New Zealand* (1992) 100, notes that as yet no New Zealand court has faced the question of the relevance of *Gillick* to New Zealand law, but concludes that the issue of a child's ability to consent to treatment should be dealt with consistently with *Gillick*.

25 See *Secretary, Department of Health and Community Services v JMB and SMB* (1992) 15 Fam LR 392. For a comparison between English and Australian approaches, see J Devereux, "The Capacity of a Child in Australia to Consent to Medical Treatment — *Gillick* Revisited" (1991) 11 OJLS 283.

26 In *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, Lord Goff of Chieveley presented a penetrating analysis of the torts principles applicable to medical treatment administered without consent. He considered that treatment without consent in cases of emergency was justified by the principle of necessity. Under the Crimes Act 1961, s61A, New Zealand doctors are immune from criminal liability if they operate for a lawful purpose with the consent of the person operated upon, or a person "lawfully entitled to consent on his behalf". The section does not specify who, other than the patient, may give consent "lawfully".

27 Though no general tort exists for interference with parental rights, (*F v Wirral Metropolitan Borough Council* [1991] Fam 69, 92), other tort remedies, such as damages for battery, might be available to the child, and possibly even parents. On these issues, see S Todd (ed), *The Law of Torts in New Zealand* (1991) 23-24, and J Fleming, *The Law of Torts* (1987) 619-621.

28 For a survey of English decisions recognising a parents' right to consent on behalf of children, see P D G Skegg, "Consent to Medical Procedures on Minors" (1976) 36 MLR 370, 375-381.

29 *Supra* n 21, 24.

to consent on behalf of their children. For Lord Donaldson MR, it made no difference if the child were *Gillick* competent. In his view, unless an independent right to consent vested in parents were recognised, doctors would be faced with an “intolerable dilemma”.³⁰ If a parent’s consent were invalid in the face of a child’s refusal, doctors, “[o]n pain, if they got it wrong, of being sued for trespass to the person or possibly being charged with a criminal assault”, would have to determine “as a matter of law in whom the right of consent resided at the particular time in relation to the particular treatment.”³¹ The other judges, Staughton and Farquharson LJ, formed no concluded view on the Master of the Rolls’ analysis, although Staughton LJ expressed some reservations. He doubted whether the result that children were competent to consent to, but not refuse, treatment was consistent with the underlying policy in *Gillick*. In the end, however, Staughton LJ deferred to Lord Donaldson’s views on this question.³²

Staughton LJ’s reticence is unfortunate, for Lord Donaldson MR’s approach raises at least two problems. First, by avoiding doctors’ apparently “intolerable dilemma”, Lord Donaldson MR gave children’s decision-making autonomy second place to legal certainty. This approach is difficult to reconcile with *Gillick*. Comment in the House of Lords suggests that certainty was not an important factor for the majority judges. The following extract from Lord Scarman’s speech indicates the realistic and flexible approach he considered appropriate:³³

Certainty is always an advantage in the law, and in some branches of the law it is a necessity. But it brings with it an inflexibility and a rigidity which in some branches of the law can obstruct justice, impede the law’s development, and stamp upon it the mark of obsolescence where what is needed is the capacity for development. The law relating to parent and child is concerned with the problems of growth and maturity of the human personality. If the law should impose upon the process of “growing up” fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change.

With respect, it seems disingenuous to justify distinguishing *Gillick* on the basis of avoiding the exposure of doctors to an “intolerable dilemma”. Far from creating certainty in the law, for doctors at least, *Gillick* generated its own dilemmas. The *Gillick* test itself confronts doctors with fiercely difficult questions about a child’s developmental capacity. To adopt Lord Donaldson MR’s language, under *Gillick*, before doctors can act on a child’s consent, they must assess the child’s capacity “on pain” if they get it wrong. Assessing whether a child is *Gillick* competent would be no more difficult in cases where the child consents than where the child refuses.³⁴ The *Gillick* court required the former of doctors. It would also be consis-

30 *Idem*.

31 *Idem*.

32 *Supra* n 21, 27-28.

33 *Supra* n 3, 186.

34 In *JMB supra*, n 25, 441, Deane J seemed unperturbed by the necessary corollary of *Gillick* that “the relationship between the child and her or his parents will ordinarily pass through a transitional stage in which authority [to consent to treatment] is shared.”

tent with *Gillick* to require the latter, rather than avoid the issue altogether by rendering the child's refusal legally invalid.

Secondly, Lord Donaldson MR's analysis is difficult to reconcile with *Gillick's* overarching concern for children's rights. This aspect of *Gillick* has attracted greatest comment. After *Gillick*, Bevan suggested, child law "will never be quite what it was."³⁵ According to Cretney, the case had "profound implications for family law."³⁶ The importance of the decision is well captured by Bainham's comment that, "[o]n the occasions when the judiciary recognise that children have rights it is considered a matter of some note."³⁷ Lord Scarman's majority speech in *Gillick* is perhaps best known for its expression of the "underlying principle" that parental rights "yield to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."³⁸ As Staughton LJ noted, Lord Scarman considered that the principle underlying the decision applied to the parents' right to determine "whether *or not*"³⁹ a child should have medical treatment abated as the child's maturity grew. The majority in *Gillick* was little concerned with the kind of legal niceties that allowed Lord Donaldson MR to distinguish children's refusals from consents. While Lord Donaldson MR's analysis is certainly tenable, with respect, it is hardly consistent with the spirit informing the decision in *Gillick*.

This view is supported by a 1992 decision of the High Court of Australia, *Secretary, Department of Health and Community Services v JMB and SMB*, which concerned an application by parents to allow an hysterectomy and ovariectomy to be performed on their 14-year-old daughter. In passing, a majority of the Court said of *Gillick*:⁴⁰

[T]he recent House of Lords decision in *Gillick v West Norfolk AHA* is of persuasive authority. The proposition endorsed by the majority in that case was that parental power to consent to medical treatment on behalf of a child diminishes gradually as the child's capacities and maturity grow and that this rate of development depends on the individual child This approach, though lacking in the certainty of a fixed age rule, accords with experience and with psychology. It should be followed in this country as part of the common law.

This passage suggests that the High Court judges perceived *Gillick* as establishing general principles for all medical decisions made by children. In a separate judgment, Deane J indicated that he considered *Gillick* to apply simply to the "relevant decision-making capacity of the child."⁴¹

Even this brief discussion should indicate that *Re R* is problematic on its own terms. According to the House of Lords, a *Gillick* competent child

35 H K Bevan, *Child Law* (1989) 1.

36 S M Cretney, "Family Law" [1985] All ER *Annual Review* 171.

37 A Bainham, "The Balance of Power in Family Decisions" [1986] CLJ 262.

38 *Supra* n 3, 186.

39 *Ibid* (emphasis added).

40 *Supra* n 25, 400-401 (per Mason CJ, Dawson, Toohey and Gaudron JJ) (emphasis added, footnotes omitted).

41 *Ibid*, 442.

could consent to treatment. According to the Court of Appeal, the same child could not refuse treatment. If followed, Lord Donaldson MR's analysis would completely override the majority *Gillick* judges' concern that legal incapacity should not follow from the mere fact of childhood.⁴² These problems were confounded by the Court of Appeal's approach to the Official Solicitor's second question — whether a court can order medical treatment to be administered if the treatment has been refused by a ward of the court.

Wardship and the Right to Refuse Medical Treatment

The Official Solicitor had argued that the court exercising its wardship jurisdiction had no greater powers than a parent to override a child's refusal. For Lord Donaldson MR, it would appear that this was more of a theoretical than a practical issue, having already decided that a child's refusal could be overridden by a parent's consent. Nevertheless, he rejected the view that the wardship jurisdiction was so limited. His Lordship considered it inappropriate to equate wardship with the exercise of parental duties and rights. In his view, it was entirely consistent with the wardship jurisdiction, "the delegated performance of the duties of the Crown to protect its subjects",⁴³ for a court to give an effective consent to medical treatment and override a child's refusal. After all, if a court in wardship was empowered to override parental decisions, Lord Donaldson MR saw no reason why it should not override the decisions of *Gillick* competent children. Though Staughton LJ had refused to express a view on the respective rights of parents and children, he agreed with the Master of the Rolls that the wardship jurisdiction was not limited by the ambit of parental rights although he reserved his opinion on the precise extent of the court's powers.⁴⁴ On this question, Farquharson LJ emphasised that "*Gillick's* case was not a wardship case and was concerned with mentally normal children."⁴⁵ He considered that if the *Gillick* test were appropriate for doctors to apply in cases of this kind, which he doubted, it would be rarely satisfied if considerable risk attached to acting consistently with the child's wishes. Furthermore, according to Farquharson LJ, a court exercising its wardship jurisdiction need not be constrained by the expressed wishes of a child whose mental capacity fluctuated from day to day according to

42 *B(BR) v B(J)* [1968] P 466 illustrates the pre-*Gillick* attitude of the English Court of Appeal. The case concerned the administration of a blood test on a child to determine paternity. At 473, Lord Denning MR commented: "A question was asked as to the extent to which the child should be consulted. If the child is of tender years — say under seven years — and thus unable to give consent, one way or the other — then the High Court judge can order a blood test without consulting the child. If the child is older, say 14 or 15 years of age, then the views of the child should be taken into consideration. But the child's views are never decisive." Even Lord Denning MR's limited recognition of the importance of the child's wishes was absent in Lord Donaldson MR's judgment in *Re R*. In *Re J*, supra n 22, Lord Donaldson MR considered that a 16-year-old's views might be of relevance to the *choice* of treatment, but not the decision to refuse treatment altogether.

43 Supra n 21, 25.

44 Ibid, 28.

45 Ibid, 32.

the effect of her illness. He was also "far from convinced" that a court need be constrained even by the wishes of a *Gillick* competent child, properly described.⁴⁶

Shortly after *Gillick* was decided, controversy arose in academic circles about its application to wardship and whether the decision should limit the scope of a court's rights over its wards. According to Eekelaar, *Gillick* "catches the court itself."⁴⁷ Eekelaar said that as wardship derives from the Crown's role as *parens patriae* he found it difficult to ascertain the principle upon which the court could exercise its delegated parental role to override a *Gillick* competent child's decision, if parents themselves were unable to do so. Though conceding that "technically" a court may override the decision of its ward, he argued that "within the spirit of the majority decision in *Gillick*" the wishes of a *Gillick* competent child should dictate any decision impacting on the child's life.⁴⁸ Other commentators took issue with Eekelaar's views. Maidment emphasised that the wishes of children are but one of many factors a court charged with their welfare need consider.⁴⁹ De Cruz suggested that the *ratio* of *Gillick* did not extend further than its specific facts and that courts dealing with other issues would not need to follow it.⁵⁰ Bainham argued that imposing a requirement that courts exercising a wardship jurisdiction must accede to the wishes of children would amount to a radical departure from the current practice of wardship courts and "be beyond the contemplation of the House in *Gillick*."⁵¹ More recently, in New Zealand, Mark Henaghan has endorsed Eekelaar's views and suggested that, consistently with *Gillick*, a court should act on the wishes of its wards.⁵²

Certainly, the *Re R* court was correct that the court may exercise its wardship jurisdiction to override the wishes of parents. A recent New Zealand case illustrates the point. *Director-General of Social Welfare v M*⁵³ concerned a 19-month-old Samoan girl who was diagnosed as suffering from bone cancer. Doctors recommended that her right leg be amputated and that she should be treated with chemotherapy to avoid the spread of the disease. Untreated, the disease would have been fatal. The parents opposed the treatment, removed the child from the hospital and had the child's great-grandmother treat her according to traditional Samoan medical techniques. While the parents were convinced that the great-grandmother's treatment was successful, the doctors disagreed. The doctors considered that the child's condition had deteriorated to a dangerous

46 *Ibid*, 31.

47 Eekelaar, "The Emergence of Children's Rights" (1986) 6 OJLS 161, 181.

48 Eekelaar, "The Eclipse of Parental Rights" (1986) 102 LQR 4. Eekelaar has made a similar argument with respect to custody: "Gillick in the Divorce Court" [1986] SLJ 184.

49 S Maidment, "The Child's Wishes" [1986] SLJ 233.

50 S P de Cruz, "Parents, Doctors and Children: the Gillick Case and Beyond" [1987] J of Social Welfare L 93, 100-101.

51 Bainham, *supra* n 37, 275.

52 M Henaghan, "The 'Rights' of Children when Decisions are made about them and which affect the Welfare and Interests of Children" in *The Family Court Ten Years On* (Family Law Conference, Conference Papers, NZ Law Soc, 1991) 48, 58.

53 (1991) 8 FRNZ 498.

level. The Director-General of Social Welfare brought an application under section 9 of the Guardianship Act 1968, the statutory equivalent of the High Court's inherent wardship jurisdiction,⁵⁴ for the child to be brought under the guardianship of the High Court. Under section 23 of the Guardianship Act, in guardianship proceedings the welfare of the child must be "the first and paramount consideration." The judge described the case as a "vivid" conflict between New Zealand and Samoan cultures that "admits of no compromise."⁵⁵ Against the wishes of the parents, the judge allowed the doctors to treat the child. As he put it, "[c]onsiderations of [the child's] welfare must be dominated by one aspect, namely the chance of saving her life."⁵⁶

It need not necessarily follow that because a court might override parental wishes, it can also override the wishes of a *Gillick* competent child. Arguably, however, it can.⁵⁷ Though Staughton LJ's reservations on the extent of the wardship jurisdiction indicate that some dissent about the extent of the inherent wardship jurisdiction may remain,⁵⁸ the position with respect to a New Zealand court's statutory guardianship seems clear. The powers of the New Zealand High Court over its wards need to be considered in their statutory context. Under section 23(2) of the Guardianship Act 1968 a court, exercising its jurisdiction in matters such as custody, access, and both general guardianship and guardianship under section 9, is required to ascertain the wishes of the child if the child is able to express them, but shall take account of them "to such extent as the Court thinks fit, having regard to the age and maturity of the child." A wardship court thus has a discretion as to the weight to accord a child's wishes. It is not bound to act on them. The Guardianship Act, by its requirement in section 23(1) that the welfare of the child be the first and paramount consideration, anticipates that the child's wishes will be one factor among many to be considered when making decisions that will impact on children's lives. Just as a wardship court need not act on a child's consent, it seems that it need not submit to a child's refusal.

54 Both the inherent and statutory forms of wardship exist concurrently in New Zealand, in addition to the limited wardship jurisdiction that has been vested in the Family Court recently by the Guardianship Act 1968, s9A. In *Director-General of Social Welfare v M*, the court suggested that the inherent jurisdiction was more appropriate when consent is sought for a "specific single treatment", whereas the statutory procedure should be used where supervision is required of a series of treatments likely to extend over a lengthy period: (1991) 8 FRNZ 498, 503.

55 *Supra* n 53, 504.

56 *Ibid*, 505.

57 Commentators on *Re R* have accepted that at least this aspect of the decision is technically correct. See Douglas, *supra* n 22, 69; A Bainham, "The Judge and the Competent Minor" (1992) 108 LQR 194, 195.

58 The consensus seems to be that the inherent wardship jurisdiction derives from the Crown's duty to care for those who cannot look after themselves and exists independently of any parental right. See *Wellesley v Beaufort* (1827) 2 Russ 1, 20; 38 ER 236, 243; *Re Eve* (1986) 31 DLR (4th) 14, 16; *JMB* *supra* n 25, 415; but see also the dissenting judgment of Brennan J in *JMB*, at 432-437, dealing with the specific issue of a court's power to authorise a sterilisation.

On the issue of wardship, the enactment of section 11 of the Bill of Rights Act 1990 would not impact greatly on the technicalities of the analysis. It is certainly possible to imagine an argument that the "welfare" discretion contained in section 23 of the Guardianship Act 1968 *must* be interpreted consistently with basic human rights. Were section 11 to apply, however, two opinions on the welfare of the child would need to be available to a court exercising its discretion over medical decisions impacting on the ward's life. Only then would section 6 of the Bill of Rights Act require an interpretation consistent with section 11. The two conclusions that allowing and not allowing the ward to refuse medical treatment would further the child's welfare would need to be equally viable. A court would rarely be at such an impasse. Reaching concluded views as to the welfare of particular children represents a large portion of the family law docket. New Zealand judges are well practised at it. Moreover, to impose a legal fetter of the specific character of that contained in section 11 upon a court exercising a discretionary decision making power as to the welfare of a particular ward seems inconsistent with the fact driven emphasis of modern family law.⁵⁹ It seems unlikely that the requirement that other enactments be interpreted consistently with the rights in the Bill meant to displace the current meaning attached to the paramountcy of the child's welfare in the Guardianship Act 1968.

Though *Re R* might be consistent with New Zealand law on the technicalities of wardship, it would be unfortunate if New Zealand courts followed this aspect of *Re R* to the letter. The Court of Appeal's analysis was fixed at the level of courts' legal powers over their wards, but, as Bainham says, "[w]hile it may be readily accepted that they have the technical jurisdiction to override the wishes of a mature adolescent, the real issue is whether they *should*."⁶⁰ Here, Staughton LJ made the pertinent comment that "good reason must be shown before the state exercises any power to control the decision of a competent person, whether adult or minor."⁶¹ Again, it is unfortunate that his Lordship did not take this point further.

Concerning this issue, it is essential not to confuse the reason why a child has been made a ward with the child's actual mental capacity. Wardship is often invoked to secure the welfare of children who cannot look after themselves or who are threatened by other people's behaviour. It may be that many such children would not satisfy the majority *Gillick* tests as to competence because of the very facts that led to their being made wards initially. For example, a girl who was mentally incapacitated and had been made a ward for her own protection might be unable to understand the implications of many decisions that would need to be made on her behalf. In other cases it may be important to resist the temptation to generalise, on the basis of the facts about a child that required the ward-

59 This analysis should not necessarily preclude recognition of other fetters on the exercise of the judicial discretion in cases concerning the welfare of children. The relationship between the Treaty of Waitangi and the discretionary powers contained in the Guardianship Act 1968, for instance, remains an under-analysed area.

60 Bainham, *supra* n 57, 196 (original emphasis).

61 *Supra* n 21, 28.

ship jurisdiction to be invoked in the first place, that the ward lacks the capacity for all decision making. Possibly, Farquharson LJ's unease with the application of *Gillick* to the decisions of a ward was prompted by conflating the problems that might cause a child to come under the wardship jurisdiction of the court with the child's capacity to decide about further problems that may arise. On the particular facts of *Re R*, the connection may have been appropriate. The child's mental disease and her refusal of treatment were very closely linked. Such a connection may not exist in all cases, however.

In New Zealand, the enactment of section 11 of the Bill of Rights Act should prompt a court to be wary of such connections. Though section 11 of the New Zealand Bill of Rights Act 1990 may not bind a New Zealand wardship court, Parliament has indicated that the right to refuse medical treatment is sufficiently important to include amongst the basic human rights contained within the Bill. Though the paramountcy of the welfare principle might render untenable any legal requirement that a wardship court exercise its discretion consistently with section 11, courts should be enjoined to do so where this approach is possible to reconcile with the welfare of the particular wards.

Both of the Official Solicitor's questions were pitched at the hypothetical level. The court responded in kind, by emphasising legal technicalities rather than the lived realities of the children and families for whom these questions have greatest meaning. The *Gillick* litigation itself was based, at least in part, on a hypothetical question.⁶² However, the majority of the House of Lords responded with a ruling that requires detailed evaluation of a child's specific circumstances. In the following section it is suggested that, if a New Zealand court faces interpretation of section 11 of the New Zealand Bill of Rights Act 1990 in the case of a child's refusal of medical treatment, the approach of the House of Lords in *Gillick* might provide a useful starting point. From the majority's emphasis on children's families, sensible and realistic principles can be derived to help decide whether overriding the child's refusal would be a justified limitation on the child's right.

IV SECTION 11 IN CONTEXT – RESURRECTING *GILLICK*

Children's decisions about medical treatment will be made against vastly contrasting personal and family backgrounds. Most families support, nurture and care. Many do not. Many children are capable of mature decision making. Some are not.⁶³ To follow *Re R* would be to accept an approach that ignores differences in personal and family circumstances. Lord Donaldson MR's rule that no child could refuse medical treatment would deny differences in lived realities by treating all children and all

62 Throughout the *Gillick* litigation it was emphasised that none of the applicant's children were contemplating sexual intercourse in the immediate future or were likely to seek contraceptive treatment. On the interesting procedural questions surrounding the litigation, including the issue of standing, see C Harlow, "Gillick: A Comedy of Errors" (1986) 49 MLR 768.

63 See M D A Freeman, *The Rights and Wrongs of Children* (1983) 45-60.

families the same.⁶⁴ Equally, regarding section 11 of the New Zealand Bill of Rights Act 1990 as according, in wholesale fashion, all children the right to refuse all medical treatment would be just as unfortunate, for this too would ignore the specific circumstances in which the right might be exercised. That children differ from adults in their emotional and physical vulnerability and the significance of their relationships within families is a point that bears emphasis whenever legal decision making concerning children is considered. To disregard either children's individuality or the contexts in which they might choose to exercise any right risks denying an important part of what makes children children.

Somewhere between the extremes of denial and permissiveness there is a middle ground, which, in the New Zealand Bill of Rights Act 1990, is marked out by the justified limitations clause. Where the White Paper was too facile in its approach was in its categorising children along with "others who are incapable of consenting to medical treatment on themselves." Children should not be excluded from the protection of the right, simply because they are children — just as, it might be added, the patient in *Re S* should not have been excluded simply because he was a committed psychiatric patient. The White Paper avoided the questions of what creates the incapacity and the significance it should be accorded. It is here that the principles articulated by the majority in *Gillick* provide useful guidance.

Differences in the majority speeches of Lords Scarman and Fraser⁶⁵ have been enthusiastically picked over in academic literature. Six years on, and in another jurisdiction, it suffices to emphasise similarities. As is well known, the majority of the House of Lords refused to render capacity a product of biological age. Instead, they required doctors to establish the extent of the child's understanding of the implications of the treatment. The capacity of children to understand such important life decisions has been the subject of much discussion.⁶⁶ Michael Freeman, for instance, is a strong supporter of the view that children appreciate more than they are often given credit for by adults.⁶⁷ It is submitted that the right of any

64 His rule is not only overtly paternalistic, it is perhaps also a product of the law's inexperience in forging legal principles that apply to family members as individuals. M Minow in "The Role of Families in Medical Decisions" [1991] Utah LR 1, 13, puts the point in these terms: "It's not that the law is new to families. Certainly, religious and secular laws have long governed marriage and inheritance, and, when allowed at all, divorce. But individuals within families, until recently, were removed from the legal rules governing all other interpersonal contacts."

65 The majority judges were Lord Fraser of Tullybelton, Lord Scarman, and Lord Bridge of Harwich. Lord Bridge expressly concurred with Lords Fraser and Scarman. One other judge, Woolf J, at first instance, decided against *Gillick*. In the Court of Appeal, Parker, Fox and Eveleigh LJ decided for *Gillick*, as did Lord Templeman and Lord Brandon of Oakbrook in the House of Lords. As Parkinson notes, the difficulty and importance of the issues at stake were indicated by the fact that the judges who heard the case lined up 5:4 in favour of *Gillick*: P N Parkinson, "The *Gillick* Case — Just What has it Decided?" [1986] Fam Law 11.

66 The psychological literature on children's capacity to understand the implications of medical treatment is surveyed by Devereux, supra n 5 294-302.

67 Freeman, supra n 63.

child to refuse medical treatment could only be justifiably limited if the child does not understand fully the implications of the choice.⁶⁸ It is essential for this to involve an individual assessment and that conclusions about a particular child's understanding not be based on application of rigid categories such as "intellectual disability". In *JMB* the majority of the High Court of Australia emphasised the point:⁶⁹

Of course, the fact that a child suffers an intellectual disability makes consideration of the capacity to consent a different matter. The age at which intellectually disabled children can consent will be higher than for most children within the normal range of abilities. However, terms such as "mental disability", "intellectual handicap" or "retardation" lack precision. There is no essential cause of disability; those who come within these categories form a heterogeneous group. And since most intellectually disabled people are borderline to mildly disabled, there is no reason to assume that all disabled children are incapable of giving consent to treatment.

It would be tempting to leave the matter there and conclude that if children have the same cognitive understanding as adults, limiting the right accorded them in section 11 would not be justified. What often goes overlooked, however, is that neither Lord Scarman nor Lord Fraser suggested that the right to consent to medical treatment followed merely from cognitive understanding. Their Lordships adopted, for want of a better expression, an holistic approach to children's understanding of the implications of their decisions. *Gillick* competent children are required to address the implications of their decisions in a manner that focuses on their family relationships. For instance, Lord Fraser required that before the doctor may act on a child's independent consent, the child must have been unable to be persuaded to involve his or her parents in the decision.⁷⁰ After stating that it is "not enough" that the child should "understand the nature of the advice which is being given", Lord Scarman emphasised that "[t]here are moral and family questions, especially her relationship with her parents."⁷¹

In these observations an attempt by the majority judges to contextualise⁷² the child's right to self-determination may be detected. Before going ahead with treatment, a doctor must be satisfied that the child has addressed

68 Although this article is limited to the right of a *Gillick* competent child to refuse medical treatment, it does not follow that a rights analysis is totally irrelevant for children who are incapable of consenting or refusing. See, further, the approach of the High Court of Australia in *Secretary, Department of Health and Community Services v JMB and SMB* (1992) 15 Fam LR 392. A considerable jurisprudence has developed in the United States on the issue of the incompetent patient's right to refuse medical treatment. See R Plotkin, "Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment" (1978) North Western University LR 461; A D Brooks, "The Right to Refuse Antipsychotic Medications: Law and Policy" (1987) Rutgers LR 339; for a recent critique of these developments see S J Brakel & J M Davis, "Taking Harms Seriously: Involuntary Mental Patients and the Right to Refuse Treatment" (1991) 25 Indiana LR 429.

69 *Supra* n 25, 401 (footnote omitted).

70 *Supra* n 3, 174.

71 *Ibid*, 189.

72 For a theoretical treatment of the issue of context in legal decisions, see M Minow and E V Spelman, "In Context" (1990) 63 Southern California LR 1597.

these questions and that they cannot be resolved in a manner that would involve the child's family. According to Lord Scarman, when contraceptive treatment is at issue, a girl should also understand the "long-term problems associated with the emotional impact of pregnancy and its termination", "the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate."⁷³ Lords Scarman and Fraser did not portray children as isolated individuals. Rather, they required evidence of sensible and honest thinking that locates the child within relationships. Major medical decisions are intense and painful.⁷⁴ It is not only the children making them who are likely to be affected. Understanding the emotional impacts of pregnancy, for instance, should require assessment of the possible reactions and capacity for support of members of the child's family. Different treatment will involve different questions, of course, and, in situations of family neglect or abuse, there may be little of significance in the requirement that children think through "moral and family questions". As is well known, if children fully understand all the issues impacting on the choice but cannot be convinced to involve their parents, *Gillick* would allow doctors to administer treatment. Importantly, however, autonomy and individuality only become organising principles in the decision making process when the doctor reaches the conclusion that the child and the family are seriously at odds. Under *Gillick*, going it alone is permissible, but it is the last, rather than the first, option.⁷⁵

This aspect of *Gillick* is of greatest potential significance for application of section 11 of the New Zealand Bill of Rights Act 1990 to children. As legal protection of rights increases in its importance for New Zealand society, it is inevitable that its role in family law will also increase.⁷⁶ As

73 *Supra* n 3, 189.

74 See Minow, *supra* n 64, 2.

75 Les Moran, *supra* n 23 at 93, observes that rather than protect children's rights, *Gillick* merely passed control of children's decision making from parents to medicine. She suggests that the majority of the House of Lords adopted its apparently liberal attitude towards children's decision making because it countenanced greater control by doctors over children's lives. Somewhat pessimistically, she argues that *Gillick* did not involve "liberating the practice of the State". An alternative view of the case is that it made a necessary and realistic acknowledgement of the way that increased participation by children in important life decisions will occur in practice. To risk stating the obvious, when children wish to make medical decisions independently of parents, doctors will be involved. Scrutiny is therefore needed of what the law requires of doctors when faced with the problem.

76 The importance of rights is not just a product of the potential for rights claims by children under the New Zealand Bill of Rights Act 1990. A further New Zealand development is the appointment of the Commissioner for Children under Part IX of the Children, Young Persons, and Their Families Act 1989. Although the statutory functions of the Commissioner, as laid down in s 411 of the 1989 Act, do not refer to children's rights, the Commissioner's function to monitor State practices has a definite constitutional flavour. Recent activities of the Commissioner indicate a determination to draw attention to children's rights. A 1992 publication from the Office for the Commissioner for Children, for instance, relies on the concept of children's rights as a basis for suggested reforms of New Zealand's child custody law: G M Maxwell and I B Hassall, *A Children's Rights Approach to Custody and Access* (1992). In addition, the United Nations Convention on the Rights of the Child will have inevitable impacts on New Zealand family law thinking. See (1992) 6 *Int'l J of Law and the Family* (Special Issue; Children's Rights).

rights come to provide family law with a constitutional gloss, family law must address how rights might be accorded to individuals while accommodating people's key relationships. On the one hand, rights claims make available to children and those charged with their protection important ways of articulating children's individual needs.⁷⁷ On the other hand, as Mary Ann Glendon notes, rights talk in the family law context can obscure the fact that "individuals benefit, not only from having 'rights', but also from being surrounded by certain kinds of social arrangements."⁷⁸ The challenge New Zealand family law will face is how best to deal with this tension in a manner that avoids "merely the crude determining of who is right and who is wrong, who wins and loses."⁷⁹ The value of *Gillick* for assessing whether restricting the right of children to refuse medical treatment is a justified limitation is in the majority speeches' emphases, not only on children's developmental capacity to understand the decision, but, as significantly, on the importance of such decisions to children's relationships with and within their families. For many children, there will be "moral *and* family questions" impacting on many decisions. It is only appropriate that the law should acknowledge them.

Principles underlying the application and limitation of the right contained in section 11 should, as far as possible, recognise children's rights and their relationships. If a child's understanding of the decision includes an understanding of its implications for the child's family, there seems to be no reason why section 11 should be limited in cases concerning children. It is submitted that a child's right to refuse medical treatment should only be limited when a child lacks appreciation of the types of issues Lords Scarman and Fraser considered important when assessing *Gillick* competence. Children who understand all that *Gillick* requires of them would hardly be childlike. Adapting the reasoning in *Gillick* to the application of section 11 in such a way would respect children's relationships and their autonomy, their connections and individuality.⁸⁰ It follows that, though an interpretation of section 25 of the Guardianship Act 1968 that is consistent with section 11 of the New Zealand Bill of Rights Act 1990 is to be preferred, this should not preclude the imposition of sensible limits on the right along the lines just discussed. This does not mean that children can be forced to involve parents and family, only that children should be required to appreciate what shutting them out might mean.

77 See the discussion by Henaghan, *supra* n 52, 49-52.

78 M A Glendon, *The Transformation of Family Law* (1989), 308.

79 B C Hafen, "The Constitutional Status of Marriage, Kinship, and Sexual Privacy — Balancing the Individual and Social Interests" (1983) 81 Michigan LR 463, 470.

80 According to some theorists, location of rights in relationships is the appropriate response to all law according rights protection, not only in cases concerning children. See M Minow, *Making All the Difference — Inclusion, Exclusion and American Law* (1989) which advocates a "social relations" approach to human rights law. For this approach applied to children's rights see M Minow, "Rights for the Next Generation: A Feminist Approach to Children's Rights" (1986) 9 Harvard Women's LJ 1.

V CONCLUSION

Consideration of the right to refuse medical treatment inevitably distils societal aspirations as to individual autonomy and self-determination. Consideration of the limits that may be placed on children's rights presents a unique opportunity for discussion of societal aspirations for the care and protection of children. Any assertion that, as section 11 of the New Zealand Bill of Rights Act 1990 does not distinguish between children and adults, children should be accorded the same right as adults to refuse medical treatment would not address the reality that there are many apparently acceptable ways of limiting children's rights. *Re R* and the 1985 White Paper suggested two ways the right to refuse medical treatment could be withheld from children. *Re R* emphasised overriding consent powers. The White Paper categorised children as outside the ambit of the right's protection. Both are marred by an "all or nothing" attitude towards the rights of children. This article has considered whether a better alternative might be forged. Limiting children's rights should involve establishing principles that both respect autonomy and recognise relationships. Drawing on the decision of the House of Lords in *Gillick*, this article has made some tentative suggestions as to how this might be achieved.

The scope of children's rights and the limits that may be imposed upon them will be marked out on an issue by issue basis. There may be some issues, such as wardship, where the relevant statutory scheme leaves little room for the requirement that enactments be interpreted consistently with the Bill of Rights Act. Nevertheless, as *Gillick* itself shows, a jurisprudence of children's rights may develop independently of express statutory recognition. Though this analysis has been confined to the right to refuse medical treatment, it is hoped that it will prompt discussion at a more general level of the principles that should inform the jurisprudence of rights protection for New Zealand children when law and families meet.