

‘Child Competence’ to Participate in and
Consent to Health Treatment:
A Foucauldian Discourse Analysis
Investigating the Meaning of
Competence

Amanda van Rooyen
MPhil

2016

‘Child Competence’ to Participate in and
Consent to Health Treatment:
A Foucauldian Discourse Analysis
Investigating the Meaning of
Competence

Amanda van Rooyen

A thesis submitted to Auckland University of Technology in fulfilment
of the requirements for the degree of Master of Philosophy (MPhil)

2016

School of Clinical Sciences
Auckland University of Technology

Abstract

Competence is a vital facet of the informed consent process. In New Zealand, despite some ambiguity in health legislation, children (less than 16 years of age) may give legally binding informed consent so long as they are competent to do so. The judgement of a child's level of competence is the responsibility of the attending health professional. Research studies have shown clear benefits to acknowledging children's competence to be included in and contribute to health discussions and decisions (Doyle, Lennox, & Bell, 2013; Gerison, 1994b). Unfortunately, New Zealand health legislation and policy do not give clear guidance on when or how to assess child competence and what makes a child a competent child.

The purpose of this thesis was to analyse the meaning of competence and its effect on children's participation in, and consent to, health treatment. The aim of this research was to highlight the discourses that construct the idea of 'child competence'. Foucauldian discourse analysis was used to explore the meanings attributed to 'competent' and 'child competence' by New Zealand health professionals, government and society. In addition it aimed to highlight the possible effects this discourse has on children's participation in important health matters that affect them. Subsequently, it may assist in the development of theory, practice, and health policy related to competent children and their rights to participate in and give informed consent. Relevant New Zealand legislation, health policy and literature written from a historical standpoint have been analysed utilising Foucauldian theories of archaeology and genealogy; including the notions of power, knowledge, and the subject.

The main findings of this study acknowledged the dominant subject positions held by health professionals and the legal system who imposed the legal version of the child competence discourse as authoritative. Factors contributing to the emergence of this discourse as authoritative in history included the requirement for children to be competent in order to enter adulthood and liberalism and individualism as the conditions required for its existence. The main innate conflict identified within this discourse included children's right to autonomous decision making versus adult's desire to protect them from undue harm. Through the analysis of what makes a child a

competent child, life experience was noted as a marginalised discourse that had a large impact on the perceived level of children's competence.

Adults' perception of competence as a binary with incompetence, rather than competence on a continuum, was noted as a possible barrier to children's participation in important health decisions. Lastly, and specific to New Zealand, the foundations of competence in individualism may have unexpected ramifications for many Māori and Pasifika children whose cultures are based on collectivism. Considerations for the implementation of competence assessments for this group of children are required so they too can realise the benefits of the recognition of competence.

Further training for health professionals may be required to support the frequency and reliability of competence assessments. Research is required to develop a working definition of child competence in healthcare so that health professionals can more regularly, reliably and easily incorporate competence assessments into their practice. Inclusion of children's voices in the development of this working definition would demonstrate respect for their rights and perspectives on this matter.

*This thesis is dedicated to my parents
Denise and Derek van Rooyen*

Through your sacrifices my dreams became possibilities

*"Pick a star, any star. When you see this star let it remind you of
who you are and where you come from." Dad 2002*

*"You are going to do something extraordinary one day, I
can't wait to see what it is!" Mom 2006*

Table of Contents

Abstract.....	i
List of Figures	vii
Attestation of Authorship	viii
Acknowledgements	ix
Definitions.....	x
Abbreviations	x
Chapter 1: Introduction.....	1
Current relevance for the study.....	2
Background	4
Assumptions.....	9
Chapter 2: Literature Review.....	11
Benefits to recognising child competence	12
Childhood as a social and cultural construct	14
The evolution of children’s rights	17
Childhood today.....	18
Gillick competent minors	20
The challenges with Gillick.....	21
A child’s right to consent to healthcare in New Zealand	22
Code of Health and Disability Services Consumers’ Rights 1996.....	23
Guardianship Act 1968 and Care of Children Act 2004	24
United Nations Convention on the Rights of the Child 1989.....	25
The Charter on the Rights of Tamariki Children & Rangatahi Young People in Healthcare Services in Aotearoa New Zealand	28
New Zealand Bill of Rights Act 1990	29
Medical Council of New Zealand.....	30
Do children have rights?	31
The right to autonomy	32
In the child’s ‘best interest’	33
The right to being informed.....	35
The concept of shared decision making (SDM)	37
A parent’s role.....	38
Competence as a moving target	39
Health professionals	40
Age and experience.....	42

Culture.....	44
Child versus adult competence.....	46
A child's right to refuse medical treatment in New Zealand	47
Competence of health professionals to assess and determine child competence	48
What makes a child a 'competent child'?	49
Conclusion.....	52
Chapter 3: Methodology	54
Introduction	54
Philosophy.....	54
Foucauldian Concepts.....	57
Discourse.....	57
Power	59
The panopticon and surveillance	61
Governmentality	63
Language and meanings.....	63
Why Foucault?	65
Chapter 4: Research Design.....	67
Data Collection.....	67
Data analysis	68
Discourse analysis process.....	68
Preparation	69
Method	69
Analysis of text.....	69
Writing up of analysis.....	70
Reflexivity.....	71
Ethical Considerations.....	72
Conclusion.....	73
Chapter 5: The archaeology and genealogy of child competence	74
Synonymy of the construction of childhood and child competence	74
The High Middle Ages: Europe (1001 – 1300)	76
The Late Middle Ages: Europe (1300 – 1500).....	77
Early modern period and its globalising character (1500 – 1790).....	79
Liberalism.....	83
The industrialisation period (1800 – 1900).....	85
New Zealand	87
The emergence of 'child competence' (1900 – 2015)	88
Summary	90

Chapter 6: The ‘truth’ about child competence	92
The legal emergence of the child competence discourse: The Gillick Case	93
The House of Lords – a brief history	93
Who has the power?	96
Protection or control – the nature of treatment	99
Language as a tool.....	101
Competence as a binary or continuum.....	103
A personal account	104
The universalisation of the child competence discourse: UNCRC	105
A product of universalisation.....	105
A facilitator of universalisation	107
New Zealand’s adaptation of the UNCRC	107
Summary	108
Chapter 7: Assessing child competence	110
Health professionals versus children’s subject position	110
The dominant legal version of the ‘child competence’ discourse	113
Competence versus Compliance.....	115
Compliance, the manifestation of surveillance	116
Summary	116
Chapter 8: Discussion.....	118
Tacit rules and conditions of existence.....	118
A conflict of ideals: Autonomy versus Protection.....	118
Apollonian Child versus the Dionysian Child.....	120
Individualism and liberalism	121
Life experience, a marginalised discourse?	122
Competence on a continuum	123
Individualism vs collectivism in New Zealand	123
Limitations	124
Recommendations	124
Conclusion.....	127
References	128

List of Figures

Figure 1: Seven factors to the informed consent process	4
Figure 2: Internal and external influences on children's competence to give informed consent	39

Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning".



Amanda Hope van Rooyen

Date: November 11th, 2016

Acknowledgements

Felix, my unwavering source of all things good, thank you. I am grateful for your patience, kindness, love and support, but most of all for always pushing me to do more.

To my family and friends, thank you for all of your words of encouragement and motivation, and of course the wine when all else failed.

To my supervisors Dr Tineke Water and Shayne Rasmussen, I can't thank you enough. Your kindness, guidance and wisdom was unprecedented. You were able to laugh with me, let the chaos of my ideas flow freely and guide my thoughts into well-polished and comprehensible concepts. Thank you for your continual motivation and inspiration, your attention to detail, your philosophical minds that continually challenged me and for normalising the emotional roller-coaster that is expected with this type of study.

Lastly, I would like to thank my many friends and colleagues at Auckland University of Technology for your support, thoughtfulness and understanding.

Definitions

Informed consent in healthcare refers to the process by which an individual (and/or their representative if the individual is not competent to provide or refuse consent) is appropriately informed and willing and able to agree to proposed health advice and treatment without coercion (Ministry of Health, 1998).

Competency and *capacity* are at times used interchangeably in the literature. These words refer to the ability or capability to make a rational, informed choice about accepting or refusing the treatment or service being offered, or authorising the collection and use of information (Ministry of Health, 1998). It can also refer to a legal status where there is a legal right to consent to treatment on the basis of having reached a certain age (Ministry of Health, 1998).

The word '*children*' in this thesis refers to those less than 16 years of age. The word *minor* has not been used as this terminology refers to an age range that specifies the *legal* competence of a child, suggests a universal childhood development trajectory and its definition across literature and countries is inconsistent. In addition, a facet of this work is to highlight how age is an inappropriate measure of a person's competence to participate in and consent to healthcare. Hence age categories, such as minor, have been avoided; rather opting for the broader and more generalised term children.

Abbreviations

COCA Care of Children Act 2004

CRC United Nations Committee on the Rights of the Child

Gillick case Gillick v West Norfolk and Wisbech Area Health Authority 1985

HDC Fact Sheet 3 The Health and Disability Commission Fact Sheet 3: The Age of
Consent and Informed Consent for Children 2014

Code Code of Health and Disability Consumers' Rights 1996

Charter The Charter on the Rights of Tamariki Children & Rangatahi Young
People in Healthcare Services in Aotearoa New Zealand 2010

UNCRC United Nations Convention on the Rights of the Child 1985

Chapter 1: Introduction

In a case that resulted in widespread media coverage, Tovia Laufau, a 13 year old Samoan boy who initially complained of a painful knee, died six months after being diagnosed with osteosarcoma in March 1999. His parents were told that if Tovia underwent treatment he may have a 60-70% chance of survival, but without it he would die. Mr and Mrs Laufau requested to speak to family before making a decision but never returned with Tovia for treatment. A concerted effort was made by Starship Children's Hospital staff to contact this family but to no avail.

As a possible consequence of the controversy surrounding the Liam William-Holloway case which occurred just prior to Tovia's case, health professionals did not seek a treatment order from the courts for Tovia. Liam was a 5 year old boy whose parents, like Tovia's, refused conventional treatment after he was diagnosed with a neuroblastoma on his jaw. Health professionals were widely criticised in the media for seeking a court order for Liam's treatment. Much of New Zealand public believed it was the court order that caused Liam's parents to take him into hiding, which subsequently resulted in his death. It is thought that the negative publicity surrounding Liam's case led to health professionals not seeking a court order for Tovia (Brandon et al., 2001).

Mr and Mrs Laufau maintained throughout the court proceedings that followed Tovia's death that Tovia had pleaded with them to not seek treatment and that it was out of their love for him that they did not ("Boy refused treatment: Mother," 2000). Ian Tucker, who represented the Laufaus, stated they were respecting the "clear and unequivocal wishes of their much loved son" ("Boy refused treatment: Mother," 2000, p. 1). Tovia's parents were given a suspended sentence after being charged with manslaughter and failing to provide the necessities of life for Tovia (Campbell, 2005).

Analyses of the outcome of Tovia's case considered factors such as a lack of information, language barriers, cultural and religious differences, misinterpretation of information and a breakdown of trust in the health professional-patient relationship to explain the behaviours of the parents and health professionals (Woods, 2007). Most

notably, Tovia's understanding of his situation was not easily found in the publicly available information on this case. Much like the Care of Children Act 2004, the Guardianship Act 1968 (which was relevant in Tovia's case) does not permit nor deny the opportunity for children less than 16 years of age to consent to or refuse health treatment. If Tovia's competence to participate in the health discussions and decisions were assessed, he may have had a different health outcome. Tovia's case is an example of the effects of health professionals' and health policy makers' possible inconsistent understanding regarding the recognition of competent children. This research addressed a possible gap in knowledge concerning competent children by posing the question; *what is the meaning of 'competence' in the context of child competence to participate in and consent to healthcare in New Zealand?* Foucauldian discourse analysis was used to highlight the power relations and conflicts within the child competence discourse to advance health professionals' and health policy makers' understanding and acknowledgement of this important issue which ultimately could promote better health outcomes for New Zealand children.

The current understanding of the child competence discourse is informed by historical perspectives and power relations between the different social groups involved in child health. Therefore, a Foucauldian discourse analysis was well fitted to inform a deeper understanding of child competence as it incorporated the effects of history via an analysis of the construction of childhood and the emergence of the child competence discourse. In addition, it integrated the dynamics of subject positions and their exertion of power on the individuals of the triad of child, parent and health professional and it embraced the social construction of competence through its epistemological lens of subjectivism. It enabled an understanding of the conditions behind the issue of child competence, highlighted and challenged assumptions and allowed hidden motivations in the triad to come to light.

Current relevance for the study

As a paediatric nurse working in Starship Children's Hospital, I was involved in many situations where children were not consulted in the consent process. For many reasons, be they right or wrong, health professionals, including myself on some occasions, would speak to the child's parents rather than the child themselves. It

seemed a natural 'reflex' to discuss the child's serious health conditions and maintain these discussions first and foremost with the parents. Through countless hours of research and discussions with colleagues I came to the conclusion that there may be a common assumption in New Zealand healthcare society that parental consent is required for children to receive health treatment. Consequently I looked for evidence to support or refute this assumption and to ascertain health professionals' current level of understanding of children's rights to participate in health discussions and to give informed consent in New Zealand. There was meagre information regarding health professionals' views on child competence to participate in health discussions and decisions, rather multiple perspectives regarding children's rights on the matter were present. One explanation for these varying perspectives stemmed from inconsistencies in New Zealand legislation, resulting in varying interpretations of the law and assumptions regarding children's competence to consent. These assumptions may have influenced the level of participation children are allowed to have in health discussions and decisions. For example, age being a measure of the amount of information given to children. The Foucauldian notion that the most dominant interpretations and assumptions are developed to serve the interests of the most dominant social groups led me to become curious about where the understanding of a competent child started, who influences/d it the most, and if there were other interpretations and discourses present but unseen.

By identifying the different subject positions that contributed to the dominant version of the child competence discourse and deconstructing the different meanings attributed to it, this work assisted in uncovering alternative discourses and consequently highlighted the possible effects this discourse has on children's participation in important health matters that affect them. This work may in turn assist in better informing theory, practice and health policy related to competent children and their rights to participate in and give informed consent to healthcare.

It is important to note that these findings may only inform healthcare theory, practice, and health policy in New Zealand for children less than 16 years of age. Competence to give eye witness testimony in a court of law, competence to make decisions on life changes when parents are divorced and competence to consent to

research are entirely separate issues.

Background

Competence is a vital factor in the informed consent process. “Seeking informed consent is an external expression of a health professional’s pivotal ethical duty to uphold and enhance their patient’s autonomy, by respecting the patient’s personhood in every aspect of their relationship with that individual” (Ministry of Health, 1998, p. 2). The main principles underlying informed consent are effective communication, full information that is freely given, and competent consent (see Figure 1) (Ministry of Health, 1998). New Zealand health legislation and policy, albeit rather ambiguously, states a child may consent to health advice and treatment, independent of their parents, so long as they are competent to do so (Health and Disability Commission, 2014).

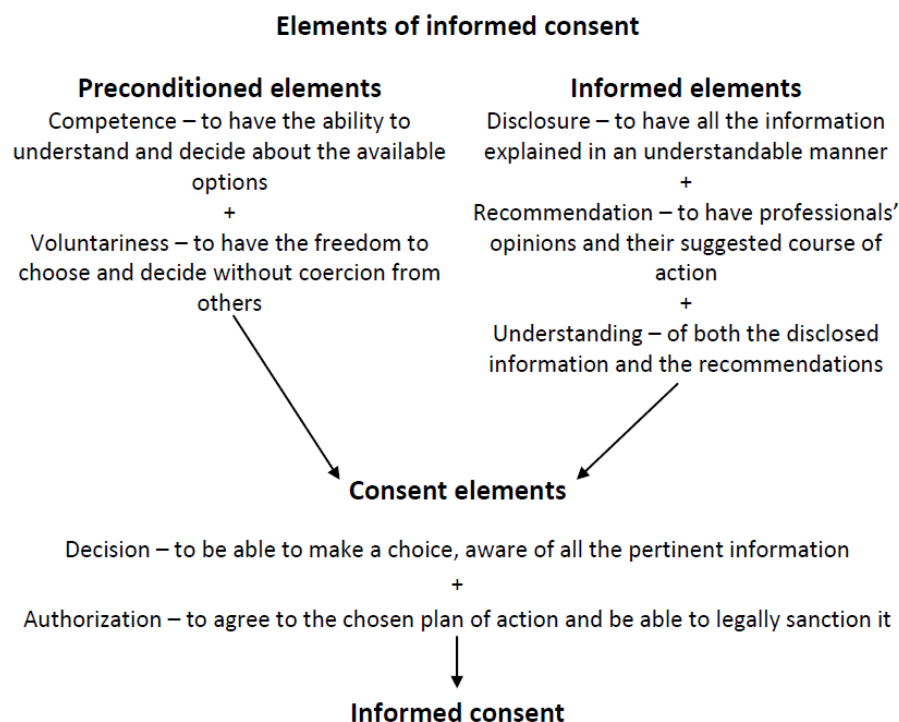


Figure 1: Seven factors to the informed consent process
(Beauchamp & Childress, 1994).

To gain a better understanding of the child competence discourse this research analysed the historical and social influences on the child competence discourse and

the effects of current New Zealand health legislation and policy guiding child competence assessments. There are multiple definitions of child competence available; one such definition is by Alderson (1992) who described it as “more than a skill, it is a way of relating and can be understood more clearly when each child’s inner qualities are seen within a network of relationships and cultural influences” (p. 123). Ambiguity however still remains with regard to what makes a child a ‘competent’ child in New Zealand healthcare.

Health is one of the most basic and essential considerations for child welfare as evidenced by article 24 of the United Nations Convention on the Rights of the Child (UNCRC) (United Nations General Assembly, 1989). Providing consent to health treatment stems from the ethical principle of autonomy. Autonomy is the right to shape our lives to our own values and it enables us to develop and express our characters and beliefs (Gilmore & Herring, 2011). An autonomous decision by a competent person is valid even if it may appear unreasonable or undesirable to others (McLean, 2000). This may not consistently be applied to children however, where it is adults who act as the protectors and gatekeepers to children’s rights and decide whether or not children may enact them or have their rights enacted for them.

Ambiguity in New Zealand health legislation regarding child competence to consent sources from the Care of Children Act 2004 (COCA), the Code of Health and Disability Services Consumers’ Rights 1996 (Code), the Health and Disability Commission *Fact Sheet 3: The age of consent and informed consent for children* 2014 (HDC Fact Sheet 3) and case law, most notably *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (Gillick case). COCA does not consider the competence of those younger than 16 years old to consent to health treatment (*Care of Children Act*, 2004). In contrast, the Code presumes all consumers of healthcare are competent to consent and does not differentiate between adults and children (Health and Disability Commission, 1996). As children are also consumers of healthcare, the Code may be interpreted as presuming children are also competent to consent, rather than first requiring proof of competence. The HDC Fact Sheet 3 however, states children may consent to healthcare, so long as they are competent to do so (Health and Disability Commission, 2014). Hence there is meagre clear guidance from New

Zealand health legislation to assist health professionals' judgments of children's competence to consent to healthcare.

Health professionals' judgements of children's competence are partly founded on the principles of the 1985 Gillick case (a UK based case that has been adopted by New Zealand health policy). Mrs Gillick, a mother of five daughters under the age of 16 years, took the West Norfolk and Wisbech Area Health Authority to court over a memorandum they published. The memorandum stated medical professionals may give contraceptive advice and treatment to girls younger than 16 years so long as they were able to understand the advice given (i.e. were competent). This case went to the House of Lords who ruled that a child of sufficient maturity, even under the age of 16 years, may consent to treatment based on their individual capacity to make an informed decision ("Gillick vs West Norfolk Area Health Authority," 1985). The principle known as the evolving capacity principle, is supported by the underlying philosophy that parental responsibilities diminish as children grow in intelligence, competence and autonomy as they move towards adulthood (Grimwood, 2009; Ministry of Health, 1998). A competent child has been dubbed 'Gillick competent'; a term used to describe a child who is able to understand the nature, purpose, and consequences of treatment and non-treatment (Medical Council of New Zealand, 2011). This concept has been adapted to New Zealand health policy, however clear guidance on how to enact its assessment has not been given. Again, an ill-defined area for health professionals remains resulting in possible inconsistencies in practice and a potential lack of realisation of its benefits for children.

With regard to health policy, child competence is referred to by the Ministry of Health (1998) in *Consent to Child and Youth Health: Information for Practitioners* and the Medical Council of New Zealand (2011) in *Information, Choice of Treatment and Informed Consent*. In contrast to the Code and COCA, both policies acknowledge the adoption of the findings of the Gillick case. Hence difficulties arise for health professionals in knowing whether to follow the 'maturity approach' (evolving capacity and assessment of competence) or the 'status based approach' (based on age as a measure of competence), as described by the Ministry of Health (1998). This lends itself to the question at hand; *what is the meaning of 'competence' in the context of*

children's participation in and consent to healthcare in New Zealand?

The process by which health professionals go about assessing and verifying the competence of a child raises concerns about the validity and reliability of its findings of children's competence or incompetence (Teoludzka & Bartholomew, 2010). *Consent in Child and Youth Health: Information for Practitioners* report was the result of a workshop held by the Ministry of Health in 1998 to standardise and formalise the process by which health professionals assess the capacity of a child to give consent (Ministry of Health, 1998). It advises health professionals to consider three important questions:

1. Does the patient understand why they need the intervention?
2. Does the patient understand what the intervention involves and what it is for?
3. Does the patient understand the probable benefits and risks and what the alternatives are? (p. 17)

It also emphasises the case-by-case nature of consent by children. It states that the children's age, their functional maturity, the complexity of the information given, the seriousness of their health condition and the implications of treatment and non-treatment should be taken into account (Ministry of Health, 1998). However, the decision of competence is heavily weighted on the health professional's unstructured judgement.

Individual attributes of health professionals may be a source of variation in competence conclusions. Differing subject positions and power relations result in subjective and unverifiable competence decisions. Bartholomew and Teoludzka (2010) conducted a qualitative study which showed medical professionals had significant variation with regards to their determination of competence. The identification of a competent child was found to be related to patients' age and gender rather than their ability to reason. There were additional complexities when a child disagreed with a proposed treatment, where they could be seen as irrational or immature, rather than exercising their right to autonomy and giving informed consent (Bartholomew & Teoludzka, 2010).

It has been suggested that children's right to exercise their autonomy and

participate in health discussions can be promoted by better recognition of children's capabilities (Lansdown, 2005). In order to improve the methods by which competence is identified, a better understanding of what competence is and what makes a child a 'competent child' is required. The aim of this research was to identify the multiple meanings and power relations that existed when 'child competence' was discussed or utilised by different social groups, such as children, parents, health professionals, policy makers and New Zealand society. It is hoped a better understanding of the foundations of the child competence discourse will assist with the construction of more reliable child competence assessments and for an increased realisation of the benefits of children's participation in healthcare. Foucauldian discourse analysis by way of a document analysis was therefore used to explore the meanings attributed to 'competence' and 'child competence'. Relevant New Zealand health legislation, health policy and literature were analysed. This document analysis was informed by Foucauldian theories of power, knowledge and the subject (Grant & Giddings, 2002). Questions listed by Payne (2010) (see page 64 of this thesis) were used to guide the method of document analysis.

A possible overarching presumption influencing the child competence discourse is that adults, in the general sense, are competent and children are incompetent (Alderson, 2007; Christensen, 1998; Wyse & Hawton, 2000). Alderson (2007) puts forwards that "Childhood is associated with being ignorant, volatile, foolish and dependent while adults tend to be identified as being informed, stable, wise, rational, reliable and above all, competent. However, "at times children can be wise and many adults can be foolish" (Alderson, 2007, p. 2276). This is a natural conclusion due to adults being recognised as autonomous individuals under the law, while children are not (Todres, 2014). For children, proving their competence is further complicated by the strong, confident, and overpowering views of adults (Wyse & Hawton, 2000). Children's incremental physical development is often used by adults to quantify children's mental, emotional, and social development, which research has shown to be a gross misjudgement (Alderson, K Sutcliffe, & K Curtis, 2006). Research conducted by Alderson et al. (2006) showed how children as young as four were able to understand the principles and recommended standards of controlling Type I

Diabetes. Hence a child's physical development, categorised by age, may not correlate with their level of cognitive development, and therefore should be used with caution when predicting children's level of competence.

Complicating the notion of proving competence, children's competence can change with changes in context, time, and the timing of the competence assessments. For example, in the context of children suffering from chronic illnesses or disabilities, research indicates higher levels of knowledge and competence relating to their conditions in comparison to healthy children (Alderson et al., 2006). This indicates experience to be a more influential factor to children's competence rather than age or ability (Alderson et al., 2006). Research conducted in third world countries; Africa, Asia, and South America, and most notably the research done by Liebel (2004) shows children have enhanced abilities, such as supporting themselves by working when forced to live independently and in the face of adversity. Liebel (2004) quotes a 12 year old girl who was asked if she would give up working if her mother was able to earn enough to support their family, "Why should I? It makes me proud to earn something myself. I learn how to look after money. It gives me independence" (pp. 1-2). These children demonstrated highly developed competencies compared to children in developed countries where these competencies are not needed to survive (Alderson et al., 2006). However, children in developed countries who suffer from chronic illness and disabilities are examples of children facing adversity. For example, children described by Alderson et al. (2006) who suffer from Type I diabetes, show advanced competencies similar to those shown by children in developing countries. These children are able to manage their insulin according to their blood glucose level, monitor their sugar intake, and show understanding of the effects of hypoglycaemia and its possible consequences including death (Alderson et al., 2006). Hence child competence is dynamic by nature and fluctuates with changes in children's contexts and experiences.

Assumptions

I have assumed that the competence of children is taken into account in the New Zealand health system. There is no data to support the notion that competence assessments are conducted on a regular basis, if at all, by New Zealand health

professionals. It is acknowledged that New Zealand legislation does not permit nor deny competent children the right to give or refuse informed consent. This grey area gives rise to a variety of interpretations and assumptions by health professionals on whether or not child competence assessments are an important process for children in healthcare (McLean, 2000).

Chapter 2: Literature Review

Child competence to consent to healthcare in New Zealand remains a grey area (Skegg, 2015). Although not clearly stated, New Zealand law infers that children, under the age of 16 years, may give or withhold consent to healthcare treatment, so long as they are competent to do so. It is the role of the healthcare professional to decide whether or not a child has the sufficient understanding and maturity to fully comprehend the proposed treatment; henceforth known as a competent child (Health and Disability Commission, 2014). The inherent complexity within the child competence discourse is further increased by the inclusion of parents as children's primary caregivers and health professionals' ethical duties of upholding children's right to autonomy but also doing what is in the best interests of the child. Inconsistency in health professionals' practice may result from this complexity and may be compounded by conservative assessments of children's abilities to be involved in decision making (Hagger, 2009).

In reviewing the literature, Foucault's ideas of archaeology and genealogy were used to underpin this review as a way to be mindful of the how the underlying structures of society at a particular time shaped people's thinking (archaeology) and how these structures have contributed to authority and truth claims in the present (genealogy) (Gutting, 2005). Foucault's concepts of archaeology and genealogy are explained in more detail in chapter 4 and 5.

Consistent with the concepts of archaeology and genealogy and the methodology of discourse analysis, this section served to not only review the current literature but also to highlight relevant documents for analysis. The discourse analysis questions listed by Payne (2010) on page 64 to 66 of this thesis were continually considered throughout the reading of literature pertaining to child competence. The cyclic reading, questioning and re-reading of the text assisted in the identification of the emergence of the child competence discourse, any inconsistencies within the discourse and the meanings attributed to the words 'competence' and 'child competence' by the different social groups involved in child health.

This chapter considers the history of childhood in an effort to identify key themes pertaining to the historical emergence of the child competence discourse. Relevant New Zealand legislation and policy are reviewed and documents central to the child competence discourse are identified. A consideration of children's rights and the different social groups who influenced these rights is undertaken to identify influences on the child competence assessment processes. Finally, current practises of assessing and identifying competent children are reviewed. With the assistance of the questions by Payne (2010), the research question; (*what is the meaning of 'competence' in the context of child competence to participate in and consent to healthcare in New Zealand?*) was continually considered throughout the review of relevant literature. To begin however, this chapter considers the benefits to recognising child competence to ensure this research topic's relevance to the central purpose of improving New Zealand children's health outcomes.

Benefits to recognising child competence

There are several reasons for supporting child competence to participate in and consent to healthcare. First and foremost, adults' recognition of children's competence supports children to enact their right to free and full information, to express their views and shows respect for their autonomy and personhood. Second, research has shown the recognition of child competence improves children's health outcomes (Gerison, 1994b). Respecting children's capacities and affording them the care and involvement they deserve contributes to the continual improvement in their health status (Ministry of Health, 1998). Doyle et al. (2013) found patient experience had a positive association with patient safety and clinical effectiveness. Both self-rated and objectively measured health outcomes, adherence to recommended medication and treatments (Carpenter et al., 2014), preventative care, healthcare resource use and technical quality-of-care delivery are directly correlated with patient experience (Doyle et al., 2013). Positive patient experiences in the paediatric population have been directly related to participation, provision of honest and open information, and the recognition of children's capacities to partake in healthcare decisions (Coyne & Gallagher, 2011; Doyle et al., 2013). The study by Coyne and Gallagher (2011) identified that children who were involved in the decision-making process had mostly

positive experiences and that the process helped them prepare for what to expect, reduced their worries, and provided reassurance. Hence, the recognition of children's capacities to participate in and make important health decisions is an integral part of consumer's satisfaction and healthcare experience.

Seeking feedback from children regarding their experience of healthcare services provides vital information for the improvement of child health services (Dickinson, Wrapson, & Water, 2014). There is little information in the public domain relating to children's views of health services, and what is available is usually in a proxy form given by adults representing children (Dickinson et al., 2014). In particular, the views of younger children are rarely sought, despite growing evidence of their competence to be valuable contributors to healthcare service improvement (Dickinson et al., 2014). Seeking feedback from children may contribute to giving health professionals a more appropriate and effective representation of child health needs.

On a more intrinsic note, listening to children and giving their views due weight can contribute to a child's personal development, lead to better decision making and outcomes, protect children, prepare them to participate in society, teach tolerance and respect for others, and strengthen accountability; all leading to better health outcomes (Alderson, 2007; Lansdown, 2011; van Staa, Sattoe, & Strating, 2015). Allowing children to have an active role in their healthcare decisions teaches them in an incremental process rather than having instantaneous responsibility at the age of 16 years (McLean, 2000). Treatment is more likely to be effective if children are allowed to take part in the decision making and for their contributions to be respected; alternatively, those who felt coerced into health treatment tended to recover more slowly (Alderson, 1990; Lewis, Lewis, Lorimer, & Palmer, 1977). Griffith (2013) used an example of a mass immunisation plan following the 2013 measles outbreak in South West Wales. The need for parental consent was found to be one of the main contributing factors to poor immunisation rates specifically in the 14 to 17 year age group (Griffith, 2013). Griffith (2013) stated that if nurses were more confident in assessing for competent children then this immunisation scheme would have been significantly more successful, resulting in improved health promotion for this age

group of children. This demonstrates the possible positive effects of listening to children and allowing them an active role in the decision-making process.

Trust, one of the most vital elements of a health professional-client relationship, can be promoted by allowing children to participate in and make important health decisions. However, if parental consent were to be compulsory for all children to receive health treatment then parents would require full information on the health status of their child. A lack of confidentiality and privacy may result in a loss of trust in the health professional-client relationship, which could have negative impacts on the health outcomes of children (Alderson, 2007; van Staa et al., 2015). Children may be unable to trust health services to respect their privacy and will avoid using them, creating a possible reduction in health promotion and, in some cases, resulting in further health complications and poor health outcomes (Alderson, 2007). Hence, child competence assessments may allow competent children to participate in health discussions and decisions independent of their parents, allowing them to maintain their privacy and develop trust in the health professional-client relationship, ultimately leading to better health promotion and outcomes. Examples of healthcare areas where the recognition of competent children, independent of their parents, may be beneficial are contraceptive advice and treatment, or in cases of child neglect or abuse.

Recognising child competence to participate in and consent to healthcare has been shown to have multiple and varied benefits, such as the intrinsic benefits of personal development and better decision making skills, and extrinsic benefits of adherence to recommended treatment regimens and improved preventative care strategies. Hence it is important to gain a more in-depth understanding of child competence so that health professionals are better informed to assess it and help realise its benefits for New Zealand children.

Childhood as a social and cultural construct

One of the central notions relating to child competence is the socio-political and cultural construction of childhood. Philippe Ariès first introduced the idea of childhood as a social and cultural construction. He described it as a complex process,

subject to change, resulting in a variety of lived experiences for children, not entirely governed by biology (Ariès, 1962; Cox, 1996). He explained the construction of childhood as "an awareness of the particular nature of childhood that distinguishes the child from the adult" (Ariès, 1962, p. 128). The nature of childhood exists as an expression of adults' perception of the desired state of childhood (Hendrick, 1997). In addition to this, the definition of 'child' changes depending on culture, history, and context, and is influenced by class, gender, and ethnicity (Miller, 2011). Changes in the definition of child and the contexts of childhood throughout history may have had an effect on adult's perceptions of child competence.

Ariès (1962) argued that in the Middle Ages the idea of childhood did not exist. Children were seen to be adults when they were physically able to be independent of their parents (Ariès, 1962). They were sent to work at a very early age, there was no distinction between children and adults with regards to being tried and punished for crimes, they interacted with adults in an uncensored and unrestricted way and they were seen as mini-adults with the same rights, duties, and skills (Ariès, 1962; Wyse & Hawton, 2000). Ariès suggested that the modern idea of childhood started to appear in the 13th century, and it was not until the 17th century that children of upper classes began wearing distinctive clothing and occupying a separate social category to adults. Between the 15th and 18th centuries the construction of childhood was fragmented and divided between the notion of 'innocence' and the 'inheritors of original sin' born of the evangelical and political anxieties of the time (Hendrick, 1997; Wyse & Hawton, 2000). Children were seen to be in need of authoritarian adult control and physical punishment to bring them in line with the will of God (Wyse & Hawton, 2000). Under the law, they were viewed as objects, chattels to be 'seen and not heard' and as the property of their parents, most notably their fathers (Lowden, 2002; Todres, 2014). On the other hand, John Lock and Jean Rousseau introduced the romantic construction of children as *tabula rasa* (blank slate) and the 'noble savage', in need of adult role models, reward and encouragement to develop their learning and innate curiosity and the recognition of their need to be children before they are adults (Wyse & Hawton, 2000). Of note, the period of the 'romantic child' was short lived.

19th century industrialisation saw children's needs become subordinate to those of adults. The French Revolution, fears of social disorder and the demands of a political economy were augmented by the jostling activists of women's rights, democrats, trade unionists, labourers and others who fought for food, political representation and the right to free opinion (Wyse & Hawton, 2000). Three separate constructions of childhood existed: the evangelical child who lacked in social goodness, the factory child inherited due to the need for free labour in the industrialisation period, and the delinquent child whom were unemployed and without the 'ideal family' of the time (Wyse & Hawton, 2000). Children were once again relocated into a world inhabited by adults; from experience children were able to survive the world of factories and life on the streets but reformers perceived these children as needing to be cared for and returned to their state of innocence (Wyse & Hawton, 2000). Postman (1994) argues that the social dimension of childhood emerged with mass literacy in the 19th century when the printed word created a divide between those who could read (adults) and those who couldn't (children). The Factory Act 1833 and the requirement for schooling contributed to the remoulding of the definition of childhood once again to a time of dependency, ignorance, separation from the adult world, protection, and subject to social control (Wyse & Hawton, 2000). Children who were once independent were disempowered and unable to be responsible for their own lives and well-being (Wyse & Hawton, 2000).

The disempowerment of children led to multiple constructions of childhood in the 20th century; the 'psycho-medical and psychological child' due to poverty, health concerns and the setting up of guidance clinics. The 'welfare child' was a result of the Children's Act 1908 and the beginning of school medical inspections, and the 'family and public child' were constructions born of the Children Act 1948 and the Children and Young Persons Act 1969 (Wyse & Hawton, 2000). Although these above mentioned Acts originate in the United Kingdom, New Zealand children were affected in a similar way through New Zealand's colonisation by the British in the early 1800's. In essence, childhood returned to a state of dependency, vulnerability, and separation from the adult world.

The evolution of children's rights

Different beliefs about children such as what is in their best interests, how they should behave and what should be expected of them, have a powerful effect on their value and position in society. These beliefs influence social policies, parenting styles, professional practices and institutional arrangements for children's education, care and welfare (Smith, 2013, p. 18).

In the late nineteenth century, reformers of the industrialisation period promoted children's identity as vulnerable and in need of protection (Todres, 2014). This led to the development of child welfare systems and juvenile courts (Todres, 2014). The first identification for the need for children's rights was observed in the Declaration on the Rights of the Child, otherwise known as the Declaration of Geneva 1924 (Todres, 2014). However, this declaration pertained to the duties of all men and women rather than the rights of the child in particular (Todres, 2014). In New Zealand, the Guardianship Act 1968 was developed but it did not specify the rights of children under 16 years to consent to health treatment (Ministry of Health, 1998). The Treaty of Waitangi Act 1975 specified tino rangatiratanga (Māori self-determination; self-identification at the personal level and self-determination culturally), as a vital ingredient for children's rights and access to healthcare (Children's Hospitals Australasia and Paediatric Society of New Zealand, 2010). The United Nations Declaration on the Rights of the Child 1959 expanded the pronouncement of children's rights, which were further asserted in the 1989 UNCRC (Todres, 2014). New Zealand's ratification of UNCRC in 1993 confirmed the belief that children and young people are active citizens and have entitlements that encompass moral, political and social agendas (Smith, 2013). UNCRC is the most widely accepted human rights treaty in history, by which most nation states, bar two exceptions (Somalia and the United States of America), have agreed (Todres, 2014). Children have made a historical shift from a mute population to one that has individual rights and a voice in decisions that affect their lives (Todres, 2014).

According to Ludbrook (2000) New Zealand's government has assumed that it is in full conformity with the UNCRC since its ratification in 1993, however the myth of full compliance has led to feelings of self-satisfaction and lack of government initiatives towards full compliance. Since Ludbrook's publication in 2000, the Charter on the Rights of Tamariki Children and Rangatahi Young People in Healthcare Services in

Aotearoa New Zealand (the Charter) was published and is based on the UNCRC 1989 (Children's Hospitals Australasia and Paediatric Society of New Zealand, 2010). It was a result of the *Self Evaluation Model and Tool on the respect of Children's Rights* which identified a number of areas that required improvement regarding children's healthcare rights in New Zealand (Children's Hospitals Australasia and Paediatric Society of New Zealand, 2010). Hence, New Zealand government is beginning to acknowledge areas of improvement required to fully comply with UNCRC, however currently these acknowledgements appear to be rhetoric rather than actualised in practice (UNCROC Monitoring Group, 2013).

Childhood today

The construction of childhood and children (tamariki) for Māori are often illustrated using the flax plant. It is used in Māori proverbs to demonstrate the importance of tamariki (children) and rangatahi (young people). "The central shoot is likened to a child, one either side of the child represents their parents, and beyond them are extended family members, all of whom protect the budding child from the ravages of nature" (Children's Hospitals Australasia and Paediatric Society of New Zealand, 2010, p. 11). This illustrates the social construction of childhood in the Māori culture; that of vulnerability and protection, which is consistent with other Anglo European cultural constructions of childhood. Consequently, it supports the requirement of adults' recognition and respect of children's rights in New Zealand.

The Charter states three reasons for the need for specific rights for children and young people. Firstly, they experience illness differently to adults and are therefore more susceptible to harm and are entitled to special care and support. Secondly, as a consequence of social structures, their developmental immaturity, and their lack of political and economic power within society and the healthcare system causes them to be vulnerable and powerless. Thirdly, children's rapid physical, cognitive, developmental, social and experiential changes, and characteristics of childhood and adolescence, results in their growth towards independence from their parents. This Charter uses words and phrases such as vulnerable, powerless, different to adults, susceptible to harm, developmental immaturity, and dependence. This highlights the

current position of the social construction of children and childhood in New Zealand, that of vulnerability and in need of adults' protection.

In contrast, it has been suggested that childhood as we know it is disappearing (Postman, 1994). These suggestions originate from the current trend of children being afforded the same rights as adults, the growing similarities of adult and child clothing and the increasing incidence of children committing crimes more commonly associated with adults (Postman, 1994). Todres (2014) argues that the dominant view of childhood today is that of dependent individuals, immature and incapable of autonomous thought or action and in need of socialisation to conform to the adult world. However, Thomson (2001) suggests the vulnerable and dependent child is increasingly the exception in modern society as children have greater awareness and levels of sophistication. Specifically, the use of technology to access unlimited amounts of information and the provision of legislation upholding children's rights has contributed to their growing independence (Thomson, 2001). Over a relatively short period of time, the place of children in society has shifted from being the property of their parents to independent and capable individuals (Miller, 2011). 'Childhood' however remains a separate category to 'adulthood' (Miller, 2011). It may be possible that adults are once again at a crossroads, fuelled by multiple ideological agendas, namely those of supporting and respecting children's rights versus the desire to protect them. As was in the industrialisation period, children are engaging in the adult realm; as much as adults strive to control children's access to adult controlled information, children's access to, for example the world-wide web, television and a consumable income, is near irrepressible. With children's increasing independence in society, seen at ever younger ages, the importance for addressing their abilities to participate in autonomous health advice and treatment becomes progressively more urgent (Thomson, 2001). Easy access to health information and freedom to express opinions are required for children to participate in health discussions and decisions, but the implications of adults' continued control of health information involving children is unknown.

A central document recognising adult's control of health information is the Charter. It highlights the significant challenges children face in exercising their rights

and their continued experiences of being disadvantaged in their health status (Children's Hospitals Australasia and Paediatric Society of New Zealand, 2010). In particular, right 6 acknowledges children's right to access full and honest information in a form that is understandable to them. Hence, in addition to the socio-political and cultural construction of childhood, an understanding of the construction of New Zealand health legislation and policy is of pivotal importance to gaining a more in-depth understanding of the child competence discourse.

Gillick competent minors

New Zealand health legislation and policy has been influenced by the 1985 case *Gillick vs West Norfolk and Wisbech Area Health Authority* (Gillick case). It was a landmark case that denotes the emergence of the dominant 'child competence' discourse and recognised that children can be independent, autonomous and competent decision makers with regards to their health care. It marked a turn in the conception of parenting being a right and a dominant and controlling process in a child's life to being a responsibility and duty.

This case concerned the right of a child to competently consent to receiving contraception advice and treatment without the consent or involvement of her parents. Mrs. Gillick took the Department of Health and Social Services to court over guidelines it published for medical practitioners to prescribe contraception to a girl under the age of 16 years (Grimwood, 2009). She argued that it was in the best interests of her children for her to be fully informed and to consent on their behalf (Grimwood, 2009). This case ended in the House of Lords, with Lord Fraser and Lord Scarman in particular giving their own specific guidelines for the provision of contraceptive advice and treatment (Grimwood, 2009). Lord Fraser (1985) stated,

Provided the patient—whether a boy or a girl—is *capable of understanding* [emphasis added] what is proposed, and expresses their own views, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and [for them] to authorise the medical man to make the examination or give the treatment which he advises. (p. 6).

Lord Scarman (1985) stated,

I would hold that as a matter of law that parental right to determine whether their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a *sufficient understanding and intelligence*

[emphasis added] to enable him or her to understand fully what is proposed. (p. 26).

This was a clear rejection of the status-based approach where a set age limit dictates the competence of a person (McLean, 2000). The House of Lords ruled that parental rights to decide whether or not their child receives health treatment ceases when the child reaches sufficient maturity and has the understanding and intelligence to make an informed decision (Drake, 2001). Antecedent to these principles is the notion that children grow and develop gradually rather than achieve full competence at a certain age (McLean, 2000). Hence as a child grows in maturity and experience, their competence to consent develops and it is the particular abilities of each individual child on which competence assessments depend (McLean, 2000). Since this case, children deemed to be competent to give informed consent based on the above principles have been dubbed 'Gillick competent'.

Lord Fraser stipulated that the assessment of a child for competence should be a last resort and every effort should be made to involve the child and the child's parents in the decision-making process (McLean, 2000). The Medical Council of New Zealand (2011) has adopted this suggestion and advises health professionals to support children by including their parents in health decisions.

The challenges with Gillick

There has been little guidance as to what Gillick competence is and when or how it can be applied (Grimwood, 2009). This leaves a grey and ill-defined area for New Zealand courts and an ethically challenging set of principles for health professionals (Grimwood, 2009). The vagueness and various interpretations of Gillick competence creates uncertainty for health professionals (Martenson & Fagerskiold, 2007; Miller, 2011). They may recognise the need for a child's competence to be assessed but the tests are unreliable and their suitability are unverified (Martenson & Fagerskiold, 2007). Hence, possible inconsistencies may be present within the healthcare system and New Zealand courts with regard to child competence assessments and the recognition of Gillick competent children (Grimwood, 2009; Miller, 2011).

The complexities of recognising Gillick competent children are further complicated by the different interpretations of ‘ability to understand’; an integral part of a child competence assessment. As per the Gillick case, a competent child is one who has the *capability* to understand, which merely refers to the *ability* to understand rather than an understanding of the specific health situation (Cave, 2013). The Ministry of Health (1998) however stated the ability to understand depends upon the complexity of the decision and situation. Cave (2013) argued that the capacity to understand is different to understanding the situation at hand, therefore according to Gillick it would be legitimate to ensure the competence of a child prior to the child making a decision. It has been suggested that the competence of a child should be ascertained prior to giving information about their health situation so that the depth, amount and form in which the information is delivered is suitable to the ability and developmental stage of the child, the latter part being in accordance with UNCRC (Cave, 2013; United Nations General Assembly, 1989). If the Gillick test required an assessment of children’s *actual* understanding (understanding of the situation) then the law would require full disclosure to all children, which could potentially cause harm if the delivery of information occurs in a manner that is not consistent with their developmental stage (Cave, 2013). All healthcare consumers retain the right to make informed decisions to the extent appropriate to his/her level of competence (Health and Disability Commission, 1996). Hence, identifying competent children is important however the application of assessing the competence of a child is still not clear.

A child’s right to consent to healthcare in New Zealand

There is a current movement globally to increase the role of children in decision making and to recognise their rights and abilities in the area of informed consent. This movement sources from the 1989 United Nations Convention on the Rights of the Child (UNCRC). New Zealand ratified this convention in 1993 and therefore has an obligation to enact the recommendations and guidelines and is committed to upholding children’s rights in policy, practice and law.

Consent to healthcare by ‘competent’ children is regulated by the Code of Health and Disability Services Consumers’ Rights 1996 (Code), the Care of Children Act 2004 (COCA), New Zealand Bill of Rights Act 1990, and common law; most notably the

Gillick case (Ministry of Health, 1998). New Zealand has shown some commitment to the principles that underpin Gillick competence; they were initially utilised in the 1968 Guardianship Act and the 1977 Contraception, Sterilisation, and Abortion Act which are specific statutory provisions in New Zealand which regulate the right of minors (less than 18 years of age) to consent to an abortion and/or contraceptive advice without parental consent or involvement. There are also specific situations whereby parental or guardian consent is not necessary for children, less than 16 years of age, such as the administration of a blood transfusion in an emergency situation, the examination of a child on the suspicion of child abuse or neglect, and cases in which the court has guardianship. However, other than these specific situations there is inconsistent guidance from New Zealand health legislation and policy for the participation in and consent to healthcare advice and treatment by children, less than 16 years of age, independent of their parents. These inconsistencies source from the varying use of the 'maturity approach', based on the evolving capacity rule set out in Gillick, and the 'status approach' based on age as a measure of competence, most notably 16 years with regard to consent to healthcare in New Zealand.

Code of Health and Disability Services Consumers' Rights 1996

The Code gives rights to all consumers of healthcare in New Zealand, which health professionals are obliged to uphold. Consumer is defined as "a health consumer or a disability services consumer" and does not explicitly exclude children less than 16 years old (Health and Disability Commission, 1996, p. 9; McLean, 2000). Therefore, regardless of a child's capacity to consent, they retain their entitlement to the other rights listed under the Code which include effective communication, full disclosure of information and inclusion in any decision-making process that involves them. In particular, Right 7(1) enforces the right to an informed choice and informed consent (Health and Disability Commission, 1996).

New Zealand is unique in that the Code presumes all consumers of healthcare to be competent (McLean, 2000). Right 7(2) states "Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent" (Health and Disability Commission, 1996, p. 5). The presumption of competence indicates the Code

values the 'maturity approach' (based on the evolving capacities of children) rather than the 'status rule' (based on age) as described by the Ministry of Health (1998, p. 50). As per article 3(1) and 3(2) of The Code,

A provider [health provider] is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code. The onus is on the provider to prove that it took reasonable actions" (Health and Disability Commission, 1996, p. 8).

Hence if a complaint were made by a parent pertaining to the competence of their child and the child's right to give informed consent, the health professional would need to evidence the 'reasonable actions' they took that led to their findings of competence or incompetence of that child.

Guardianship Act 1968 and Care of Children Act 2004

In contrast, the Guardianship Act and the Care of Children Act are based on the 'status approach'. The Guardianship Act 1968 detailed the position of informed consent to health treatment for people over the age of 16 years and only gave specific guidance pertaining to a person under 16 years who is married. The Ministry of Health (1998) states, "The Act [Guardianship Act 1968] does not otherwise specifically refer to the rights of children/young people under 16 to consent to medical treatment and there has been a presumption that parental consent is necessary with any child or young person under 16" (p. 37).

The 1968 Guardianship Act was later revised and titled the 2004 Care of Children Act (COCA). COCA gives prominence to children's rights and recognises children as active participants of society (Miller, 2011). COCA, s 36, and the Guardianship Act, s 25(1), stipulate that a child 16 years or over can consent or refuse any medical, surgical or dental treatment or procedure (Miller, 2011; Ministry of Health, 1998). They do not clarify the situation for children less than 16 years of age (Miller, 2011). However, Part 1 s3 (2C) rather ambiguously states the purpose of the Act is to "respect children's views and, in certain cases, recognises their consents (or refusals to consent) to medical procedures" (*Care of Children Act*, 2004, p. 1984). The 'certain cases' are in fact specific cases that are detailed further on in the COCA document such as a blood transfusion in a medical emergency, abortion and the rights of a married child less than 16 years of age (*Care of Children Act*, 2004). Neither of

these Acts permit nor deny the right to consent to health treatment by competent children. This is despite there being a large number of submissions on the Care of Children Bill recommending clarification on the issue and proposing adoption of the maturity approach in line with the Gillick principles of 'evolving capacities' (Miller, 2011).

United Nations Convention on the Rights of the Child 1989

The 1989 UNCRC challenged the prevailing image of childhood at that time ('to be seen and not heard') and introduced a new culture of rights, broadly categorised as participation, protection, and provisional rights (Smith, 2013). These cover economic, social, cultural, civil, and political rights which are afforded to all children without exception. It was ratified by New Zealand in 1993, recognising children as citizens with moral, social, and political equalities (Smith, 2013). The UNCRC strives to create "an atmosphere of happiness, love, and understanding" within a family environment and "in the spirit of peace, dignity, tolerance, freedom, equality and solidarity" (United Nations General Assembly, 1989, p. 1). In particular article 42 obligates governments to ensure the principles and provisions of the UNCRC are widely known by adults and more importantly, by children (Gray, 2002; United Nations General Assembly, 1989).

The UNCRC however instructs both the maturity and status approaches for those working with children. The principle of the maturity approach is reflected in the UNCRC article 5 and 14(2) which states that the rights and responsibilities of the parents should be respected in order to provide direction and guidance for their child "in a manner consistent with the evolving capacities of the child" (United Nations General Assembly, 1989, p. 2). Article 12 and 13 declare that any child who is able to form their own views has the right for those views to be freely expressed, which includes the freedom to seek, receive, and impart information and ideas of all kinds, and for those ideas and expressions to be given due weight in accordance with the *age* and *maturity* [emphasis added] of the child (United Nations General Assembly, 1989). Article 3(1) also includes the statement "...according to the age and maturity of the child" which suggests both the maturity and status rules are applicable, consequently adding further complexity to the assessment and recognition of competent children in New Zealand (United Nations General Assembly, 1989, p. 4).

An additional complication is the notion of 'the child's best interests' described in article 3 of the UNCRC which supersedes children's rights of self-determination, freedom of expression (article 13), and respect for their views (article 12). Thirty years prior to the UNCRC, the House of Lords recognised that it can be detrimental to a child's health if their rights to consent to health treatment are not identified and respected ("Gillick vs West Norfolk Area Health Authority," 1985). However, if the child's opinion is not in their best interest (according to their parents or other authoritative adult) then that opinion may not be respected or upheld (Miller, 2011). Article 3 of the UNCRC states that the best interest of the child must be the primary concern when making decisions about them (United Nations General Assembly, 1989), which at times may challenge the Gillick principles on which the maturity approach is based.

The New Zealand Children's Commission established the UNCRC Monitoring Group in late 2011 to address the February 2011 Concluding Observations of the UN Committee on the Rights of the Child (CRC) on New Zealand. This group meets quarterly to monitor and review the progress made on implementing the UNCRC in New Zealand. The UNCRC Monitoring Group comprises of representatives from a number of non-governmental organisations (NGO) including UNICEF New Zealand, Action for Children and Youth Aotearoa, Save the Children New Zealand, Every Child Counts, and the Child Poverty Action Group. It also includes representatives from two Independent Crown entities; the Office of the Children's Commissioner and the Human Rights Commission (UNCROC Monitoring Group, 2013). According to the UNCROC Monitoring Group (2013) the New Zealand government's response to the UNCRC has been less than satisfactory. The CRC recommendations advised the New Zealand government to undertake public awareness campaigns aimed at the public and specifically children, and to carry out systematic education and training on the principles and provisions of the UNCRC for all professionals working with and for children, including health personnel (UNCROC Monitoring Group, 2013). In response to the CRC recommendations, UNICEF conducted a survey of New Zealand government agencies including those responsible for education, law enforcement, military, and some tertiary education institutions to establish a baseline of the UNCRC education

and training available for health professionals working with children (UNCROC Monitoring Group, 2012). This research highlights the following key findings;

- There is no evidence of any government or departmental investment in formal UNCRC training. Despite CRC recommendations (since 1997) it has not been given any priority.
- Training for public sector professionals is inconsistent and irregular.
- There are no formal mechanisms that public sector professionals must use to check for the consideration of children's rights in decision making (UNCROC Monitoring Group, 2012, p. 4; UNICEF New Zealand, 2011)

The report *Kids Missing Out* was released by UNICEF in December 2013. It is a stocktake of New Zealand's progress in implementing the UNCRC. Again decision making in healthcare was not addressed, however children's participation in decision making was noted on a general scale. The report states,

Initiatives to allow children to have a say in matters that affect them have not always been sustained, there are very few processes for eliciting children's views on legislative and policy development, and children's ability to participate in judicial and administrative proceedings is variable (UNICEF New Zealand, 2013, p. 14).

The Human Rights Commission (2015a) *Fifth Periodic Report under the UNCRC* noted the Government UNCRC Work Programme's strategy to investigate what the New Zealand government can do to help children have a say on matters that affect them. This strategy has been identified as one that requires further attention to enhance compliance with the UNCRC and infers that although this issue has been acknowledged, there are no details as yet as to how it will be addressed (Office of the Minister for Social Development, 2014). Child participation is also recognised by the Human Rights Commission in the National Plan of Action for the Promotion and Protection of Human Rights (NPA) which was completed in June 2015. Taking into account the opinions of children in the Children's Symposium 2003, the NPA acknowledge that children need to be listened to, their opinions given due weight, and their participation rights under the UNCRC be implemented (Human Rights Commission, 2015b). It suggests a program is needed to improve children's participation in governmental and non-governmental sectors and that educational resources need to be developed to assist organisations to involve children in decision making (Human Rights Commission, 2015b). The NPA states the importance of children's participation is recognised by both the Agenda for Children 2002 (Ministry of

Social Development and Ministry of Youth Affairs) and the Youth Development Strategy 2002, however taking into consideration the results from the Children's Symposium 2003 and the recommendations by the NPA, it becomes more clear that the importance of children's participation has been mentioned in governmental policy but little has been done to implement strategies to support it. Children's participation in healthcare is one area that has been recognised by New Zealand government as requiring improvement but little has been done to actualise it in practice (UNCROC Monitoring Group, 2013).

The Charter on the Rights of Tamariki Children & Rangatahi Young People in Healthcare Services in Aotearoa New Zealand

The Charter on the Rights of Tamariki Children and Rangatahi Young People in Healthcare Services in Aotearoa New Zealand (the Charter) was developed in response to the identification of the need to align the rights of New Zealand children and young people in healthcare services with the UNCRC (Children's Hospitals Australasia and Paediatric Society of New Zealand, 2010). It recognised that the responsibility for child health in New Zealand lies with many health organisations. It extended an invitation to all these organisations to commit to the charter in order to maintain uniformity with regard to the commitment and responsibility to promote, protect and respect the rights of children and young people (Children's Hospitals Australasia and Paediatric Society of New Zealand, 2010). This Charter is dedicated to upholding the principles of the UNCRC in New Zealand and hence maintained similar complexities as the UNCRC with regard to recognising competent children. It supported the maturity approach alone but recognised that children's best interests are one of its main goals.

The three principles that underpin the Charter are children's best interests, taking children seriously and the recognition of family as the fundamental group in children's lives. It constitutes eleven rights which are based on the UNCRC; in particular it pertains to the inclusion of children in decision making about their healthcare with consideration of their abilities to understand and participate, their evolving capacities, and the rights and responsibilities of parents to provide direction and guidance for them (Children's Hospitals Australasia and Paediatric Society of New Zealand, 2010). Right 6 and 7 are pertinent to the discussion around informed consent

as they consider the issues of children's right to full and truthful information in a manner in which it can be understood by the child, and granting children the opportunity to make decisions for themselves and respecting those decisions (Children's Hospitals Australasia and Paediatric Society of New Zealand, 2010). Hence the Charter supports the maturity approach and concurrently the best interests of children, which like the UNCRC, in some situations may supersede the maturity approach and children's rights to autonomous and independent decision making.

New Zealand Bill of Rights Act 1990

The purpose of the New Zealand Bill of Rights Act is to "affirm, protect, and promote human rights and fundamental freedoms in New Zealand, and to affirm New Zealand's commitment to the International Covenant on Civil and Political Rights" (*New Zealand Bill of Rights Act*, 1990, p. 1). It applies to all individuals regardless of age (Ministry of Health, 1998). In conjunction with the UNCRC, the New Zealand Bill of Rights Act protects children's rights to refuse medical or scientific experiments or treatment (*New Zealand Bill of Rights Act*, 1990; United Nations General Assembly, 1989). In particular s 11 is applicable. Relevant sections include:

Section 10 Every person has the right not to be subjected to medical or scientific experimentation without that person's consent

Section 11 Right to refuse to undergo medical treatment; Everyone has the right to refuse to undergo any medical treatment

Section 13 Freedom of thought, conscience, and religion; Everyone has the right to freedom of thought, conscience, religion, and belief, including the right to adopt and to hold opinions without interference.

Section 15 Manifestation of religion and belief; Every person has the right to manifest that person's religion or belief in worship, observance, practice, or teaching, either individually or in community with others, and either in public or in private.

Section 20 Rights of minorities; A person who belongs to an ethnic, religious, or linguistic minority in New Zealand shall not be denied the right, in community with other members of that minority, to enjoy the culture, to profess and practise the religion, or to use the language, of that minority (*New Zealand Bill of Rights Act*, 1990, pp. 4-10).

Similar to the Code, which presumes all consumers are competent, this Act refers to all individuals regardless of age. Hence, it can be inferred that it supports the Code's presumption of competence and the maturity approach, however only to the extent of refusal of medical treatment in s 11.

Relevance of this Act to the child competence discourse is evidenced in the case of *Re J (An Infant)* (1996), whose parents claimed that the right to the free practise of religion included the right to raise their children and make health decisions for them in accordance with the parents' religious beliefs (Ministry of Health, 1998). This was overruled by the Court of Appeal which stated, "We define the scope of the parental right under s 15 of the Bill of Rights Act to manifest their religion in practice so as to exclude doing or omitting anything likely to place at risk the life, health or welfare of their children" (*Re J (An Infant)*, 1996, p. 146). It is unlikely that s 15 could be used to deny a child the right to life-saving or other essential treatment (Ministry of Health, 1998). For example, this is relevant to Tovia Laufau whose parents opted for him to receive alternative therapies based on religious grounds rather than conventional medicine. After the death of their child, they were given a suspended sentence for failing to provide the necessities of life (Carter, Stickley, Inglis, & Laxon, 2002). Under the New Zealand Bill of Rights Act Tovia could arguably have independently refused or consented to health treatment.

Medical Council of New Zealand

The Medical Council of New Zealand clearly supports the maturity approach. Guidance from the Medical Council of New Zealand on informed consent by children states "People under 16 years of age are not automatically prohibited from consenting to medical, surgical or dental procedures so judgement of the patient's competence to make an informed choice and give informed consent is needed in each instance" (Medical Council of New Zealand, 2011, p. 3). This statement is based on the common law approach to determining competence of a child and is informed by the Gillick case (Medical Council of New Zealand, 2011). The Medical Council of New Zealand supports the assessment and judgment of a child's competence to give informed consent and describes a competent child as an individual who "is able to understand the nature, purpose and possible consequences of the proposed investigation or treatment, as well as the consequences of non-treatment" (Medical Council of New Zealand, 2011, p. 4). This document recognises the lack of direction on the subject from COCA and states that the principles set out in Gillick, that of parental consent not always being

necessary, will most likely be followed by New Zealand Courts (Medical Council of New Zealand, 2011).

The lack of clarity in New Zealand health legislation and policy may lead to inconsistent child competence assessments in practice, presumptions of child competence to participate in and consent to health treatment and defensive practices where health professionals find it necessary to gain consent from children's guardians so that they do not risk legal actions (Miller, 2011). New Zealand health legislation and policy does not clearly uphold children's rights to autonomy, freedom of expression and participation in matters that are important to them. Subsequently, the benefits from the promotion of children's competence may not always be realised in New Zealand healthcare.

Do children have rights?

Ferguson (2013) states children's rights are "a class of rights that includes both rights targeted specifically at children and rights in relation to which the identity of the right-holder, who happens to be a child, is critical" (p. 178). The idea of children's rights however is problematic in that the term 'right' suggests a relationship between one person asserting a claim and the other recognising or guaranteeing it (Manful & McCrystal, 2010). Hence difficulties arise if adults do not respect or support children's rights. There are two theories to children's rights; 'interest' and 'choice'. The 'interest' theory regards rights as the protection of interests; a person has a right when others have duties or obligations which protect that person's interests (Manful & McCrystal, 2010). However, some rights are not always in the best interests of the rights holder, such as the right to full information that in the health setting could be damaging to younger children. Some rights are also not in the best interest of the person obliged to uphold the right for the right-holder, for example a competent child's autonomous decision that does not comply with adults wishes. The 'choice' theory considers rights as the ability to make a choice; "to have a right is to have the power to enforce or waive the duty to which the right corresponds" (Manful & McCrystal, 2010, p. 87), as for example, the choice of participating in important health matters or not. However, if rights protect an individual's choice, then those who cannot choose have no rights, such as infants. This is problematic for children as, in the health setting, health

professionals decide whether or not children may choose according to the child's level of competence.

It is important to note that children's rights are interdependent (Lake, 2014). For example, children's right to participation in matters that are important to them depends on the realisation of their rights to autonomy and free speech. Health professionals and health policy makers are important groups who create, analyse, influence and implement children's rights (Manful & McCrystal, 2010). There is however little evidence on how these groups of professionals conceptualise children's rights (Manful & McCrystal, 2010); in particular the right to autonomy, the right to having others (adults') actions being conducted in children's best interests and the right to be informed.

The right to autonomy

Living under the adult construction of childhood and children's rights, children must then rely on adults to uphold these rights. From an adult's perspective, children are being seen more and more as independent and autonomous beings rather than the property of their parents. This is reflected in the increasing recognition of children's rights in New Zealand legislation and policy, as detailed in previous sections. Autonomy has been suggested to be the most basic and fundamental moral principle which should be afforded to all human beings (Lowden, 2002; Orr, 1999). It is the right to make self-determining choices and the freedom to have full ownership and control of personhood, which includes independence and decision making. The Ministry of Health (1998) described autonomy in the context of informed consent as "the right to think, decide and act on one's own deliberation freely and without coercion even if in the end the person involved decides to let someone else guide him or her" (p. 2). Inherent in the definition of autonomy is the importance of voluntariness; freedom from control and coercion of others (Orr, 1999), and personhood which, depending on culture, may mean individual independence or the process of absoluteness and wholeness, or self-esteem and integrity (Ministry of Health, 1998). A competence test is reliant on measuring maturity, understanding and intelligence in order to determine whether or not a child has the capacity to exercise autonomy over their own body (McLean, 2000).

Respect for a person's autonomy in the healthcare setting is seen in part by enacting the informed consent process. McLean (2000) stated a child's competence assessment concludes at the specific point in time at which the child has made a choice to consent or refuse the proposed health treatment. Cave (2013) and McMurdo and Gillett (2013) argued that this contradicts the rights of respect and autonomy as the child's decision should not bias the competence assessment. No matter how unreasonable the decision is every individual has the right for their decision to be respected and protected (Cave, 2013). This is relevant to the 'choice' theory of rights and children's non-compliance with adults wishes. Lord Donaldson stated in *Re T* regarding a competent adult's decision to refuse lifesaving treatment,

An adult patient who...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...this right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent (Thomson, 2001, p. 147).

This is relevant to competent children whose decisions may not comply with adults' wishes but none the less are within their rights to exercise autonomy and personhood. Alderson and Goodwin (1993) and Coyne and Gallagher (2011) found that the majority of children want to make their own healthcare decisions; some want parents and healthcare professionals to assist them in the decision-making process, and some would prefer the decisions to be made for them. Children's wish for the right to autonomy and respect for their decisions is represented in this quote from a 9 year old girl:

I think it's my decision. I never heard anyone saying do you want me to do this or not and it's not their decision, it's not their bodies they are doing it on, it's mine and other children's, that maybe we don't want it changed (Coyne & Gallagher, 2011, p. 2338).

In the child's 'best interest'

An autonomous decision is synonymous with the individual's choice and is valid even if it may appear unreasonable or undesirable to others (McLean, 2000), however in the case of children, their views are often not upheld in the name of the 'best interest' principle. Although child advocates argue for children's opinions to be respected, the notion of 'best interest' triumphs and is related to professional

obligations and duty of care (UNCRC, article 3). Lansdown (2011), an international children's rights consultant, states that participation is in the best interest of all children and that consideration of a child's views is an integral part of determining their best interests. Hence, what is in a child's best interest may not always be thought of as independent to their views; rather their views could be included in the process to identifying what course of action might be in their best interest.

The current positioning of 'best interests' as independent to children's views can be identified during the occasions when children and/or their parents disagree with the course of treatment recommended by the health professional. The Ministry of Health (1998) suggests that if the issue of disagreement cannot be resolved then the health professional should act in the child's best interest, which may involve applying to the court to remand the child as a ward of the court and implementing treatment that is believed to be beneficial to the child. The ethical dilemma of reconciling the two commitments, the best interests of the child and giving due weight to the child's own views, may be a common predicament experienced by health professionals due to the current prioritisation of family centred care and children's participation in healthcare decision making (Archard & Skivenes, 2009). If a child and/or their parents refuse recommended treatment (which has occurred on occasion in New Zealand as result of religious, cultural or quality of life beliefs), health professionals are guided by the 'best interest' concept for the child (Ministry of Health, 1998). The Liam Williams Holloway case is a prime example. It involved a disagreement between Liam's parents and healthcare professionals as to what constituted his best interests. Liam's parents declined conventional treatment which would have given Liam a 50% chance of survival, and opted for alternative therapies. Health professionals disagreed and submitted a custody order to make Liam a ward of the court. As a result of the court action Liam and his family felt forced into hiding, only to resurface four months later. The 'best interest' requirement originates from Lord Fraser in the Gillick case. According to Lord Fraser, children's and/or their parents' wishes will only be respected if they align with the opinions of the health professional as these are considered to be in the child's best interest (McLean, 2000). McLean (2000) argues the best interest principle is inconsistent with the purpose of the competence test and undermines the

principle of autonomy, participation and freedom of expression which requires respect for an individual's views.

The right to being informed

In accordance with the UNCRC (1989, article 13) all children have the right to freedom of expression which includes freedom to seek, receive and impart information. For children to give autonomous independent consent, free of coercion, they require all relevant information in a manner appropriate for their age (Health and Disability Commission, 1996). Lansdown (2011) describes the integral role information has in the act of participation,

Participation is an ongoing process of children's expression and active involvement in decision making at different levels in matters that concern them. It requires information sharing and dialogue between children and adults based on mutual respect and requires that full consideration of their views be given, taking into account the child's age and maturity. (p. 3).

Many academics and child activists have detailed children's preference to be informed and have indicated the benefits of giving children full and honest information (Alderson et al., 2006; Curtis, Liabo, Roberts, & Barker, 2004; Gerison, 1994a; McPherson & Thorne, 2000). The work by Coyne and Gallagher (2011) particularly highlighted these preferences. They interviewed 55 children between the ages of 7 and 18 and almost all spoke about the need for information so that they knew what to expect with regards to their illness, procedures, risks, outcomes, medications and length of stay in hospital. A 14 year old boy said "He [Medical Practitioner] broke it down into English words, like he explained to my Mam in medical words, but then he explained it to me, like what the words meant" (Coyne & Gallagher, 2011, p. 2337). A 13 year old girl talked about being ignored and how it made her feel:

He [MP] kept having to talk to Mam on her own and I was getting really worried cause if they want to speak to Mam about something either it's because they need to do something really bad. I need to know because otherwise I'm going to be sitting there panicking going all paranoid thinking the worst scenario (Coyne & Gallagher, 2011, p. 2337).

Coyne and Gallagher (2011) found health professionals tended to 'do things' to children with brief or no explanation. Many of the children interviewed talked about their lack of choice or opportunity to decide, and their feeling of having to comply with

decisions largely determined by health professionals. Children reported feeling disappointed, sad, confused, angry, worried, shocked, betrayed, lonely, ignored and rejected due to their lack of involvement in the decision-making process, which subsequently may have negatively impacted the health outcomes of these children (Coyne & Gallagher, 2011). Most of the children interviewed indicated their willingness and preference to being involved and fully informed regarding their healthcare (Coyne & Gallagher, 2011).

Right 5 of the Code (1996) stipulated the need for “effective communication in a form, language and manner that enables the consumer to understand the information provided” (p. 4), and an environment that enables open, honest and effective communication. Right 6 of the Code details a consumer’s right to full information and to honest and accurate answers to questions relating to health services. Inconsistent delivery of information by health professionals in the above described manner can cause children to misunderstand and become fearful of the hospital system and health professionals themselves (Henaghan, 2012). Dr Peter Watson, a defence witness in the Tovia Laufau case, believed this was the case for Tovia and his family which resulted in them going into hiding and eventually with the loss of Tovia’s life (Henaghan, 2012).

A child’s competence and participation in decision making can be limited by an inconsistent process of imparting information using language that is not developmentally appropriate for them (Brook, 2000; Coyne, 2006). Different sources children use to make sense of their illnesses secondary to a lack of appropriate information include reading clues off pharmaceuticals, analysing adults’ behaviour around and towards them, and exchanging and discussing information with their peers on the hospital wards (Christensen, 1998). A 9 year old boy who participated in the study conducted by Coyne and Gallagher (2011) stated, “I let my mum ask the questions and she tells me because I hardly understand anything they say. Before the operation he [health professional] said one big word and I was just thinking what does that mean” (p. 2338). In the study by Curtis et al. (2004) a 14 year old expressed the need for better information in a clear and appropriate manner, “They come out with some long words man. They talk to my parents but even my parents don’t understand.

What does it take to be a nice doctor? Not all them long words” (p. 154). No matter the age of the child, they have the right to information and consultation in a manner relevant to their abilities (McLean, 2000; Miller, 2011; Ministry of Health, 1998).

The concept of shared decision making (SDM)

Central to children’s rights regarding the consent process is the ability to participate in health matters that are important to them. Shared decision making (SDM) is a model that was introduced to allow greater participation by children and their families in health discussions and decisions. It is a process whereby both the health professional and the patient provide information and determine a treatment plan together. This contrasts with informed decision making (IDM) where the patient simply says yes or no to the suggested treatment plan. “SDM is a collaborative respectful partnership where the expression of patient preferences and values is encouraged and considered, and both sides [health professional and patient/family] share responsibility in deciding the best care option for optimal health outcomes” (Smalley, Kenney, Denboba, & Strickland, 2014, p. 1316). It may be seen as a step towards lessening the power imbalance between the health professional and the child/child’s family.

A quote from a 13 years old boy in the study conducted by Coyne and Gallagher (2011) indicates that children have a desire for participation and to partake in SDM; “I think the children should get the opportunity to tell what they think it is and not just what their parents or the doctors think it is ... because it’s about me then I should be part of it” (p. 2338). In order to promote the inclusion of children in healthcare decisions the approach of SDM has been suggested in place of IDM (Smalley et al., 2014). Wilson et al. (2010) conducted a randomised control trial where they compared medication adherence in adults with poorly controlled asthma to two different treatment decision making models; IDM versus SDM. The participants in the SDM group of this trial reported a greater role in the treatment decisions (Wilson et al., 2010). Wilson et al. (2010) found SDM significantly improved participants’ adherence to asthma pharmacotherapy, better clinical outcomes and a significantly higher quality of life was reported at follow up. Lipstein, Brinkman, and Britto (2012) conducted a literature review on parental perceptions of treatment decisions and found greater

satisfaction among parents who were involved in a SDM approach compared to a paternalistic model. Fiks and Noonan (2013) and Smalley et al. (2014) have suggested SDM is a natural progression for the paediatric population secondary to the complex dynamics of the informed consent process and the recent prioritisation of family centred care and children's participation in health decision making. SDM may be seen as a stepping stone or a method to improve children's participation in healthcare.

A parent's role

Parents may at times advocate for or inhibit children's participatory rights in healthcare. Lipstein et al. (2012) found that most parents prefer an active role in decision making but require assistance in determining when and how to include children in decisions. The level of involvement and the intensity of the parent's role has been linked to the child's diagnosis and acuity, the specific decision and the parent's knowledge base and experience (Lipstein et al., 2012). Depending on the context of the decision, parents have been found to either support or inhibit their children having an active role in decision making.

Parents can, on occasion, create the largest barrier to a child's access to information and decision making. Lipstein et al. (2012) found two thirds of adolescents and parent dyads disagreed with the preferred role for the adolescent. Disagreements were identified with the preferred treatment and the key influences on the treatment decision (Lipstein et al., 2012). A similar finding was made by Coyne and Gallagher (2011) whose participants described situations where their parents inhibited their participation by answering questions for them, telling them to be quiet, reprimanding them for interrupting discussions, withholding information and not supporting their attempts at gaining information.

Parents' opinions concerning decision making in healthcare was explored by October, Fisher, Feudtner, and Hinds (2014). They utilised the 'Good Parent Tool', an empirically based decision-making construct to explore parent's values and preferences around decision making in the Paediatric Intensive Care Unit environment. The three most important themes found were 'putting my child's needs first', 'advocating for my child with the clinical team', and 'focussing on my child's quality of

life' (October et al., 2014, p. 294). Coyne and Gallagher (2011) also had reports of children preferring their parents to make decisions because 'they know best', they feel unsure that they would know what to do and are used to their parents making the decisions.

The level of participation parents allow their children in the decision-making process can have an effect on the amount and quality of information their children receive and on the opportunities their children may have to voice their opinions or ask questions. A lack of information or opportunity to be involved may have implications on the child's level of competence to participate in subsequent health discussions and decisions.

Competence as a moving target

A child's competence is not a fixed state but is dynamic in nature; a child's ability to understand develops and modifies with their experiences and changes in their social contexts (Alderson, 2007). Figure 2, described by Alderson (1992) and illustrated by Orr (1999), depicts the myriad of internal and external influences on adults' perceived level of a child's competence, the majority of which fluctuate with changes in the child's context.

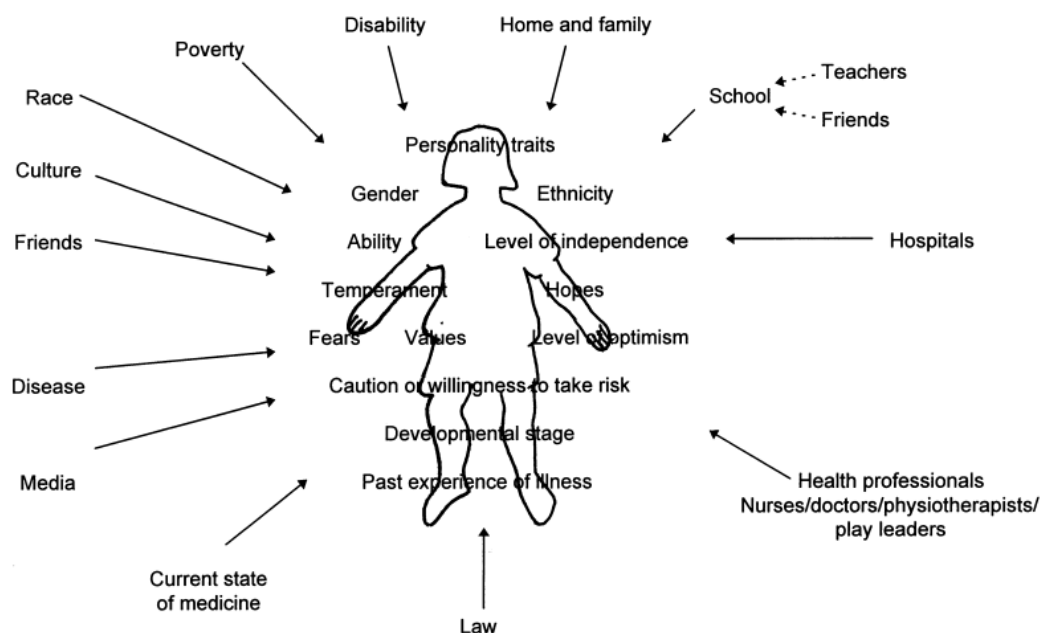


Figure 2: Internal and external influences on children's competence to give informed consent (Alderson, 1992).

Children's competencies can be recognised, denied, encouraged, or inhibited and can greatly depend on supporting adults' capability to be supportive, generous, courageous and 'big enough' to respect children's decisions (Alderson, 2007; Alderson, Katy Sutcliffe, & Katherine Curtis, 2006). Part of supporting children's views involves imparting information to children about their healthcare in a manner that they can understand. Being informed and understanding the information given is a large component of the process in determining competence and enabling children's participation in their healthcare and decision making (Brook, 2000). Researchers have argued that without the correct, full and age appropriate information and the opportunity to participate it is not possible for children to make competent decisions about their own care (Martenson & Fagerskiold, 2007). Hence, competence can be enhanced or diminished depending on the environment and the nature of the assessor and/or process.

Health professionals

During health consultations, health professionals often include children in information gathering but they rarely include children in treatment planning or discussions; consequently children's involvement typically makes up 3 to 15% of the total health visit interactions (Cahill & Papageorgiou, 2007; Carpenter et al., 2014). Health professionals have a large impact on the level of involvement children have in health consultations, not only through their subjective judgement of child competence, but also in the manner information is delivered, the amount of information given and the number of opportunities they allow children to speak and ask questions (Carpenter et al., 2014; Curtis et al., 2004). A literature review conducted by Martenson and Fagerskiold (2007) which analysed children's decision making competence concluded that children's competence was dependent not only on the child's own capacity, but also on parents and health professionals' attitudes towards children and healthcare decision making. Right 6(2) and 6(3) of the Code addresses the delivery of information by health professionals:

Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent. Every consumer has the right to honest and accurate

answers to questions relating to services (Health and Disability Commission, 1996, p. 4).

Children older than 14 years with chronic illnesses have identified their growing abilities to be more assertive in stating their preferences for care delivery and in decisions about their care (Coyne & Gallagher, 2011; van Staa et al., 2015). Children younger than 14 years however cited communication and relationships with health professionals to be the largest barrier to full information and participation in healthcare (Curtis et al., 2004). Being friendly and attentive has been cited by children to make health professionals more approachable and easier to communicate with, and left children feeling like they were involved in their healthcare decisions (Coyne & Gallagher, 2011; Curtis et al., 2004). Lack of time, lack of frequent contact, busy workloads and a lack of continuity were barriers cited by children that caused them to have difficulty in getting to know and trust health professionals (Coyne & Gallagher, 2011). Some children were fearful of asking questions in case they got into trouble or were an annoyance or inconvenience (Coyne & Gallagher, 2011). They described waiting for health professionals' attention rather than requesting assistance as being more beneficial as it caused less annoyance to the health professional. This indicates children having to assess the appropriate time to access information (Coyne & Gallagher, 2011). Christensen (1998) suggests children's position is constrained and dependent due to their perceived inferior status to adults and, in particular health professionals, resulting in children being resigned as mute actors in clinical consultations.

Miller (2011) interviewed eight paediatric nurses to investigate the ways in which they felt they could facilitate children to make decisions. The paediatric nurses believed children should be included in decision making but that certain types of knowledge was required to aid this. They believed they could promote children's participation in decision making by knowing the individual and the context and by providing children with age-appropriate information. Other studies found children's participation could be promoted by nurturing their self-determination, advocating for their wishes and perspectives to be heard, and by valuing their thoughts and feelings (McPherson & Thorne, 2000; Penticuff, 1990).

Alderson (2007) demonstrated the difference in results from studies that were conducted under intimidating and foreign environments compared to studies conducted in the context of the child's everyday life utilising toys, drawings and other nonverbal media. The research showed that studies conducted under intimidating and foreign environments were more likely to correlate with Piaget's developmental theories due to the cool detached manner in which the studies were conducted, making children nervous and inhibiting their performance (Alderson, 2007). Alderson (2007) found even pre-schoolers were capable of having a viewpoint and expressing it when approached in the appropriate environment and manner. Further research is required to develop appropriate and non-intrusive ways of accessing children's perceptions (Smith, 2013).

Age and experience

Linear approaches to children's incremental physical development, measured by age stages, is often used by adults to quantify children's mental, emotional and social development. This approach has failed to capture the complexities and diversity of child development (Alderson, 2007). Piagetian age-stage theories of child development appear to dominate in the area of informed consent by children (Alderson, 2007; Weithorn & Campbell, 1982). Piaget's experiments found that children under the age of 7 years could not imagine the perspective seen from another person standing at a different position around a model of mountains, inferring that children were egocentric and unable to distinguish themselves from others (Alderson et al., 2006). Piaget's research was challenged when researchers remodelled his methodology and found children as young as 3 years could not only solve more difficult geometric puzzles than the ones posed by Piaget, they were also aware of others' viewpoints (Alderson et al., 2006).

Tates, Meeuwesen, Bensing, and Elbers (2002) suggested the older a child is the more information they get, resulting in older children being assessed as more competent according to age. Weithorn and Campbell (1982) demonstrated that 14 year olds had the same mental capacity as adults to make informed decisions based on four standards of competency; evidence of choice, reasonable outcome, rational reasons, and understanding, and four hypothetical dilemmas; diabetes, epilepsy,

depression and enuresis. They found 9 year olds were less competent than adults with regards to understanding and rational reasonable process but were competent in evidence of choice and reasonable outcome (Weithorn & Campbell, 1982). The authors also demonstrated that 9 year olds were capable of meaningful involvement in the decision-making process (Weithorn & Campbell, 1982). A qualitative descriptive study done by Coyne and Gallagher (2011) indicated that some children were happy to leave the serious decision making up to their parents and the health professionals, but some children felt they had the right to make decisions and that they wanted to have the final say. The children interviewed by Coyne and Gallagher (2011) identified the age range of 9 to 18 years of age to be actively involved in decision making with some saying age didn't matter and competence should be established on an individual basis. In the same study, a 10 year old girl was describing the difference between a small and serious decision, proving her full understanding of consequences "If you wanted medicine, like if you're only having a little operation and a cut gets infected, that would only be a little [decision] and big [decision] would be like an operation that was life threatening" (Coyne & Gallagher, 2011, p. 2338). This demonstrates her ability to understand the severity of proposed treatments and their possible consequences. These studies show how children's abilities are greater than previous estimations but also the difficulties of attaching an age to a level of understanding, maturity or intelligence due to the heavy dependence on individual experience. This can be clearly seen in the inconsistencies across multiple countries; for example, autonomous decision making in the United States of America is age 18 and onwards, in the Netherlands it is 12 years and in Denmark it is 15 years (Hein, Troost, Lindeboom, et al., 2015).

Experience, particularly in the form of adversity (such as chronic illnesses), has been cited by Alderson et al. (2006) to be the main factor enhancing children's competence, rather than age or ability. Children as young as two years who have cancer have been shown to understand the purpose of and need for their treatment (P Alderson, 1990). Recent qualitative social research conducted with children who have chronic illnesses or disabilities indicate higher levels of knowledge and competence relating to their conditions in comparison to healthy children (Priscilla Alderson et al.,

2006). The study *Children as partners* illustrated children's experience of chronic illness and showed how it enabled children to develop the understanding, skill and maturity to make decisions about their healthcare (Priscilla Alderson et al., 2006). Children as young as four with diabetes were able to understand the principles and recommended standards of controlling their illness (Alderson et al., 2006). Alderson et al. (2006) described the children's decisions as wise and in their own best interests, and suggested their research shows children's competence to consent develops through experience rather than age.

Age is a measure that increases in predictable increments as a person grows, whereas experience is dynamic, unpredictable and individualised. Age is an inappropriate measure of child competence whereas experience is a large contributor to its development (Alderson et al., 2006). Child competence to participate in and consent to health treatment is not an attribute that all children experience in increasingly predictable increments as they grow. It is dynamic and highly dependent on individual children's experiences, cultures and contexts.

Culture

All cultures do not regard childhood in the same way, therefore different cultural constructions of childhood as well as differences in cultures in the healthcare setting can create barriers to the understanding and processing of health information. Factors such as how children are regarded by society; how their lives are organised, regulated, and valued, affect children's abilities to function in that society. "In a cultural approach 'competence' is understood not as a psychological property of an individual but as a relational constitution or attribution that is socially constructed and negotiated" (Christensen, 1998, p. 189).

In New Zealand, the bi-cultural construction of childhood within Te Whariki (New Zealand early childhood curriculum guidelines) and Learning Stories (a narrative approach to assessing children's learning based on Te Whariki) respects children as active learners who choose, plan, act and challenge (Smith, 2013). Hence at a young age, Māori children are encouraged to be involved in decisions about their lives. This in conjunction with the Māori culture of tino rangatiratanga (self-identification at the

personal level and self-determination culturally) which encapsulates the link between Māori children and whakapapa (genealogy), place (rivers, mountains, etc.), māoritanga (Māori culture) and to Te Reo (Māori language), and the cultural construction of childhood, as discussed in *Childhood today* (p. 20 of this thesis), imparts ideas as to how information may be received differently. For example, autonomy in an Anglo-European culture is concerned with individual independence whereas in a Māori culture it may be concerned with wholeness and collectivity (Ministry of Health, 1998). Māori tamariki (children), for example, belong not only to matua (parents) but to kaumatua and kuia (grandparents) and tipuna (ancestors); they are a part of a whanau, hapu (extended family) and iwi (tribe), they belong to the whenua (land) and are considered to be very special taonga (treasures) (Ministry of Health, 1998). Consequently, when a child is faced with a health decision, so is the whanau and hapu, as a large interconnected relationship, rather than the simple dyad of parent and child. A Māori child's competence can be influenced if they are approached on individual terms rather than receiving support in a more collective manner (Ministry of Health, 1998).

The same collective approach may also be applicable to children of Pacific cultures. In New Zealand, Pasifika families come from 22 different countries, all varying in their use of the English language, and involvement in church and other supporting groups. Much like Māori children, Pasifika children are part of a large extended family and community and their wellbeing is contingent on their integration with the family and community as a whole, and on the communities overall wellbeing (Ministry of Health, 1998). Pasifika children and families often hold a traditional respect for those in authority positions such as elders and church ministers, but also health professionals; as a consequence there may be times Pasifika children and families do not ask for clarification of information if there is a misunderstanding (Ministry of Health, 1998). These cultural norms may also mean that decisions concerning consent for healthcare may be heavily influenced by views of elders or church leaders (Ministry of Health, 1998). However ethnicity is not necessarily synonymous with culture; diversity exists within the collectivism approach for many Māori and Pasifika families (van Rooyen, Water, Rasmussen, & Diesfeld, 2015).

Health professionals' understanding of the importance of the extended family and the church, and the requirement for an appropriate time frame to make decisions, may assist in the empowerment of Māori and Pasifika children to participate in health decision making (Ministry of Health, 1998). Without cultural sensitivity, the way in which health information is imparted may create misunderstandings and gaps in knowledge. Miscommunication and information misinterpretation was one of the contributing factors in Tovia Laufau's case ("Boy refused treatment: Mother," 2000; Henaghan, 2012).

Child versus adult competence

Re C, a landmark United Kingdom court case, is an example of the level of competence an adult is deemed to require to consent to healthcare advice and treatment. Mr C suffered from chronic paranoid schizophrenia with grandiose delusions of being a world famous doctor ("Re C (Adult: Refusal of Treatment)," 1994). He also suffered from gangrene in his right foot from which doctors told him he would have a 15% chance of survival if he did not agree to have his foot amputated. Mr C refused consent. Justice Thorpe determined that Mr C had sufficient understanding of the nature, purpose, and effects of the proposed amputation and that he was competent to consent to, or refuse, medical treatment. Justice Thorpe described three criteria for competence which later became known as 'the Re C test' (Debski, Buckley, & Russell, 2008). These included:

- A. understand and retain the information relevant to the decision in question
- B. believe that information, and
- C. weigh that information in the balance to arrive at a choice ("Re C (Adult: Refusal of Treatment)," 1994, p. 295).

Comparatively, Lord Scarman's guidelines (as a result of the Gillick case) for assessing a competent child hold that the child must fully understand the moral, emotional and familial, and long and short term implications of the decision (Grimwood, 2009). These factors show the ability to exercise a 'wise choice'; health professionals therefore may hold a higher requirement for children than they would expect from some adults to prove their competence (Parkinson, 1992). The court case in NZ about 13 year old Tovia Laufau is an example of the level of competence a child

requires to consent, or refuse, health treatment. Faafetai Laufau (Tovia's mother) testified that her son said he would never forgive them if they took him to hospital, that he believed that if he went to the hospital he would die straight away, and that on two occasions he tried to jump from a moving car to avoid hospitalisation ("Boy refused treatment: Mother," 2000; Henaghan, 2012). Tovia told his uncle that "if he went to hospital his leg would be cut off and he would still die" (Henaghan, 2012, p. 100). Dr Peter Watson, a defence witness in the case against Tovia's parents and a specialist in adolescent health, believed it was a failure of the healthcare system for not identifying the needs of young people and for not appreciating the importance of clear information at such a stressful time, especially when it involves an additional language and a foreign environment [hospital setting] (Henaghan, 2012). Henaghan (2012) suggested Tovia and his family did not fully understand of the situation, but even so, Tovia's parents believed their son was mature enough to make his own decisions about his future health. Following the case, health professionals were surveyed to ascertain their opinions on the actions of their fellow colleagues who were involved with Tovia; most indicated a 13 year old (the age Tovia was at the time of his death) had the potential to understand Tovia's proposed treatment (Brandon et al., 2001; Henaghan, 2012).

A child's right to refuse medical treatment in New Zealand

The power to consent must include the right to refuse treatment. The English Court of Appeal interpreted the Gillick principle as the ability to consent to medical treatment rather than the ability to refuse medical treatment; stating that a child's refusal of medical treatment could be overridden by parental consent even if they are competent under the Gillick test (Cave, 2013). As was the case in *re R (a minor) (Wardship: Medical Treatment)* and *re W (a Minor) (Medical treatment: Court's jurisdiction)* where the refusal of treatment was vetoed by the English Court of Appeal. There is however no case law in New Zealand to support the overturning of an informed decision by a verified competent child.

In New Zealand, the COCA addresses children's refusal of consent in s 36(2) by stating "a child's consent, or refusal to consent" (p. 2005). The Bill of Rights Act 1990, s11, supports children in their refusal of health treatment where there is evidence of

competence stating 'Everyone has the right to refuse to undergo any medical treatment' (Ministry of Health, 1998; *New Zealand Bill of Rights Act*, 1990, s 11).

Therefore, in the case of refusal of medical treatment, it is once again up to the health professionals to determine whether or not the child is competent to give or withhold informed consent. A child's refusal of treatment however produces further complexities, as they may be seen by the adult world as ill, scared, irrational and immature and therefore incompetent to make decisions, rather than exercising their right to autonomy, respect and making informed decisions (Miller, 2011). Increased recognition of children's participation, as supported by the UNCRC (1989, s12), encourages the support of children making their own informed decisions and the provision of information about matters that affect them (Ministry of Health, 1998).

Competence of health professionals to assess and determine child competence

Miller (2011) clearly outlines concerns regarding health professionals' assessment of competence:

- they may not have the training on cognitive development of children
- they may feel committed to acting in the child's best interests and may assess the child as not having capacity in circumstances where the child disagrees with their professional opinion
- they may be unaware of the child's personal circumstances to make a considered judgment
- they may not have sufficient time to spend with the child to accurately gauge the child's maturity and views (pp. 4-5).

Health professionals need an in-depth understanding of relevant information and the skill to explain it in an appropriate manner and environment for children; they also need to respect the child's decisions without coercion and the influence of their own opinions (Alderson et al., 2006). McLean (2000) interviewed four New Zealand doctors and found that some showed acceptance and use of this approach to consent. Two of the doctors were unsure of the legal age to consent as they considered the capacity to consent was not determined by age (McLean, 2000). One general practitioner's opinion was that the capacity to consent had moved to 12 years old and even less in some circumstances (McLean, 2000). One of the doctors was a

paediatrician who said that although Gillick has some relevance it was more likely to be utilised by general practitioners and family planning (McLean, 2000). The last doctor specialised in sexual health and was aware of Gillick and its applications (McLean, 2000). Alderson et al. (2006, p. 26) interviewed a craniofacial surgeon who stated “most children can actively participate in major surgery decision making at about eight years”. Bartholomew and Teoludzka (2010) conducted a qualitative study which indicated that general practitioners had significant variation with regards to their determination of competence. The variation in opinions of competence were often based on extra-legal factors and stereotypical attributions based on their patient’s age and/or gender. These studies demonstrate a wide variation in understanding of child competence and how to assess it, however more research is required to identify who would be more suited than medical practitioners to assess capacity (Miller, 2011).

What makes a child a ‘competent child’?

There have been multiple attempts to measure child competence. Weithorn and Campbell (1982) studied 96 people at the ages of 9, 14, 18, and 21 years old, of whom “all were normal, white, healthy individuals, of high intelligence and middle class backgrounds” (p. 1596). They developed a competence test based on four personal attributes; evidence of choice, reasonable outcome, rational reasons, and understanding. These were measured by giving each participant four hypothetical dilemmas in an interview setting. Each attribute had specific questions aimed at measuring that attribute. Within each attribute category, the participant’s responses were judged using a rating scale by 20 experts on a panel. The participants’ instructions were to put themselves in the position of the person suffering from these four illnesses; diabetes, epilepsy, depression, and enuresis. Evidence of choice was simply showing an expression of preference during the interview process. Reasonable outcome and rational reasons were judged and scaled by the experts on the panel, “since, in reality, professional opinion is the criterion against which patients’ preferences usually are measured for such determinations” (Weithorn & Campbell, 1982, p. 1592). Understanding was divided into two subscales; rote recall (measuring factual understanding) and inference (measuring appreciation). Some of the questions asked to measure factual understanding included, “What are the disadvantages [for 9

year olds, ‘bad things’] about phenobarbital?” (epilepsy dilemma) and “What is a psychotherapist in this story?” (depression dilemma) (Weithorn & Campbell, 1982, p. 1593). The authors acknowledge that the information to answer these questions were provided in the hypothetical dilemma stories. Some of the questions asked to measure factual understanding included, “If a person needs to take insulin injections every day for the rest of his/her life, how might this be a problem or get in the way of things?” (diabetes dilemma) and “What might happen if Fred/Fran was in class and had a seizure?” (epilepsy dilemma) (Weithorn & Campbell, 1982, p. 1593). The authors stated their results supported predictions of cognitive development made by Piaget. The only age group to fail to measure up to the competence standard of an adult [unsure what this standard is] was the 9 year olds who were unable to fulfil the requirements of understanding and rational reasons, however they were able to show evidence of choice and reasonable outcome (Weithorn & Campbell, 1982).

Appelbaum and Grisso (1988) identified four main criteria for competence; the ability to communicate a choice and maintain conviction to that choice long enough to have his/her wishes carried out, understand the decision in the context of his/her health condition, understand the consequences of his/her decision, the risks and benefits of treatments, and the motives of the health professional, and the ability to logically weigh and appreciate these issues. One of the first competence screening tools was developed by Appelbaum in 1981 called the Competency Questionnaire (CQ) which addressed psychiatric patients’ competence to consent to voluntary psychiatric admission and to evaluate patients’ understanding of their illness, reasons for hospitalisation and treatment, and its legal implications (Pollack & Billick, 1999). Since then, additional competence screening tools have been developed including the Hopkin’s Competency Test (HCAT) by Janofsky, McCarthy, and Folstein (1992). This was used by McAliley, Hudson-Barr, Gunning, and Rowbottom (2000) to measure the competence of adolescents to be entered into a study concerning advanced directives. The HCAT assessed the ability to read, understand and retain text, and consisted of a short essay followed by 6 comprehensive questions. Other tools developed include the mini-mental state exam (MMSE); the Competency Interview Schedule (CIS) (based on the four criteria by Appelbaum and Grisso (1988) and used to measure patient’s

competence to consent to electroconvulsive therapy); and the Brief Psychiatric Rating Scale (BPRS) (Pollack & Billick, 1999). These tools were however designed with a mentally ill population as participants. Billick, Edwards, Burgert III, Serlen, and Bruni (1998) subsequently developed and conducted the Competency Questionnaire-Child Psychiatric (CQ-ChP) test which evaluated 25 child inpatients for competence, and utilised the Wechsler Intelligence Scale for Children-Revised Edition (WISC-R). The main aim of this test was to identify an age at which competence was achieved. The mean age of competency was found to be 10.1 years with participants showing a 5th grade (10 to 11 years old) reading level (Billick et al., 1998). However they concluded it was not possible to associate competence with an age. The CQ-ChP test was then revised as the Competency Questionnaire-Pediatric Outpatient Modified Version (CQ-Peds) which consisted of 19 items and emphasised the developmental aspect of competence in children (Billick, Burgert III, Friberg, Downer, & Bruni-Solhkhah, 2001). Again, an age at which competence was achieved could not be determined. Reading level was correlated with competence, however this may be a result of increased access to health information.

Most recently, the MacArthur Competence Assessment Tool for Treatment (MacCAT-T), initially developed by Grisso, Appelbaum, and Hill-Fotouhi (1997), was modified to include simple language for children and used in a pilot study designed to investigate age standards for children's competence to consent to predictive genetic testing (Hein, Troost, Lindeboom, et al., 2015). Seventeen paediatric outpatients between the ages of 6 and 18 years were assessed. It measured four aspects of decision making,

[u]nderstanding the disclosed information about the nature of the disease and the proposed intervention; reasoning in the process of deciding about the proposed intervention, with a focus on abilities to compare alternatives in the light of their consequences; appreciation of the effects of the intervention (or failure to undergo the intervention) on patient's own situation; and expressing a choice about the intervention (Hein, Troost, Lindeboom, et al., 2015, p. 3).

This study confirmed the feasibility of the MacCAT-T in children by comparing its outcomes of competent/incompetent to the judgements of an expert panel; which consisted of a clinical geneticist, child psychiatrists, child psychologists and a social worker. The modified MacCAT-T's findings showed those less than 10 years to be

incompetent (90% sensitivity) and those over 11.8 years to be competent (90% sensitivity) (Hein, Troost, Lindeboom, et al., 2015).

Competence assessments in New Zealand are based more on guidelines rather than competence questionnaires and centre on the document *Consent in Child and Youth Health: Information for Practitioners* by the Ministry of Health 1998 that indicates the necessities for a child to be deemed competent. It states,

Regardless of age, to be deemed competent an individual must be able to understand that they have a choice (freedom from coercion), why they are being offered the 'treatment', what is involved in what they are being offered, and what the probable benefits, risks, side effects, failure rates and alternatives are (Ministry of Health, 1998, p. 4).

Instructions from the Medical Council of New Zealand (2011) state "a competent child is one who is able to understand the nature, purpose and possible consequences of the proposed investigation or treatment, as well as the consequences of non-treatment" (p. 4). Lord Scarman and Lord Fraser from the Gillick case state the need for sufficient understanding and intelligence ("Gillick vs West Norfolk Area Health Authority," 1985). Brook (2000) however acknowledges that competence, at a practical level, is difficult to define, assess and measure. The complexity of this issue may lead health professionals to take the easier option of assuming adults are competent and children are not (Brook, 2000).

Conclusion

Although children may give legally binding informed consent independent of their parents, they require a level of competence to do so. It is the responsibility of the health professional to utilise reasonable actions to ascertain the level of competence of the child prior to delivering health investigations or treatment. Although inconsistent, New Zealand health legislation and policy place this responsibility on health professionals who may not be the best people to assess the competence of children secondary to their clinical judgements being affected by vested interests, stereotyping and innate biases (Bartholomew & Teoludzka, 2010; Miller, 2011). To add complexity to the matter, competence may change in relation to the culture, history and prior experiences of the child, and with changes in the environment of and support people involved in the informed consent process. The perceived level of a

child's competence may also have an effect on the level of participation they are allowed in health discussions and decision making. Alderson (1992) may be most correct in saying "competence is more than a skill, it is a way of relating and can be understood more clearly when each child's inner qualities are seen within a network of relationships and cultural influences" (p. 123). On a practical level however, ambiguity still remains with regard to what constitutes a competent child and how to assess for child competence. This literature review supports the use of a Foucauldian discourse analysis approach, specifically Foucault's ideas of archaeology and genealogy, which are further described in the next chapter, through its identification of the influence history has on the current understanding of the child competence discourse in New Zealand, the ambiguity in health legislation and policy evidencing multiple power relations present within the dominant discourse, and the identification of multiple subject positions and power relations between the social groups involved in children's participation in health discussions and decisions. A dominant legal version of the child competence discourse was also identified, lending itself to an analysis using Foucault's concept of genealogy. A further understanding of what conditions of existence were required for this dominant discourse to emerge and the truth claims associated with it that has led to it being held by society as the authoritative understanding on child competence and its assessment.

Chapter 3: Methodology

Introduction

Michel Foucault [1926 - 84] was a French philosopher, historian, social theorist and prolific writer. He was intrigued by the abnormal and studied the ways 'normal' people described and categorised the abnormal; for example madness versus civilisation. Along with madness, he studied illness, criminality and perverted sexuality. Foucault did not contribute new knowledge or provide alternative theories to these domains, but rather utilised unique understandings of power, knowledge and the subject to bring an awareness of the forces and influences within these domains (Downing, 2008). He taught us that if we only look at the well-worn paths of their accepted interpretations then we can only appreciate a partial view of history (Downing, 2008). Hence, alongside the common-sense or authorised versions of what a competent child is there may be ulterior narratives and unspoken understandings of the topic. By utilising Foucault's philosophical notions on power, knowledge, and the subject I was able to look beyond the dominant discourses that constructed the meaning of a competent child and bring to light repressed and marginalised discourses that may challenge our accepted views of these children today.

Philosophy

There is ongoing debate as to whether Foucault's ideas can be categorised as poststructuralist or postmodernist. "Poststructuralism (Derrida in particular) is a theory of knowledge and language, whereas postmodernism is a theory of society, culture and history" Agger (1991, p. 112). Agger (1991) however, also argued that it is impossible to cleanly separate one from the other. Foucault moved from the structuralist orientation, where he focused on language and the construction of the subject in discourses, to post-structuralism where he shifted from linguistic determination to the view that individuals are constituted by power relations (Crotty, 1998).

Initially, he was labelled a structuralist (a label he rejected) who dabbled with the Heideggerian phenomenological perspective of experience (Downing, 2008).

Structuralism is an approach to the study of human culture, centred on the search for constraining patterns or structures, where individual phenomena only have meaning within a larger systematic structure (Crotty, 1998). The other dominant methodology at the time of Foucault's initial writings was the Heideggarian phenomenological perspective which was concerned with the meaning of the lived experience (which he also rejected, declaring himself an advocate of the 'philosophy of the concept' rather than the 'philosophy of experience') (Downing, 2008). It nevertheless influenced his work, most notifiable in the *History of Madness* (1961) that looked at a history of the experience of the mentally ill (Crotty, 1998; Downing, 2008). Foucault's connection with structuralism can be identified through the use of discourses; a central term in his writing that broadly means anything written, said, or communicated using signs (linguistic, anthropological or literary) (Downing, 2008; Fillingham, 1993). The observation of inner rules, codes and patterns (most predominantly through language) rather than its content and meaning denotes his association with structuralism (Downing, 2008; Fillingham, 1993). However Foucault was also interested in change over time; which is inconsistent with structuralism (Fillingham, 1993). It is argued that Foucault went beyond structuralism and hermeneutics, the most dominant methods of his time, by exploiting the gradual breaking up of Marxism, traditional history of ideas and structural linguistic disciplines of the 1960s and 1970s, and emerged with reconstituted and dynamic ideas of power, knowledge and discourse respectively (McHoul & Grace, 1993).

Structuralism is associated with the impossibility of social truths due to the subjective language and meanings that we attribute to our realities. Derrida explained that it is in the "nature of language that we produce meaning only with reference to other meanings against which it takes on its own significance" (Agger, 1991, p. 113). For example, competence only has meaning when it is in the context of children, consent to health treatment and the implications of incompetence. Meanings are open to influence by language, and language in turn is the "result of the differential significances that we attach to words" (Agger, 1991, p. 113). Consequently, meanings are multiple, unstable and open to interpretation (Grant & Giddings, 2002). Foucault

added to this philosophy by finding an appreciation for the effects of history and culture through postmodernism.

Postmodernisation seeks to deconstruct the tenets of “totalising thought, the operations of power, the legitimating function of knowledge and truth, and the discursive practices of self-constitution” (Elliott, 2006, p. 1). It examines and deconstructs the uni-linear assumption that one theory can account for all human behaviour and relationships across time and space, and rejects the ‘grand narratives’ like Marxism that attempt to explain the world in terms of patterned interrelationships (Agger, 1991; Payne, 2010). Postmodernism suggests that multiple explanations exist that vary with time and culture, and that no single truth exists as suggested by modernism (Payne, 2010).

Foucault combined the philosophy of knowledge and language (poststructuralism) with a historical and cultural approach and sought to disrupt common interpretations and understandings of society by critically examining the past (postmodernism) (Downing, 2008). Hence, Foucault quickly became known as the philosopher of ‘discontinuity’, a key factor in his analysis of ‘official’ or ‘dominant’ knowledge/discourses (McHoul & Grace, 1993). This is congruent with Foucault’s description of the present being not the triumph of historical progress, but one outcome of a series of complex and discontinuous forces and influences over time (Downing, 2008). Child competence may be a form of modernised language used for a discourse that has been present for centuries and which has been subject to multiple discontinuities and forces throughout history. For example the manifestation of different child identities throughout history, such as the Early Modern Period’s innocent Apollonian Child versus the Dionysian Child full of original sin, continue to influence adult’s perceptions of children today.

Subjectivism is the epistemological paradigm in which postmodernism and poststructuralism lie. It implies meaning is imposed on an object by a subject; that knowledge is subjective and that there is no external or objective truth (O’Leary, 2007). Foucault acknowledges that constructions of subjectivity shift historically and culturally (Payne, 2010), shedding light on the ontological base of Foucault’s work. Hence there may not be a universal truth of what competence is and what a competent child

consists of. Rather, there are meanings imposed on 'competence' and the 'competent child' by health professionals, parents, children themselves, and New Zealand society and government.

Foucauldian Concepts

Discourse

There are multiple definitions of discourse, one of which described it as interrelated systems of social meanings that "systematically form the objects of which they speak" (Foucault, 1972, p. 49; Grant & Giddings, 2002). Payne (2010) afforded it a broader definition and described it as "a body of knowledge or a particular way of thinking about and a way of acting in relation to something" (p. 3). Parker (1992) suggested a workable definition of discourse as "a system of statements which constructs an object" (p. 5). Crowe (1998) regarded the concept of discourse as patterns of ways of representing phenomena through the use of language. However, Mills (2003) argued that it is not the simple translation of reality into language, but a system which structures the way in which we perceive reality. These definitions of discourse suggest that discourses have limits and boundaries, regularities and rules of what can and cannot be said (Payne, 2010). "Discourses do not simply describe the social world, but categorise it, they bring phenomena into sight" (Parker, 1992, p. 4). The concept of 'child competence' in healthcare was brought to light in 1985 when children were given the right to consent to health treatment so long as they had 'adequate maturity and intelligence' ("Gillick vs West Norfolk Area Health Authority," 1985). Competence became an entity and thus allowed us to talk and develop theories about it. Certain behaviours and ways of speaking are recognised as belonging to and constituting the notion of child competence. However, there are often multiple discourses attributed to a certain phenomenon and which construct the phenomenon in different ways (Payne, 2010). For example, one discourse may construct competence as a natural developmental milestone that all children eventually achieve, signifying the move from childhood to adulthood. Another discourse may construct competence as individual qualities that are not constant in quality and quantity, and is ever changing depending on who it serves.

‘Conditions of existence’, otherwise known as the historical unconscious of the period, is a phrase Foucault used to describe necessary factors for a discourse to exist (Foucault, 1972). These factors include the conceptual, social, economic and political conditions which exist within a historical and cultural context. For example, one condition of existence of the dominant child competence discourse is the ‘truth’, as dictated by historical legislation and social practice, that all children are incompetent compared to their competent adult counterparts. In addition to conditions of existence, Foucault stressed that discourses are associated with relations of power (Mills, 2003). Fillingham (1993) states Foucault has a specific meaning with regard to discourse; namely that it is areas in which there are specialists, specialised or technical knowledge, and specialised or technical vocabulary which establishes a dominant field of ideas which profoundly shapes the structure of society. Therefore, discourses are inherently political and offer speaking positions whose legitimacy depends on the social context (Grant & Giddings, 2002; Payne, 2010). Discourses additionally change over time where the current dominant discourses mainly serve the interests of the dominant social group (Grant & Giddings, 2002). In the context of this research, the overarching dominant social group is adults; their power is manifested in their ability to dictate what children can and cannot say or do. Within the context of children consenting to healthcare, policy makers and legislators have the most legitimate and authoritative speaking position. Their power is enacted to dictate the legal circumstances of if or when a child may consent to health treatment. Health professionals and parents are interchangeably the dominant social groups with the most legitimate speaking positions in the context of children participating in and consenting to health treatment. The social context of health institutions gives legitimacy to the health professional as the expert and, albeit possibly to a lesser extent, the parent as the child’s lawful guardian.

From speaking positions, it is a natural progression to the creation of subject positions/identities and subjectivity (Payne, 2010). Identities are not only ways of being and thinking about oneself (Payne, 2010) but also the ways by which one conceptualises others. Subjectivity is similar in that it refers to “the conscious and unconscious thoughts and emotions of the individual, their sense of self and ways of

understanding their relation to the world” (Weedon, 1997, p. 32) which can shift and change depending on the historical period. Foucault insisted that the self should be an ongoing process of creation rather than a fixed identity or personality (Downing, 2008). He famously said, “Do not ask me who I am and do not ask me to stay the same” (Foucault, 1969, as cited in Downing, 2008, p. 1). The creation of the competent versus incompetent child identity is dependent on the discourse (in this case, participation in and consent to healthcare), their varying subject positions within the triad of health professional, parent, and child and the sociohistorical context at the time of the construction of the particular identity.

Closely aligned with subject positions, McHoul and Grace (1993) discuss discourse as a form of discipline. Discipline refers to the knowledge associated with a discipline and the practices of social control which occurs in institutions (McHoul & Grace, 1993; Payne, 2010). Foucault’s concept of discipline is closely aligned with the language of ‘the gaze’, as Foucault describes in *The Birth of the Clinic*, which was linked to practice (dissection of cadavers) signifying a turn in medical thought and practice in *La Clinique* at the end of the 18th century (Foucault, 1963). A key theme to this research was the linking of the language that signifies competence to the practice of ‘being competent’ and looking at the disciplinary practices and power relations involved.

Power

If power were never anything but repressive, if it never did anything but to say no, do you really think one would be brought to obey it? What makes power hold good, what makes it accepted, is simply the fact that it doesn’t only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body much more than as a negative instance whose function is repression (Foucault, 1980a, p. 119).

Foucault refused to offer a definition of power; rather he was concerned with how power was exercised. The common understanding of power as a centralised commodity or a ‘thing’ flowing from the top down, restraining and negative, is rejected by Foucault. He understood power to be more of a dynamic mechanism or action, which can be experienced as a diverse and positive force and has the potential to be

peripheral and individual (Payne, 2010). Power is not a disposition, capacity, resource or commodity; it is understood as something that is exercised rather than possessed (Gallagher, 2006). It is not concentrated in the hands of institutions or certain classes of people, it is diverse and distributed throughout society (Gallagher, 2006). Foucault asserted that power can create reality and that it is impossible to extract oneself from power and the discourses it affects (Crotty, 1998; Payne, 2010). Therefore a different perspective can be found pertaining to the balance of decision making power between children and adults and the extent of its impact (Gallagher, 2006). For example, the extent of the impact of health professionals utilising the shared decision making model versus the informed decision making model when conducting the informed consent process with children.

Foucault was particularly interested in the knowledge of human beings and the power that acts on human beings (Fillingham, 1993). Power is exerted on others by a powerful minority who are able to impose their idea of the right or the 'true' on the majority (Fillingham, 1993). The powerful minority (legislators, policy makers and health professionals in the case of child competence to consent to healthcare) exercise power to create belief and to decide what is knowledge, and in turn claim to be the most knowledgeable (Fillingham, 1993). Hence, "power exists only when it is put into action" (Foucault, 1983, p. 219) which in turn stimulates objects of knowledge (Payne, 2010). One might then ask how power is made more powerful. Foucault viewed power exercised on a large scale as the sum of power exercised on multiple smaller scales, with the smaller scales of power being made possible by larger scale strategies of power. For example, health legislation is a strategy of power which health professionals utilise in addition to the power exerted by their specialised knowledge, to exert even larger scales of power.

In order for power to be exercised by one entity over another there is the requirement for a relationship between those two entities. Hence power is also relational. For example children may exercise power to comply with, resist, evade, colonise, appropriate or reproduce the power exercised over them by health professionals (Gallagher, 2006). The medium by which knowledge and power are exchanged is language, which can be examined through the discursive practices

between children, adults and health professionals. Through the use of language and the exercise of power, the dominant social group can decide what is true which can then affect humanity and people in general (Fillingham, 1993). The dominant discourses of child competence legitimise knowledge and the exercise of power by health professionals and parents.

Foucault believed that power exerted on others enhances individuality rather than creating regularity as some may initially think.

The individual is not to be conceived as a sort of elementary nucleus, a primitive atom, a multiple and inert material on which power comes to fasten or against which it happens to strike, and in so doing subdues or crushes individuals. In fact, it is already one of the prime effects of power that certain bodies, certain gestures, certain discourses, certain desires, come to be identified and constituted as individuals. The individual, that is, is not the *vis-à-vis* of power; it is, I believe, one of its prime effects (Foucault, 1980b, p. 98).

Foucault identified power as “dispersed, decentralised, diverging in difference rather than converging around similarities” (Gallagher, 2006, p. 398). Foucault believed power was circular and all around us, rather than localised, in a particular person’s hands, or functioning in a linear form. The expression of a child’s competence is contextual; what matters is *how* the health professionals, children, and their parents exercise power in their network of relations, in what *context*, over who, and with what *effects*.

The panopticon and surveillance

Surveillance, as used by Foucault, is a technique by which seeing or observation induces the effects of power and conversely the means of coercion (Downing, 2008). It is different from the all-seeing ‘gaze’ as described in *The Birth of the Clinic* where power is wielded by the gazing doctor over the gazed-at-body, alive or dead (Downing, 2008). Foucault posits that modern culture is a disciplinary society, motivated and implemented by the move from ‘quarantine’ (e.g. the control of the plague of 1300s) to the multiple and diverse operation of power in the most minute, multivalent, and internal aspects of social life (Downing, 2008) (e.g. the control of children’s behaviour within the triad of health professional, child and parent in the health setting).

Foucault described the changing nature of surveillance through history by first discussing the measures taken to control the plague. People were partitioned and quarantined, sentinels were posted, and only a few select people were permitted to move between different sections of the town (Downing, 2008). According to Foucault, “inspection functions ceaselessly, the gaze is alert everywhere” (Foucault, 1977, p. 196). He moves on to describe the control of lepers. Methods of control of the plague were intensified and techniques of observation became more complex by the addition of binary distinction; ‘them’ and ‘us’ (Downing, 2008). With the introduction of the no longer unimpeachable ‘sovereignty of law’, Foucault saw surveillance become increasingly subtle and insidious (Downing, 2008). Central to Foucault’s account of surveillance is the panopticon.

The idea of the panopticon first came from Jeremy Bentham (1748 - 1832) who described a new type of circular prison; prisoners in separate cells on the circumference and the guards in an ‘invisible’ single tower in the middle, affording the guards the perfect view of the prisoners. In *The Panopticon Writings* he states “Morals reformed - health preserved - industry invigorated, instruction diffused - public burdens lightened - Economy seated, as it were, upon a rock - the Gordian knot of the Poor-Laws are not cut, but untied - all by a simple idea in Architecture!” (Fillingham, 1993, p. 126). Hence, as the watcher cannot be seen by the watched, the watched develop an impersonal and anonymous relationship with power and discipline and become self-regulatory (Downing, 2008). The panopticon effect of health institutions and health professionals may result in children’s self-discipline and regulation of behaviour and emotions in that environment. For example, the study by Coyne and Gallagher (2011) suggested children found access to information was easier if they waited for a health professional’s attention rather than causing annoyance by asking for it. In this situation, children have self-regulated their behaviour in the specific environment of health institutions. Health professionals’ and parents’ tacit surveillance of children regarding what is ‘correct’ behaviour results in children self-regulating their behaviour that is specific to the health setting.

Governmentality

Foucault used the term governmentality to explain the power exercised in the management of groups of people (Gallagher, 2006). Governmentality is a way of acting to affect the way others conduct themselves (Gallagher, 2006). Foucault looked at the subtle interplay between the hierarchical, coercive power of the governor over the governed, and the governed subject's power over themselves, which could be called their autonomy (Gallagher, 2006). Hence, the governor's attempt to make the governed so effective at regulating their own behaviour that external supervision can be reduced to a bare minimum, however one might say the ability to regulate and conduct oneself is the basis of autonomy and freedom (Gallagher, 2006). There is no reason to believe that the power of agency is consistent with the power of subjection (Gallagher, 2006). Children are one of the most intensely governed groups in modern society; one of many examples being their ability to consent to health care. Children's participation in the consent process could be seen as securing their complicity in the process or as supporting the agency of the child. As power is circular and exerted by all, the will of children and the will of health institutions are in a constant battle in an attempt to influence and re-align one another through endless 'actions upon actions' (Gallagher, 2006).

Language and meanings

When describing a phenomenon, words do not predispose it. Language does not originate within us to give universal explanations of discourses (McHoul & Grace, 1993). We choose words that best fit our current context and moment in time, that resonate with us or that influence a vested interest for us. We use words and language to construct discourses and, with the use of multiple discourses, give meaning to objects, experiences and the self that does the experiencing. The language used by health professionals has changed over time and changes with different cultures.

Discourse analysis examines patterns of language across texts and considers the relationship between language and the social and cultural contexts by which it is used (Paltridge, 2012). Subjectivism is inherent in the use of language where rather than taking account of a 'true' reality, we conform to a system of social meaning embedded in language (Crotty, 1998). Hence from the relationship between language

and sociocultural contexts one can identify different views and understandings of the world by studying the language used by others. Discourse analysis assumes that language constructs how we think about and experience ourselves, our relationships with others and the realities we experience (Crowe, 1998; Grant & Giddings, 2002). However, language is not stable or a transparent representation of reality (Grant & Giddings, 2002). Language is a historical and unconscious method of forming realities of ourselves and our experiences (Grant & Giddings, 2002). It is also influenced by relationships, social identities and relations (Paltridge, 2012). Language, and hence discourses, change over time and in different contexts. The patterns of language used in different conditions of existence will help identify the different views or discourses that construct the identity and meaning of the competent child. Foucauldian discourse analysis builds on the methodology of discourse analysis by analysing the influences of knowledge, power and the subject. Hence, an analysis of the Gillick case for example (which continues to influence practice) would first require an analysis of the relationships, social identities, historical speaking positions and sociocultural context of the House of Lords. With a deeper understanding of the House of Lords, the language they used to construct the identity of the competent child can be analysed and movements in knowledge, power and the subject can be identified.

Archaeology and genealogy

Foucault's concept of archaeology was initially developed in *The Birth of the Clinic* (1963). It was further developed in *The Order of Things* (1966) which was closely followed by *The Archaeology of Knowledge* (1969). Foucault's notion of archaeology "attempts to uncover the tacit rules governing the organisation of knowledge at a given historical moment" (Downing, 2008, p. 9). It is an analysis of the conditions necessary for a discourse to emerge and impose itself authoritatively (Downing, 2008). The rules and conditions of existence for the child competence discourse, otherwise known as the historical unconscious of the period, became evident in the discussion of the historical concept of childhood. As per Foucault's concepts of archaeology, an exploration of the rules governing the child competence discourse in the past continue to guide it in the modern day. Rather than using the past as an explanation of the causal effect of the present or the progress (regress) of society, Foucault means for it

to be a 'history of the present' where the underlying 'rules' of the past still operate or influence us today (Downing, 2008). The main tool utilised to explore the 'rules' is through the discourse of language.

With time, Foucault's concepts grew and his ideas evolved. Foucault's later works on knowledge, power and discourse evolved as he began writing *The Will to Knowledge* where it described discourse as "the intersection of knowledge and power and the forms of expression and articulation they take in different fields" (Downing, 2008, p. 9). This description of discourse relates to the method of *genealogy* which, much like archaeology, analyses the conditions required for the emergence of a discourse, but goes further by analysing the effects of the institutional and resistant operations of power within systems of thought (Downing, 2008). That is, Foucault called 'truth' into question, cataloguing the invention of forms of knowledge; most notably abnormal versus normal, and explored the conditions of their consolidation into institutions of authority (Downing, 2008). A second facet to Foucault's notion of genealogy is his central focus on the body which he maintains is the central locus in and over which power operates (Downing, 2008).

Why Foucault?

I chose Foucault and his philosophical theories because during my reading of child competence literature, no easy answers or categories were apparent that might answer the question 'what makes a child a competent child?' which could then be analysed. Foucauldian discourse analysis enables an understanding of the conditions behind the issue, highlights and challenges assumptions and allows a higher awareness of hidden motivations in others and ourselves. By utilising Foucault, influences and forces involved in the dynamic process of identifying a competent child were highlighted.

The issues around competence are complex and emotional, especially when stories are heard of children who are not afforded their rights to information, appropriate environments, and a chance to say what happens to their body; such as was the case for Tovia Laufau. Child competence is an individual and case-by-case issue; not all children are the same and their level of competence can change

depending on the situation, time, stresses and other people involved. However, although each child's situation is contextual, they may experience similar power relations within each of their individual contexts. By utilising Foucault's notions of knowledge, power and the subject I was able to bring to light resistant or marginalised discourses to better understand the complexities surrounding the identification of competent children.

The effect of power is more important than who exercises it. To be true to Foucault, the analysis of child competence focused on its outcomes and impacts. Gallagher (2006) stated "methods for the standardised, objective measurement of participation outcomes would be yet another form of utilitarian instrumental rationality by which childhood is increasingly governed; a kind of infernal government of government" (p. 403). He believed a more Foucauldian approach would be to study participation in a less systematic and more interpretive manner. Crotty (1998) suggested, "There is no standing back from power and the discourses it affects. All that one can do is to engage with the dominant discourse from within, attempting to disrupt and demystify it by revealing its indeterminacy and, paradoxically, the possibilities it thereby has to offer" (p. 205). Foucault gives us a way to understand the effects and impacts of power, and in turn identify marginalised or silent discourses. He does not give us a way to understand power in order to oppose oppression or turn the tables on dominant discourses. Crotty's quote indicates the need to work with dominant discourses, albeit to 'disrupt and demystify', but then to find the possibilities they have to offer. In order to better understand these possibilities, the main principle of discourse and the multiple facets of Foucault's notions regarding power, surveillance, language and meaning was used to inform the document analysis of the child competence discourse.

Chapter 4: Research Design

The initial review of literature in Chapter 2 identified the most prominent and influential documents on the subject of child competence to participate in health discussions and decisions. The process of reading literature relating to child competence and writing the literature review helped to identify central texts and documents from New Zealand health legislation and policy and literature written from a historical standpoint. The subsequent analysis of these texts was informed by Foucauldian discourse analysis, drawing on theories of power, knowledge and the subject (Grant & Giddings, 2002). Questions listed by Payne (2010) were used to develop the author's thinking regarding how one might approach a document analysis. Finding an answer to each of Payne's questions was not the purpose of the questions, rather they were used to guide the thinking and analysis of the literature regarding the child competence discourse. The writing up and reporting of the information assisted in the identification of discourses, their relationships with each other, and what aids in the construction of the individual discourses (Payne, 2010).

Data Collection

Health legislation and policy texts central to the child competence discourse in New Zealand were read and processed to identify the different discourses regarding competence. The following texts were analysed.

Legislation and case law

- Care of Children Act 2004
- Code of Health and Disability Services Consumers' Rights 1996
- HDC Fact Sheet 3 by Health and Disability Commissioner, 2014
- *Gillick vs West Norfolk and Wisbech AHA* 1985
- United Nations Convention on the Rights of the Child 1989

Health policy and literature

- Consent in Child and Youth Health: Information for Practitioners 1998 written by the Ministry of Health
- Information, choice of treatment and informed consent 2011 written by the

Medical Organisational texts

- Auckland District Health Board (ADHB) guideline on the consent of minors

The analysis of these texts were supported by relevant literature pertaining to the child competence discourse. It is important to note that legislation and health policies from other countries were excluded as they are not valid to the context of New Zealand.

Data analysis

Foucauldian discourse analysis is a process of marrying poststructuralist theory on knowledge and language, with postmodernist theories of society, culture and history. The analysis of the child competence discourse first utilised the context of history and society to understand the conditions required for its emergence and looked for changes, similarities and inconsistencies across time that may have informed the present day understanding of child competence in New Zealand. Multiple discourses relating to child competence were identified, which clarified a deeper understanding of how the dominant version of the child competence discourse was positioned as authoritative. Hence, the historical analysis informed the articulation of the dominant discourse, the subject positions within it and identified and analysed the power positions that subjects occupied within the discourse (Payne, 2010). Engaging with the dominant discourse by analysing the language and power relations emulated in the governing documents on the matter, disrupted its accepted and authoritative narrative and subsequently offered other possibilities or ways to think about and understand this discourse. Ultimately it led to a further appreciation and realisation of the benefits of recognising competent children.

Discourse analysis process

The analysis process was informed by the following questions and guidelines listed by Payne (2010). These questions and guidelines were useful in guiding a novice researcher and novice scholar using Foucault. Although other scholars (such as Clare O'Farrell, Mitchell Dean, Graham Burchell, Colin Gordin or Paul Rabinow) have provided a road map to using Foucault, using a local scholar of Foucault was useful in relation to the context of this research. The wide-ranging questions listed by Payne were useful in helping the author contemplate aspects regarding the child competence

discourse that otherwise may not have been considered through the author's subjective and novice lens.

Preparation

1. Brainstorm with colleagues i.e. "a process of free association where by the connotations, allusions and implications which the text evoke are explored" (Parker, 1992, p. 6).
2. Explore the multiple meanings of competence
3. Investigate how the discourse of 'competence' is shared or socially constituted - where did it originate, by who, and how was this knowledge disseminated. "The meaning [of competence] is not one dreamt up by researcher or participants. Rather we draw on words and meanings that pre-date us and that we have read or heard others speak of" (Payne, 2010, p. 8).
4. Be receptive to the multiple possible discourses without being selective or uncritical.
5. Reflexivity - What are my beliefs as a researcher and how are they socially constructed? How do these beliefs influence my interpretations of the research? What are my own experiences and views of child competence to consent to health treatment?

Method

1. Select a broad variety of data sources and explore which discourses are dominant in these sources as described under Data Collection.
2. Reading the texts - become familiar with the text in order to identify the different discourses and the theoretical concepts related to the discourses.
3. Analysis of texts
4. Writing up and reporting of analysis

Analysis of text

1. How do people talk about child competence? Who and what are they allowed to say and not say?
2. What are the different meanings they give to competence?

3. What are the similarities, differences and contradictions within the discourses identified?
 4. What are the continuities and discontinuities across time?
 5. What is the historical context over this same period of time?
 6. What are the different discourses that relate to the topic?
 7. What are the rules of each discourse: what statements can be made when speaking or practising the discourse?
 8. Who can make such statements?
 9. In what places/institutions and when can the statements be made?
 10. Where do the discursive objects emerge?
 11. What is the object named in the discourse?
 12. How is it constructed by the discourse?
 13. What are the conditions that allowed the discourse to exist and to continue to exist?
 14. What theories and concepts are part of this discourse?
 15. What subject positions/subjectivities does the discourse constitute?
 16. What power positions does the discourse offer for the speaker and the subject?
- (Payne, 2010, p. 12)

“Discourse analysis seeks to articulate the various discourses and the subject positions that are offered within each discourse, and to identify and analyse the power positions that the speaker and the subject of the discourse may occupy” (Payne, 2010, p. 11).

During the reading of the afore mentioned texts these questions were continually asked in order to identify the emergence of this discourse, the inconsistencies within the discourse and the meanings attributed to the dominant version of this discourse.

Writing up of analysis

The process of writing was used to achieve analysis and to reveal and deconstruct each of the discourses (Payne, 2010). Through this process the emergence of discourses, their relationship with each other, and what gave rise to individual discourses were discovered (Payne, 2010). Original text is included to allow the reader to ‘hear’ the discourse in the language of expression (Payne, 2010).

No matter how seemingly insignificant, every rhetorical gesture of the text contributes to its overall meaning. We can learn to read these gestures not simply as embellishing 'subtext' but also as a central text in their own right, making an important contribution to the argument of science (Agger, 1991, p. 115).

This quote gives rise to the importance of nuance in original text. For this reason, the original reporting of the Gillick case from the House of Lords, for example, was analysed rather than subsequent literature that speaks as proxy for the meanings behind the Lords decisions.

Reflexivity

Nothing in Foucauldian discourse analysis is neutral (Strauss & Feiz, 2013). Each and every instance of discourse has an element of stance and is motivated by perspective (Strauss & Feiz, 2013). Payne (2010) recommended the discourse analyst record their own views and experiences. For this reason it is important to acknowledge my stance as a Paediatric Nurse and the influence of this on my perspectives of possible discourses present in the subject area. In addition, a discourse analyst needs to be open to the multiple discourses that circulate around the object of research (Payne, 2010). This form of reflexivity is evidenced in Chapter 5 for example, where multiple discourses relating to child competence were considered within the historical construction of childhood.

Payne (2010) described rigor in a discourse analysis to be the "constant awareness of knowing what one brings to the study and how one proceeds through the study" (p. 16). With regard to the process of the study, the steps from the initial data collection to the final analysis and writing needs to be apparent to the reader. Unfortunately, there is no set method of conducting a Foucauldian discourse analysis therefore it is paramount that the process or questions chosen to guide the analysis are clear and evident to the reader. Concomitantly it is important for the reader to understand the author's position on the topic and what they bring to the study. As previously stated, I am a paediatric nurse and have witnessed some situations where children have not been allowed to participate in important health discussions and decisions about their health. I am a woman, yet not a mother, therefore my views are based more on professional and gender related experiences, rather than personal

experiences of children's participation in healthcare. While there have been advances in the recognition of children's abilities, it is my view that a gap still remains between what they are capable of and what adults allow them to be capable of, which may limit the possible health benefits they could experience from better recognition of their level of competence. I am biased towards promoting child competence and its assessment so that children can more regularly exercise their rights to full information, free expression of their views and autonomous decision making. I acknowledge that my position is, in a way, a limitation to this study as it may cloud my view of other possible marginalised discourses pertaining to child competence.

It is important to acknowledge this study's limitations that may affect its findings and the extent to which the findings can be generalised to other contexts and times (Payne, 2010). For example, it will only be possible to utilise this research in New Zealand; its findings cannot be generalised to other countries. However, an awareness of the historical and cultural position of the research may improve the trustworthiness of the study (Powers, 1996); referring to New Zealand, its cultures and the modern day context of this research.

Ethical Considerations

As this research only utilised information and texts that were already in the public domain and public knowledge, ethics approval was not needed, as stated in the Auckland University of Technology Ethics Committee (2012) guidelines and procedures, principle 6.2. However, social and cultural sensitivity and commitment to the Treaty of Waitangi still applied. The ontological basis of the research is the social and cultural contexts of these texts. Therefore the Treaty of Waitangi and the principles it values were relevant to this study and its analysis. Overarching principles include those of participation, protection and partnership (Woods, 2007). As a Foucauldian document analysis, this study did not seek participation or partnership with Māori. However the protection and acknowledgement of their values and traditions, relevant to this research topic, was ensured by incorporating important texts such as the Charter on the Rights of Tamariki Children and Rangatahi Young People in Healthcare Services in Aotearoa New Zealand. The voice of the Māori culture through such texts ensured this research was done in partnership with them and

enhanced their involvement and passive participation. A possible outcome of the research is greater participation of Māori and other children through more effective partnership with children in their healthcare.

Conclusion

Foucauldian discourse analysis methodology was used to guide a document analysis of relevant New Zealand health legislation and policy documents. This process was supported by literature and guided by the questions and guideline listed by Payne (2010). To support the rigor and trustworthiness of this study the author notes the importance of considering personal biases toward the topic which may influence the identification of certain discourses. The next chapter utilises Foucauldian discourse analysis methodology, in particular the concepts of archaeology and genealogy, to analyse the historical construction of childhood in relation to the child competence discourse.

Chapter 5: The archaeology and genealogy of child competence

This chapter focuses on the history of competence, its emergence, and links its development with changes in childhood over the centuries. Childhood has been defined by legal status, chronological age and sometimes by physical and/or sexual maturity (Gittins, 2009). Gittins (2009) suggested there are three main categories to the study of the history of childhood. Firstly, focusing on socioeconomic situations as the material conditions of the families and households change through time (Gittins, 2009). Second is the understanding of the emotional and psychological changes in childrearing and the experience of childhood, and third is the legal and political changes in governmental attitudes to childhood, childrearing and children in social policy (Gittins, 2009). The development of these three categories are intertwined and analysed in conjunction with changing socio-political and historical contexts of childhood and draws on Foucault's concepts of archaeology and genealogy for guidance (as described in chapter 4).

Through an analysis of the language used over the course of history, the conditions for the existence of the child competence discourse in earlier times were analysed. The purpose of this analysis was to identify the subject positions and knowledge that exert the current dominant version of the child competence discourse as authoritative and to uncover silent or marginalised versions of this discourse. Utilising Foucault's notion of the 'history of the present' and analysing the knowledge, power and subject positions of the past, the tacit rules and conditions for the existence of this discourse in the modern day could be identified.

Synonymy of the construction of childhood and child competence

In order to question a discursive practice one must map the system by which particular objects are formed and how they are articulated and brought to attention (Graham, 2005). Consequently, to explore the meaning of competence, rather than debate the truth of its existence, one must consider how it may have been formed. "For Foucault, it followed that discourse cannot be analysed only in the present,

because the power components and the historical components create such a tangled knot of shifting meanings, definitions and interested parties over periods of time” (Powers, 2007, p. 26). Therefore this chapter focuses on the historical construction of childhood and its links with the child competence discourse, however it is helpful to first understand the destination of the historical journey of this discourse.

The current understanding of childhood, the end result of small and multiple shifting meanings over time, is aptly described by Alderson (2013) as:

The status of being a minor, the early-life state of immaturity whether actual or ascribed, and the process of growing towards adulthood. Childhood largely consists of a conferred status; many attributes are imposed or ascribed to children, such as ignorance, dependence and volatile emotion, when they are not necessarily integral to childhood and when many children and young people demonstrate their knowledge, generous interdependence and reliable wisdom. (p. 4).

Smith (2013) defined childhood and children as

...passive recipients of adults’ teaching, protection and care, as objects to be shaped and socialised, as the properties of their families, and as *incomplete beings* [emphasis added] who are not yet humans. Ideas of what is ‘normal’ for particular age levels have shaped our assumptions about what children can and cannot do, and often these assumptions have greatly underestimated children’s competence. (p. 15).

Gittins (2009) stated,

The concept of ‘child’ concerns an embodied individual defined as non-adult, while the notion of ‘childhood’ is a more general and abstract term used to refer to the status ascribed by adults to those who are defined as not adult. (p. 26).

‘Child’ pertains to a developmental stage in the lifespan whereas ‘childhood’ is a social construct. It is positioned as the binary of adulthood and founded on the understanding of children as ‘incomplete beings’. Subsequently, our understanding of adults is as ‘complete beings’. Underpinning the notion of ‘childhood’, as it is commonly understood today, is the assumption that children are inherently incompetent while adults are inherently competent. This tacit rule governing the understanding and treatment of children by adults would have emerged at some point in history. One argument could be that the construction of ‘childhood’ is intertwined with the construction of ‘child competence’. When children were identified as needing to occupy a separate social and political space to adults, the notion of child

incompetence for the adult world could have been conceived. The conditions required for the 'invention' of childhood may have been the same conditions necessary to impose the notion of child incompetence, from the point of view of the adult world, as an authoritative discourse in modern society.

The High Middle Ages: Europe (1001 – 1300)

Philippe Ariès was one of the first social historians to introduce childhood as a social construction, rather than a biological or 'natural' state that has existed throughout time. During the High Middle Ages, children and adults occupied the same socio-political space. Ariès suggested that during the Middle Ages there may not have been a concept of childhood or recognition that children were a part of a special group with their own needs, interests, and capacities (Ariès, 1962; Demos, 1970). Although adults were not indifferent to children, they were not concerned with their development or wellbeing, as is the case in modern society (Ariès, 1962; Gittins, 2009). He based his theory on the lack of representation of children in Medieval Art; childhood was not depicted as any different to adulthood and children were painted merely as little adults (Gittins, 2009). This finding was corroborated by Demos in *A little commonwealth: Family in Plymouth Colony* 1970 who suggested children were seen as 'little adults' and once physically able, were expected to work (Demos, 1970). Shorter (1976) and Stone (1977) added to Ariès and Demos's view by suggesting there was a lack of affection for children prior to the Late Middle Ages (LMA). Albeit not without their critics, they proposed an emotional evolution towards children whereby formalisation and indifference towards children was replaced with empathy, spontaneity and protectiveness (Gittins, 2009).

Over the last 50 years however, there has been debate on when the concept of childhood emerged. Kroll (1977) opposed Ariès and Demos' views and stated that in the Middle Ages children were viewed differently compared to the modern day version of a child. His argument was that if you were looking for the modern day concept of childhood in the Middle Ages it is not surprising that you do not find it because world views were different (Kroll, 1977). Kroll (1977) argued that most relationships were different; where today relationships are defined as personal feelings, in the Middle Ages they were regulated by rules and expectations (Kroll, 1977); such as those of

husband and wife, and lord and vassal (Kroll, 1977). Hence, there may never have been a 'turn' of adult's attention towards children; rather there was always the recognition in one form or another that they were different to adults. Kroll (1977) suggested that "in the medieval period there was a realisation and accommodation to the specialness of childhood, derived from and consistent with their [medieval] world views" (p. 385). By this, Kroll (1977) proposed that children have always been seen and treated differently to adults, and that it is not surprising that these differences have changed over time with changes in socio-political and historical contexts.

As the reader keeping Kroll's opposing view in mind, Ariès (1962) may have been partially correct by saying childhood did not exist in the Middle Ages in the ways that it exists today. Children may have in fact always been seen and treated differently depending on the socio-political and historical climate although it may not have necessarily been in a manner that separated them from the adult world and rendered them incompetent to participate in adult activities, discussions and decisions. Discovering the time when children were separated from the adult world may shed light on the socio-political contexts and conditions required to position children as incompetent for the adult world.

The Late Middle Ages: Europe (1300 – 1500)

Due to high numbers of sickness, plague and accidents during childhood, Ariès claimed parents were reluctant to attach themselves to their children, and hence would care for them without emotional involvement (Frijhoff, 2012). Shorter (1976) believed that children in the Late Middle Ages were regarded in such low esteem that they were not even regarded as human with the same capacities for joy and pain as their mothers, however he does not refute an existence of a residual biological affection. DeMause (1976) agreed with Shorter and states, "It is, of course, not love which the parent of the past lacked, but rather the emotional maturity needed to see the child as a person separate from himself" (p. 17). During the fourteenth to the seventeenth centuries, DeMause (1976) described the child as "a container for dangerous projections but was allowed to enter into the parent's emotional life" (p. 51-52). During this time, adults, as a result of the conditions of society, were ambivalent towards their children; often fostering them out or being generally

unmoved by the loss of an infant (Stone, 1977). Pollock (1983) considered a more cultural history of childhood and disagrees with the afore mentioned authors. Pollock believed the historical materials had been misread and that parents were always emotionally attached to their children through an innate sociobiological connection (Bellingham, 1988). However, Bellingham (1988) argued that this concept does not account for the dramatic change in child-rearing practices and conditions of child life from the Late Middle Ages to the Modern Day; especially during the industrialisation period.

Childhood of the Late Middle Ages was set against a backdrop of great innovation and crisis. The Italian renaissance, the Age of Discovery and progress in art and science was combatted by the Western Schism, the Great Famine, the Black Death and centuries of intermittent social unrest and war. The rapid interchanging, and sometimes simultaneous movements between progress and regress in the socio-political climate of the Late Middle Ages may have affected children's position in that society. The growth of the Ottoman Empire and the fall of Constantinople drove many intellectuals out of the city and mostly into Italy which helped fuel the Italian Renaissance. This influx of intellectuals renewed interest in ancient Greek and Roman text. This occurred in conjunction with the invention of the printed word which led to the wider dissemination of information and learning. It was also the Age of Discovery; as trade routes were cut off to the east with the fall of Constantinople, trading routes to the west were explored which led to the discovery of the Americas by Christopher Columbus in 1492 and the circumnavigation of India and Africa by Vasco da Gama's in 1498. This led to the strengthening of the economy and power of European nations.

The growth of the Ottoman Empire however put Christendom at risk as the Ottoman armies were free to advance into Europe. The Protestant Reformation was motivated by the eroding of people's faith in the Papacy (Western Schism), the introduction of humanism (Italian Renaissance), and the rise of nationalism. People began to recognise themselves as being separate from the patriarchal lineage of the church; free to choose what to believe in and who to follow. However it was not until the seventieth century that a clear change was seen in family structures evidencing this move from the patriarchal pyramid (Stone, 1977). Burckhardt (1860) made one of

the most famous comments about Renaissance individualism in his book *The Civilisation of the Renaissance in Italy*,

In the Middle Ages both sides of human consciousness – that which was turned within as that which was turned without – lay dreaming or half-awake beneath a common veil...Man was conscious of himself only as a member of a race, people, party, family or corporation – only through some general category. In Italy this veil first melted into air...man became a spiritual individual and recognised himself as such. (p. 121).

In the introduction of individualism lies the emergence of the core ethical principles of informed consent today; that of autonomy, individual competence for decision making, and voluntariness. For each of these principles to exist there is a requirement for an assumption of individualism and the freedom of choice. Just as people began to see their families as separate from the patriarchal pyramid of the Church, people began to see themselves as individuals separate from the familial structure, and this included children. The introduction of individualism and later the development of liberalism allowed people to make decisions about matters that were important to them. This can be followed through to today's world where children may now make decisions about their health matters, albeit still only to a certain extent.

Early modern period and its globalising character (1500 – 1790)

An increased division between adults and children could be seen from the sixteenth century onwards (Gittins, 2009). The humanism of the Renaissance, growth of capitalism and demise of the feudal order, new religious beliefs, the rise of the bourgeoisie and advances in science and technology all contributed to profound changes in the western culture (Gittins, 2009). The designation of childhood as different from adulthood occurred at some stage during these socio-political changes (Stearns, 2011). Most authors have tried to connect the history of childhood with other trends in society; Aries with education, Bremner with democracy, Pinchbeck and Hewitt with public policy towards children and Stone with individualism (Pollock, 1986). However, the 'invention' of childhood remains a highly debated subject between historians. In the roots of the 'invention' of childhood and the separation of children from the adult world, may lie the requirement and hence the emergence of child competence to participate in the adult world. Emergence of the competence

discourse may be linked with the changing social construction of childhood and the emergence of individualism and liberalism, but also through the simultaneous and opposing paradigm; the inception of disciplinary institutions such as schools. This may account for the segregation of child and adult worlds.

The rise of Puritanism (subgroup of Protestantism) has been denoted as a pivotal point of change in attitudes towards children during the sixteenth century. Individual responsibility to God was seen as the day to day abidance by the principles of a Christian life rather than merely forgiveness of sin (Gittins, 2009). “Emphasis was put on correct behaviour in daily life which led to rigorous training and socialisation in Christian values and behaviour” (Gittins, 2009, p. 31). As sin was seen to be innate from birth, parents were required to eradicate the sin from even the youngest children in a bid to save their souls (Gittins, 2009). This was the era of the ‘Dionysian’ child, “seen as possessing intrinsic evil or corruption that seeks outlet in the child’s behaviour and thought, unless rooted out by moral training” (Duschinsky, 2013, p. 79). Children’s inferiority to adults was further corroborated by Hewitt and Pinchbeck (1969) who analysed the development of public policy and the rise of statutory protection of children. Illick (1974) states, “there is no denying that parents in seventeenth-century England were interested in their children, but that interest took the form of controlling youngsters – just as adults restrained themselves – rather than allowing autonomous development” (p. 323).

The rise of Puritanism had an undoubtable effect on the bourgeoisie (Gittins, 2009). Shorter (1976) and Bellingham (1988) attribute changes in private dispositions towards the young, beginning with the bourgeois in the sixteenth century, and the proliferation of public institutions for managing and disciplining child life to the invention of childhood. Ariès identified that child portraits, in a stylised form specific to children, and religious images of children were becoming more popular among the wealthy (Gittins, 2009). This coincided with the development of specialised clothing for children, the growth of education, and the production of child specific literature (Frijhoff, 2012; Gittins, 2009). Evidence of the separation of the child from the adult world can be seen. It was in fact middle-class boys who the bourgeoisie differentiated from adults; hence childhood was historically constructed on an age, gender and class

basis (Gittins, 2009). Gittins (2009) points out that “they [bourgeoisie] were presented and represented not as ‘the middle-class family’ but as ‘*the* family’, not as ‘middle-class boyhood’ but as ‘childhood’” (p. 35).

This concept suggests childhoods are equal, universal and fundamentally identical, and denies the meanings and assumptions inherent in it (innocence, dependency) were constructed by a certain social group at a certain point in time, but later used to define what all families and all childhoods should be (Gittins, 2009, p. 35).

The positioning of the concept of the universal childhood can be seen in the statement by Bernard (1963), “It was not until the seventeenth century that the term child took on its present meaning. Not until then did childhood become anything more than an incidental phase in the developmental pattern” (p. 503).

Through the introduction of individualism, the bourgeoisie came to value domesticity within the boundaries of marital privacy (Bellingham, 1988). Stone and Shorter attribute the sentiments of ‘affective individualism’ or domesticity to the change from a patriarchal familial structure to the nuclear familial structure (Bellingham, 1988). Stone believed familial ideology at the end of the sixteenth and beginning of the seventeenth century was dominated by the father as the ‘king’ of the family and perceived society as a pyramid of families where the origin of authority is always paternal (Aries, 1978). Although Ariès (1978) disagrees, Stone associates affectivity with the introduction of individualism at the end of the seventeenth century. Affective individualism is defined as “the formation of marriage ties on the basis of personal attraction, guided by norms of romantic attachment” (Marshall, 1998, p. s "A"). In his book *The Family, Sex and Marriage in England: 1500-1800* Stone chronologically describes five family structures. Most important is the differences between structure two; the restricted patriarchal nuclear family (end of the sixteenth century), and structure three; the closed domesticated nuclear family (late seventeenth and eighteenth centuries) where the introduction of domesticity can be seen (Aries, 1978). It is in this change of family structure that the effects of individualism were enacted, as parents began to have more autonomy over their children’s upbringing.

This transformation of the family coincides with the development of schools and colleges, as detailed in Stones' 1964 *The Educational Revolution in England 1480-1660* (Aries, 1978). Children became a market for services and separated from adults in sites such as schools, nurseries and playgrounds (Bellingham, 1988).

Foucault's view of disciplining the body of the child by surveying and punishing him and by restructuring society as a grid of institutions in which young and old are enclosed for the benefit of their own education as docile members of our society, owes much to Ariès image of the child "le grand renfermement" (the great confinement) of youth in schools, colleges, workhouses and other disciplining institutions (Frijhoff, 2012, p. 25).

As a form of social control and surveillance, historians argue schools played a twofold role; originally as a tool to suppress the innate evil within the child and later paradoxically to ensure the child remained untainted by the world with the introduction of the 'Apollonian child' by Rousseau during the Enlightenment period and the *tabula rosa* (blank slate) by Locke (Ariès, 1962; Duschinsky, 2013). This form of childhood, which had not seemed necessary before, was concerned with the love and protection of children from moral and physical hazards (Bellingham, 1988). The arguments that were used to position children as inheritors of original sin were reorganised by Rousseau who rendered childhood "as a paradise of goodness and asexual innocence" (Duschinsky, 2013, p. 77). The competing discourses of the Dionysian child and the Apollonian child, are examples of the effect of power. Utilising surveillance and language as tools, dominant sections of society during the Early Modern Period (arguably the Church and the Bourgeoisie) wielded their social positions and knowledge to position these two childhood identities as the dominant discourses of childhood at that time.

From the eighteenth century onwards, these dominant discourses of childhood began to merge as children (and women) were equated more and more with nature (Gittins, 2009). Nature is often used to describe that which is not 'culture', as for example gardens and fields of corn. However, these have in fact been constructed by man and the concept of nature has changed over time. Initially it was the separation between mind and body with the rise of scientific rationalism (Gittins, 2009). The boundaries between humans and animals were becoming more defined whilst children were increasingly compared to angels and seen as needing protection and nurturing

(Gittins, 2009). However, if a child displayed 'animal like' behaviour it would be dealt with in the most severe manner. Rousseau and Lock, who both had a hand in the rise of liberalism and who urged the creation of 'the romantic child' and the *tabula rasa* (blank slate), recognised the need for the right environment for children to gain 'correct' experiences. "The garden itself had become a metaphor for childhood, especially girlhood, where nature, purity, innocence and transience are portrayed in a sentimental way" (Gittins, 2009, p. 37). With adult's need to protect children's innocence and purity, children became less affiliated and further separated from the adult world.

Liberalism

The concept of individualism, weakening of the feudal order, new religious beliefs and the progressive separation of people from the Church allowed the notion of liberalism to emerge. It has been suggested that liberalism was the product of the industrial (starting in the 1760s) American and French revolutions (Bell, 2014). "One of the roots of liberalism is the struggle of England against monarchical tyranny" (Titlestad, 2010, p. 95). The earliest accounts of liberalism were detailed by James Fitzjames Stephen in 1862,

As generally used... 'liberal' and 'liberalism'... denote in politics, and to some extent in literature and philosophy, the party with wishes to alter existing institutions with the view of increasing popular power. In short, they are not greatly remote in meaning from the words 'democracy' and 'democratic' (Bell, 2014, p. 694).

Liberalism, in one form or another, is still seen today across the world. Perry Anderson, a British Marxist left stated, "for the first time since the Reformation there are no longer any significant oppositions [to liberalism] – that is, systematic rival outlooks – within the thought-world of the West and scarcely any on a world scale" and Raymond Geuss, professor and political philosopher stated "We know of no other approach to human society that is at the same time as theoretically rich and comprehensive as liberalism and also even as remotely acceptable to wide sections of the population in Western societies" (Bell, 2014, p. 689).

It may be possible that liberalism was the initial "system of formation" of consent (Foucault, 1972, p. 107). Foucault identified the emphasis of liberty, equality

and fraternity of human beings to coincide with the emergence of philosopher's humanist perspective around the 17th century (Powers, 2007). Concomitantly, a change in social thought caused by the emergence of the physical sciences, the industrial revolution and the rise of capitalist nation-states challenged the power relations previously established under religious monarchies (Powers, 2007). According to Foucault these changes were accompanied by "gradual and generally unrecognised change in the management of people" (Powers, 2007, p. 26). Liberalism can be argued to first appear at the time of *Magna Carta*, otherwise known as *The great charter of liberties*, agreed to by King John of England in 1215 (Titlestad, 2010). However it gained more traction towards the end of the sixteenth century as lawyers and historians argued its importance to Englishmen's rights to freedom (Titlestad, 2010). By the end of the seventeenth century liberalism was a known competitor of absolute sovereignty. This is analogous with adult's absolute control of children during the Late Middle Ages and the Early Modern Period and children's subsequent movements to a more autonomous and individualised society in the modern world. The introduction of individualism and liberalism created the conditions of existence for the child competence discourse.

Autonomy and authority over ones' personhood are the two main ethical dimensions to consent. This resonates with the stipulated definition of liberalism, that although contested by some, includes the inter-relation of core concepts such as liberty, authority, autonomy and equality (Bell, 2014). The relationship between individualism and liberalism can be clearly seen in the description of John Locke's (1632 – 1704) foundational role in liberalism.

Locke challenged Divine rule and suggested a new political framework where the power of the King is transferred to 'men' as independent individuals, who will govern by consent...Locke's liberalism also demanded new rational individuals where reason rather than preordained right were the source of authority (May, 1997, p. 4).

Competence, although not yet identified as a finite personal attribute, can be identified in Locke's definition of liberalism. There is little difference between liberalism's call for 'independent individuals who will govern by consent as rational individuals' and competence's call for 'the maturity and intelligence to understand the

nature, purpose and consequences of one's decisions. Both refer to rational beings making autonomous and authoritative decisions over one's personhood.

Foucault described sovereignty as "the right disposition of things so as to lead to a convenient end" (Foucault, 1991, p. 93). "Liberalism as I understand it, the liberalism as an art of government formed in the eighteenth century, entails at its heart a productive/destructive relationship [with freedom]" (Foucault, 2008, as cited in Gane, 2008, p. 354). Foucault saw liberalism as an invention by liberal economists to promote the natural processes of economies and populations through 'certain forms of freedom' (Foucault, 2004). In other words, Locke gives people freedom to challenge divine rule and be individual beings, free from the constraints of the King. However this form of freedom comes with the requirement of rationality; freedom for only those who are competent to reason. This denotes a specific form of freedom to make autonomous and authoritative decisions over one's own matters. Hence, the roots of competence can be found in the emergence of liberalism and its specified form of freedom. Personal accountability further constrains the liberalist's notion of political freedom. To be a rational individual and to have authority and autonomy over one's own personhood, detached from a pyramidal hierarchy, suggests the outcomes of decisions made by individuals would be their responsibility. Understanding the short and long term consequences is a prerequisite to giving competent and informed consent.

The industrialisation period (1800 – 1900)

The industrial revolution moved the 'familial mode of production' to the 'labour market mode of production' (Bellingham, 1988). Although child labour was not uncommon in the Early Modern Period and children often had to work in adverse conditions for long periods of time, it was within the family and under parental care (Kertzer, 1987; van Nederveen Meerkerk & Schmidt, 2008). By the mid-1800s the largest employers of children were the traditional sectors of the economy such as agriculture, small-scale manufacturing and services, whereas factories and mechanization were only small pockets of modernity (Humphries, 2013). As technology advanced and productivity grew so did the demand for labour. The introduction of proletarianisation, otherwise known as wage labour, forced parents to

accept the requirement of child labour in the nineteenth and early twentieth century (Bellingham, 1988). For the family's survival, children had to contribute to the family's income (van Nederveen Meerkerk & Schmidt, 2008). The horrifying working conditions for some children during this era was described by Radbill (1974); "children from five years of age upward worked sixteen hours at a time, sometimes with irons riveted around their ankles to keep them from running away. They were starved, beaten and in many other ways maltreated" (p. 12). The social and economic pressures were so great that the child "associated with dependence and innocence, and childhood, identified as a time for learning and training in preparation for adulthood" (p. 161), was almost none existent during the industrial revolution; particularly for the poor (Baxter, 2008). The industrialisation period could be seen as a regression to the pyramidal hierarchical social structure seen in the times of the Church or Monarchies of the Late Middle Ages and Early Modern period. Although arguably to a slightly lesser extent as the culture of liberalism had already taken hold. Through economic oppression people and especially children no longer had the freedom of choice or authority over their personhood. In order to survive all members of the household, when able, had to work. This meant working gruelling hours in poor conditions with little choice to do otherwise.

Uneven economic development resulting in urban and rural divides, gender divides and class divides added to a growing diversity of childhood (Mintz, 2012). The factory child, the delinquent child and the evangelical child all coexisted in this time of upheaval. In most cases the rights of the parents meant the rights of the father. The 'women's movement' of the 19th and 20th century saw the fight for a mother's right to have some say in the protection, maintenance and education of her children (Pollock, 1986), rather than a fight for the rights of children's independence. Through the Equal Rights of Guardianship Act 1925 mothers in the United Kingdom gained some significance in the matter of their children, however it was at this time that the welfare of children had started to take precedence over guardian's rights for their children (Charlton, 1974).

New Zealand

It was during the European industrialisation period that the European influence on Aotearoa (New Zealand) began. The influx of British and Irish Europeans was relatively homogenous, not only in their religion and ethnicities, but also in their occupations (Pool, 2010). The majority were British, Protestant, and mostly traditional craftspeople who immigrated secondary to urban mass-scale industrialisation (Pool, 2010). The first Christian service in New Zealand was held in 1814 and by the mid-1800s baby farmers, crèches and kindergarten had been developed (Ministry for Culture and Heritage, 2013). This was the result of a class difference, where wealthier middle-class people had charitable interests in the children of working class families. Māori children were 'boarded out' which involved placement with European families (Atwool, 2006). The late 1800s were marked by economic depression which resulted in massive loans to fund railways, roads and immigration schemes. The British population doubled and school became compulsory, aligning with the European socio-political movements of the industrialisation period. It was also the time of the famous Minnie Dean trial evidencing the "stark realities of paid childcare and the lack of choice that many women faced in this period" (Ministry for Culture and Heritage, 2013, p. 3). In 1891, the first political party, the Liberals, was formed. It was a time where people were seeking social reform such as welfare for the poor and improvement in women's place in society. It was at this time that liberalism became officially enacted in New Zealand.

In contrast, prior to colonization, Māori tamariki (children) were cared for in the context of whanau (family), hapu (subtribe) and iwi (tribe) (Atwool, 2006). Rather than being considered as property, they belonged to the whanau in an open arrangement where adults, other than the child's biological parents, could raise the children under the whangai system to strengthen kinship ties and structures (Atwool, 2006). "Whangai was a public affair, and the decision-making process involved whanau and hapu with consideration for both the child and the maintenance of kinship structures...to be whangai was something special, a powerful system aimed at protecting the child and the hapu's rights and privileges" (Atwool, 2006, p. 260). This is an example of the nature of the collectivist approach to children and child raising, an

approach that came into conflict with the Pakeha (European) individualistic approach. Contemporary Māori however, having been exposed to European influence since the early 1800s, may be more inclined to lead more individualised lives separate from their iwi. This gives rise to another conflicting discourse; individualism versus collectivism. As previously argued, individualism and liberalism may be the conditions of existence of the child competence discourse, however if this discourse is to encapsulate all New Zealand children then issues may arise for Māori Tamariki whose foundation may be collectivism and not individualism.

The emergence of 'child competence' (1900 – 2015)

At the turn of the twentieth century there was a sharp response to the treatment of children during the industrialisation period. Ellen Key wrote *Barnets århundrade* (1900) and Viviana Zelizer wrote *Pricing the priceless child* which both emphasised the emotional, non-useful value of children (Sandin, 1995). This was a result of the conflict between the different constructions of childhood which created a move of forces to rescue children from the unsuitable conditions often seen in the nineteenth century. Consequently, the first legislation protecting children's rights was introduced as the Children's Act 1908 (Charlton, 1974; Pollock, 1986). However, much like the United Kingdom's Family Law Reform Act 1969, New Zealand's Guardianship Act 1968 did not mention the rights of children under the age of sixteen and subsequently initiated the legal construct of childhood and their capacity to conduct certain behaviours based on their age (Bainham, 1986).

At his time of writing, Bainham (1986) gave examples of children in the United Kingdom who at the age of five could be given intoxicating liquor in private, at ten a child could be convicted of a criminal offence in certain circumstances, at fifteen they could possess a shotgun, and at sixteen a child could work full time if they had left school and could claim a supplementary benefit in their own right. Currently in New Zealand, a five year old child can enrol in school, a ten year old can be convicted of murder and a fourteen year old is legally regarded as a 'young person' who can be left alone at home and baby-sit other children (Citizen's Advice Bureau, 2015). At sixteen a child can get a learners drivers licence, leave home or get medical treatment without the consent of their parents (Citizen's Advice Bureau, 2015). Competence to conduct

these certain behaviours has been based on age rather than the acquisition of certain personal attributes such as maturity or intelligence. However as these ages are sourced from legislation, the power the legal system exerts on society positions the discourse of child competence as the acquisition of a certain age to be an authoritative measure. Hence, contemporary constructions of childhood as universal, biological and natural are based on age as the measure of a child's progress through this discourse (Baxter, 2008).

The modern day childhood has been stamped as a market place for products and services. Each age section, i.e. infant, child, young person, is a niche requiring professionals to guide their care, upbringing and socialisation and are objects in need of protection under legislations, policies and organisations who concern themselves with the health and well-being of children (Mintz, 2012). Much like Locke's *tabula rosa*, the modern day child is moulded, tailored and guided into the perceived 'correct' notion of adulthood.

In the eyes of a historian of childhood, the United Nations Convention on the Rights of the Child is fraught with ambiguity. Recognising the full rights of childhood, it also keeps children confined into their childhood and the interpretation given to this stage of life in the different parts of the world, streamlining their personality ever more into a standard child, distrustful with regard to autonomous growth, and rejecting the right to adventure (Frijhoff, 2012, p. 16)

In contrast, some say childhood is disappearing (Darbyshire, 2007). With open access to uncensored information through the internet and media outlets and adult's desire to uphold children's basic human rights, children are again participating in the adult realm. Children's participation in adult's socio-political arena is in conflict with adult's desire to protect, and consequently control children's experiences of childhood. With regards to healthcare, child competence may be the product of this conflict; emulating both the adult's desire to protect children and children's rights to autonomy and participation in important health matters.

An example of adult's changing attitudes towards children in the modern day is the repeal of Section 59 of the New Zealand Crimes Act 1961. For parents who abused their children, Section 59 previously provided (by way of the clause 'reasonable force') the defence that they used force for correction purposes (Debski et al., 2008). Once

repealed it was dubbed by some as the 'anti-smacking law'. A study of New Zealanders' changing attitudes towards children based on the submissions on the bill to repeal Section 59 found that those who supported the repeal were more likely to conceptualise children as a person with full human rights who actively contributed to society (Debski et al., 2008). Those who did not support it were found to consider childhood as a stage of development, and the child as not yet an adult, unable to reason and requiring constant guidance (Debski et al., 2008). The repeal of Section 59 was mostly concerned with the protection of children; the attitudes of adults who supported the repeal indicates children are gradually being recognised as having rights and responsibilities that had previously been considered to only be within the realm of adulthood. As children progressively re-enter the adult realm, this change in attitudes has implications for the possible assumption that children are innately incompetent compared to their adult counterparts, and require proof of competence to exercise their full rights.

Summary

This section considered the history of child competence, its emergence and the conditions of existence that still govern this discourse as tacit rules today, giving evidence to Foucault's notion of the history of the present. The mental, physical, emotional and social abilities required for children to enter adulthood may have been the foundational concept of competence; although not spoken about in today's modern language, it is similar to children being incompetent for the adult world and requiring protection, control and tailoring in order to grow successfully and competently into adulthood. Hence the assumption that children are incompetent compared to their competent adult counterparts is a condition required for the existence of the child competence discourse, and which still exists today as a tacit rule, evidenced by the existence of child competence assessments in order for children to practice autonomous decision making.

The synonymy of childhood and child incompetence was further realised through the analysis of power relations secondary to the socio-political climate at different intervals through history. These power relations manifested themselves in the different child identities that at times contradicted each other, giving evidence to

the magnitude of power exerted by the needs of the dominant social group, adults. For example during the Early Modern Period, the Dionysian Child seen as intrinsically evil, was born of the rise of Puritanism and the requirement for day to day devotion to the principles of God. Comparatively, the Apollonian Child seen as innocent and in need of protection, was born as a result of the power exerted by the Bourgeoisie class. The power relations were also manifested in the fluctuation of children in and out of the adult realm, again depending on the needs of adults.

Individualism and liberalism were identified as conditions of existence as well as factors of the historical present. As families once freed themselves from the patriarchal structures of religious and feudal orders to become independent units, so too do children have the opportunity in the modern day to practice autonomous decision making free from the patriarchal structure of the family and the health system. Even though adults, still being the dominant social group, allowed this titrated form of freedom that came with conditions (that is, children need to acquire certain attributes in order to practice autonomous decision making) it would not have been possible without the individualism or liberalism that gave people the freedom of choice.

The conflict between children's rights to practice autonomous decision making and adults desire to protect them was the final condition of existence identified that also remains present in the modern day. This conflict is emulated by the competence assessment. These assessments acknowledge children's rights to autonomy and promote it where possible (i.e. if the child is competent) however children's protection from undue harm remains in the form of requiring certain attributes, such as maturity, intelligence and understanding, in order to exercise their autonomy. This conflict is further emulated in New Zealand health legislation and policy which contributes to the legislative ambiguity that surrounds child competence to participate in health discussions and decisions.

Chapter 6: The ‘truth’ about child competence

This chapter builds on the findings from the previous chapter; that of the historical emergence and conditions required for the existence of the child competence discourse. It discusses the political and legal version of the child competence discourse and how it was positioned as authoritative. Prior to the 1985 Gillick vs West Norfolk and Wisbech Area Health Authority case (Gillick case) the notion of child competence was a sociocultural construction rather than a legal factor in child health matters. It was more of a social norm or tacit rule required for children to participate in the adult realm. The Gillick case was the first legal account of children in the western world requiring a certain level of capacity to participate in important health decisions; at which time child competence in healthcare became an entity. The purpose of this chapter is to analyse the power relations exerted during this case, which may highlight the necessary conditions of existence of the legal version of the child competence discourse. Foucault suggests power is “productive of truth, rights, and the conceptualization of individuals, through the discursive practices of the human sciences, social sciences, bureaucracy, medicine, law and education” (Powers, 2007, p. 41). This case imposed an authoritative definition of competence and defined the identity of a competent child.

Four years after the Gillick case, the 1989 United Nations Convention on the Rights of the Child (UNCRC) was released and has since become the most highly ratified United Nations Convention. Over the proceeding 25 years, nation states, bar two (United States of America and Somalia), signified their alignment on the main concepts in this founding document on child rights by ratifying it. Reciprocally, this document affected change as ratified countries incorporated the UNCRC principles into legislation, albeit adapted to varying extents. This chapter considers how the power, knowledge and subject positions in the Gillick case constructed the ‘truthful’ version of the child competence discourse, and how the UNCRC universalised this discourse. Together, the UNCRC and Gillick ruling marked a more institutional recognition of child competence and the ‘official’ beginnings of child competence. Subsequently, through the power exerted by the law, these documents imposed their notions of child

competence as the authoritative ('truthful') or dominant version we know today. Foucault's notions of power were utilised to guide the analysis of the conditions required for the emergence of the legal version of the child competence discourse, how it was imposed as authoritative and the conditions required for its universal dissemination.

The legal emergence of the child competence discourse: The Gillick Case

The child competence discourse's most dominant form is that of its legal construction that first emerged in the 1985 Gillick case. Mrs Gillick, a devout Roman Catholic and mother of four daughters, took the West Norfolk and Wisbech Area Health Authority to court over a memorandum they published that guided doctors to give contraceptive advice and treatment to girls less than 16 years of age without the consent of their parents. Mrs Gillick felt this intervention was a breach of her parental rights. She lost that case and her appeal went to the House of Lords where she again did not succeed. In the House of Lords, Lords Fraser, Scarman, Bridge, Oakbrook and Templeman voted 3:2 (respectively) that girls under the age of 16 may receive contraceptive advice and treatment without the consent or involvement of their parents. Lord Fraser (1985) indicated that a doctor may proceed with contraceptive advice and treatment so long as the girl was,

1. Able to understand the advice given
2. The doctor was not able to persuade the girl to inform her parents
3. The girl was likely to continue having sexual intercourse with or without contraception
4. The girl's physical and/or mental health would suffer if she did not receive the treatment
5. Treatment was in the best interests of the girl. (p. 5).

It is in the first criteria '*Able to understand the advice given*' that the interaction of relational power exerted by the Lords produced the dominant discourse and the 'truth' about child competence. It was in this ruling that child competence was conceptualised and made a legal entity.

The House of Lords – a brief history

The social and historical context of the House of Lords allowed the Lords an authoritative position to dictate what is 'true'. It is the upper House of the Parliament

of the United Kingdom and consists of Lords Spiritual, mostly bishops from the Church of England, and Lords Temporal, life peers appointed by the monarch on the advice from the Prime Minister and the House of Lords Appointments Commission. It may also include some hereditary peers. The House of Lords is a historic constitution that was not deliberately designed to serve its current purpose; rather it grew and developed throughout history (Ballinger, 2012). Pollard (1964) stated “The House of Lords is not, in fact, founded on any principle; its basis is a patchwork of legal fictions, inconsistent rights, illogical decisions, and palpable uncertainties” (p. 299). It was, and still is to a certain extent, a group of individuals who hold the power to accept or decline legislation that would affect societal practices on a large scale, yet this power was not founded on expertise, rather on their positions in society.

The House of Lords can be traced back 1000 years where there were originally ‘wise men’, bishops and earls, who advised the king in an *ad hoc* nature (Ballinger, 2012). In 1230 these ‘wise men’ delineated themselves from the monarch and transformed into the upper house; a body of legislators “basing their right to legislate and their independence of the crown upon the principle of primogeniture” (Pollard, 1964, p. 300). Shortly after the time of Henry Tudor it became law that both the consent of the House of Lords (the upper house) and the House of Commons (the lower house), through independent deliberations, was required for a bill to become law, resulting in a bicameral parliament (Ballinger, 2012). Over the centuries the House of Lords attempted a series of reforms, of which very few were successful. Throughout the 19th century, although their power continued to wane, the House of Lords still had power over the House of Commons on matters where they could control its membership. In 1865 at least a quarter of the House of Commons was connected with 31 Great Families and another quarter had links with the peerage and baronetage through birth or marriage (Ballinger, 2012). By the end of the 19th century the House of Lords was represented by hereditary peers, representative peers for Scotland and Ireland, noblemen, bishops and lords of appeal; indicating little change in its membership or political agenda since the Tudor times (Purvis, 2011). Hence, their power was not necessarily a result of knowledge or founded on expertise (as the Lords positioned the doctor as the expert in the Gillick case), but for some on familial

succession and for others their place in society. Just as the original 'ideal childhood' was in fact middle class boys, a large portion of the Lords (at the time of the Gillick case) who dictated the law of society were actually descendants of members of the Church of England and of the aristocratic class with links to other individuals who held positions of power.

In the twentieth century the House of Commons became democratised and progressed with institutional and political changes, however membership to the House to Lords did not follow suit. Despite calls from the House of Commons for membership change in the form of judicial expertise, the House remained resistant to change. It was only in 1999 that hereditary peers were reduced by 600, leaving 92 (Purvis, 2011). This reduced the House's position of aristocratic power but the House also avoided abolition by evolving its role, function, size and composition to align with the shifting power of the political system (Ballinger, 2012). Hence they were and still are commemorated as the experts in law as a result of their social position in society rather than their knowledge of the law or society. Their subject position is in contrast with their positioning of the doctor as the 'expert' in the Gillick case. The health profession holds a certain position in society that is perpetuated by the perception of their expertise and knowledge of health practice. Their power is generated through knowledge whereas the Lords power was generated through their affluence, control of information and their position in society.

The historical context of the adjudicating body, the House of Lords, influenced the legal version of the child competence discourse when it emerged in the Gillick case. Lord Scarman (1985) identified three features of emerging society at that time; "contraception as a subject for medical advice and treatment, the increasing independence of young people and the changed status of women" (p. 20). Arguments put forth for the denial of women's admission to the House included the essentialist arguments related to women in general (that women were unsuited to politics due to physiology and temperament), and their experience due to the few who had been elected to the House of Commons (Sutherland, 2000). Those refusing the claim of women in the upper House used these arguments as evidence of women's inadequacy and of voters' preference for male representation (Sutherland, 2000). They also used

the argument of the 'slippery slope' where if women were granted a position in the upper house then they would start to demand and receive further concessions; most notably the right to vote at 21 years, as men did, rather than 30 as agreed in 1918 (Sutherland, 2000). Lastly, the constitutional argument where peeresses stated their admission was the next most important step of the House's reform, with which the peers disagreed (Sutherland, 2000). In 1962, following the 1958 Life Peerages Act, there were 19 peeresses (women) by succession who held positions in the House of Lords, however they could neither sit nor vote (Ballinger, 2012). If they could neither sit nor vote then it may be construed that their purpose was to merely hold the familial position of power in the House of Lords. The arguments put forth by those opposing women in the upper house gives an indication of women's position in law and society at that time and has significant inferences for the Gillick case; a woman and mother addressing contraception for girls less than 16 years of age. It remains important to consider the implicit and gendered subject positions of Mrs Gillick and her female daughters in contrast with the male dominated medical profession and House of Lords in the 1980s. This is clearly demonstrated in the Gillick case report where the Lords refer to the doctor as 'he' and that at the time of Gillick males constituted approximately 91% of the upper house (Purvis, 2011).

Who has the power?

Lord Templeman concisely summarised the Gillick case as "[The] consideration of the independence of a teenager, the powers of a parent and the duties of a doctor" (Lord Templeman, 1985, p. 38). This statement resonates with Foucault's notion of bio-power, "a network of interacting forces that are goal-driven, relational and self-organised, and creates tensions between, within and among individuals or groups" (Powers, 2007, p. 28). The judge, doctor, parent and child; each with their own agendas and objectives, construct and conceptualise the identity of a competent child. However, the Lords delivered the final report in the Gillick case and spoke as proxy for all interested parties; with children being the only group not privy to the discussion or allowed to participate by adding their perspectives. The Lords demonstrated control of information and knowledge; other than their societal position, this may be one mechanism the legal system utilises to position themselves as the dominant distributor

of power and the authoritative voice on child competence. In this case the Lords dictated the power of the 'clinical judgement' of the medical professional, the rights and role of the parent and the rights and abilities of children.

Lord Templeman (1985) contested the arguments put forth for a doctor to be the best person to decide what is in the best interests of the child and to judge their competence. Instead he positions parents to be the better judge based on parental rights. Interference by a doctor "would constitute an unlawful interference with the rights of the parent to make that decision on behalf of the girl and to influence the conduct of the girl by the exercise of parental powers of control, guidance and advice" (Lord Templeman, 1985, p. 44). He stated this "deprives the parent of the opportunity to protect the girl from sexual intercourse" (Lord Templeman, 1985, p. 40). His main objection, in line with Mrs. Gillick's main objection, was that in his opinion contraception was an offense of morality and religion. Lord Templeman (1985) agreed with Mrs. Gillick's argument and stated,

[the Memorandum] enables an inexperienced doctor in a family planning clinic, exuding sympathy and veiled in ignorance of the *girl's personality and history*, to provide contraceptives as if they were sweets withheld from a deprived child by an unfeeling parent; and that any parent who was concerned with the girl's immortal soul or with moral or religious principles might be said to be 'entirely unresponsive' to a proposal that an unmarried girl under the age of 16 should be provided with contraceptives. (p. 44).

The language used in this quote by Lord Templeman diminished the position of power held by the doctor and supported the position of the parent as the main individual responsible for the moral upbringing of their children. Hence, Mrs Gillick also held a relatively strong speaking position, as allowed by Lord Templeman in particular.

In opposition to Lord Templeman, Lord Fraser gave weighting to the rights of parents but concluded in favour of the doctor by saying,

There may be circumstances in which a doctor is a better judge of the medical advice and treatment which will conduce to a girl's welfare than her parents. [This] result ought not to be regarded as a licence for doctors to disregard the wishes of parents on this matter whenever they find it convenient to do so. The medical profession have in modern times come to be entrusted with very wide discretionary powers going beyond the strict limits of clinical judgement and, in my opinion, there is nothing strange about entrusting them with the further responsibility which they alone are in a position to discharge satisfactorily (Lord Fraser, 1985, p. 12).

Lord Scarman agreed with Lord Fraser;

[It] leaves the law in the hands of doctors...so that law can be kept in line with social experience, which is that many girls are fully able to make sensible decisions about many matters before they reach the age of 16. Responsibilities will lie on the medical profession. It is, however, a learned and highly trained profession regulated by statute and governed by a strict ethical code which is vigorously enforced (Lord Scarman, 1985, p. 29).

The only guidance Lord Scarman offered was that this situation would only occur in exceptional or unusual cases, but what that might encompass is not known. Ultimately the ruling gave doctors precedence and the power to determine what is in the best interests of the child.

Lord Scarman (1985) reiterated the appeal is less about what constitutes parental rights and more about “the extent, and duration of the [parental] right and the circumstances in which it can be overridden by the exercise of medical judgement” (p. 22). He agreed with Lord Fraser and stated it is the intention of the doctor to make “a medical judgement based upon what he honestly believes to be necessary for the physical, mental, and emotional health of his patient” (p. 28), however he may only give advice or treatment “if she [child] has the capacity to consent or if exceptional circumstances exist which justify him [doctor] in exercising his clinical judgement without parental consent” (Lord Scarman, 1985, p. 28). In addition, Lord Scarman identified two obscurities in the Memorandum; the absence of the definition of exceptional case and clinical judgement (Lord Scarman, 1985).

Children were neither present nor participated in the Gillick case however Lords Fraser and Scarman initiated an opportunity for children to exercise power in accordance with the judgement of their competence by a doctor. Lord Fraser and Lord Scarman noted the abilities rather than the age of a child to be the more accurate measurement of a child’s competence to exercise their rights to autonomy. “I am not disposed to hold now, that a girl aged less than 16 lacks the power [legal capacity] to give valid consent to contraceptive advice or treatment, merely on account of her age” (Lord Fraser, 1985, p. 7). Lord Fraser was also against the sudden onset of responsibility and acquisition of independence when a child reaches the age of majority (18 years old at that time in the United Kingdom). He believed that parental control diminishes and their encouragement of their child’s independence should grow

as their child develops. Lord Templeman (1985) addressed the evolving capacity of children by stating “The prudent parent will pay attention to the wishes of the infant and will normally accept them as the infant approaches adulthood” (p. 39) but also indicated that the court would support the parent “to decide on behalf on the infant all matters which the infant is not competent to decide” (p. 39). However, he does not define the limits of ‘infant’ competence. Rather than allowing for the exercise of power as they did for parents and doctors, the Lords merely gave children the opportunity or potential to exercise power depending on the opinions of either their parents or their medical professional. As with the history of childhood, children remain subject to the needs of adults rather than adults exercising their responsibilities to be attentive and respectful of the needs of children.

Protection or control – the nature of treatment

The level of competence a child requires to conduct certain activities is not consistent in New Zealand legislation. For example, in New Zealand a child can be held accountable for manslaughter at the age of 10 but is not considered a young person with the competence to be left alone at home until the age of 14 years (Citizens Advice Bureau, 2015). Adults appear to be conflicted with regards to the level of competence a child requires to consent to or participate in different facets of society, including healthcare. One cause of this conflict may be the nature of treatment. This conflict is most easily seen in Lord Templeman’s argument when he states an intelligent child may be competent to consent to the removal of tonsils or the appendix but not to intercourse or contraception. Lord Templeman (1985) believed a girl would not have “the knowledge of the facts of life and of the dangers of pregnancy and disease, or the understanding of the emotional and other consequences on herself, her family and her male partner” (p. 39). He did however believe a child could make the decision about invasive, albeit trivial, surgery. Lord Fraser (1985) agreed;

It seems to me verging on the absurd to suggest that a girl or a boy aged 15 could not effectively consent, for example, to have a medical examination of some trivial injury to his body or even to have a broken arm set. (p. 6).

In contrast to a trivial injury, Lord Scarman sighted the moral considerations of prescribing contraception to girls less than 16 years by saying,

There are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate” (Lord Scarman, 1985, p. 27).

Lord Bridge (1985) reiterated Lord Scarman’s position by suggesting it is more about “the protection of young girls from the untoward consequences of intercourse” (p. 32). Consent to surgery, even though its consequences could be disability or death, does not seem to require the same level of competence as consent to contraception requires. The nature of treatment appears to be closely linked with the consequences of treatment. At the time of the Gillick case consequences of the body alone seemed more trivial than those of the mind and body. Lord Templeman (1985) stated, “...regular or casual sexual intercourse fortified by the illusion that medical science can protect her in *mind and body*” (p. 39), further illustrates adult’s assumption of children’s cognitive incompetence. Modern understanding of disability secondary to surgery would refute the notion that its affect were only that of the body rather than the body and mind.

Some acknowledgement of the gravity of the consequences of intercourse and contraceptive treatment versus invasive yet trivial surgery is important to note, however there is also an element of protection and control. Adults’ perceived difficulty of controlling children’s practice of intercourse may be buffered by controlling their access to contraception. The act of control may be one manifestation of the power exerted regarding the child competence discourse. Adults have the power to judge whether or not a child is competent and can exercise the right of autonomy, but the moment a child is deemed competent the power of adults to say otherwise could be silenced. Hence, adults maintain this power over what children can and cannot do or access, whether it be through protection or control, or protection by control. In this instance it is protection by control of access to contraception and on a higher level protection by control of which discussions and decisions children are and are not competent to participate in and consent to.

Language as a tool

Language can be used as a tool to depict or understand meanings attributed to certain discourses. The word competence was first used around the 1860s to describe ‘age of discretion’ cases. These cases involved the desires of children (boys less than 14 years and girls less than 16 years) to leave home against their parents’ wishes. A court order would be granted “if the child had sufficient *intelligence* and *understanding* [emphasis added] to make up his own mind” (Lord Scarman, 1985, p. 25).

Foucault suggested the practice of how language is used could demonstrate the discursive practices within socio-political relations of power and the meanings, objects and subjects produced through the particular relations of power (Graham, 2005). The language in the Gillick case was used to prescribe and dictate the identity of the competent child in healthcare. However the meanings of the words used was not a result of this discursive practice but rather contributed to its conception. The language used in the Gillick case predisposed the discourse of child competence to participate in and consent to healthcare. Lord Bridge (1985) described a girl less than 16 years as “immature and irresponsible” (p. 32), which contributed to the construction of the child competence discourse rather than resulting from it. Lord Scarman (1985), when referring to children consenting to healthcare in general, stated they required “sufficient understanding and intelligence” (p. 24). Lord Scarman (1985) adds the need for a girl under the age of 16 to have “sufficient maturity” (p. 27) and be “able to appraise” (p. 27) the situation in order to safely be deemed competent. Lord Templeman (1985) regarded an unmarried girl under the age of 16 as “not sufficiently mature” (p. 38). Each individual Lord attributed his own meaning to each of the words prior to attributing them to the child competence discourse. This in turn leaves this discourse open to interpretation depending on the meanings attributed to the words used by the Lords. In addition, the interpretation of the child competence discourse is dependent on the historical and social contexts in which these words were first spoken. The Gillick case was the first time the child competence discourse, specific to healthcare, was discussed hence in order to further understand the meanings behind this discourse it is important to understand the context of the Gillick case. The House of Lords in 1985 was a different historical and social context to the interaction of

health professionals, children and parents in 21st century New Zealand. For example, the Lords all agreed that it would only be in exceptional and unusual cases that contraception would be supplied to a child less than 16 years without the consent of their parents. In contrast, contraception has now become legally available to children and young people irrespective of age in modern day New Zealand.

Lord Templeman used the language to demonstrate the links contraception had with the ability to decide to have intercourse rather than the ability to decide on matters of healthcare. Lord Templeman (1985) acknowledges that a child may give consent in opposition to a parent's opinion based on religious grounds, but that the acceptance of the child's consent would depend on "the *nature of treatment*, and the *age and understanding* [emphasis added] of the infant" (p. 39).

Contraceptive treatment for females usually requires daily *discipline* in order to be effective and girls under 16 frequently lack that *discipline*. The decision to authorise and accept medical examination and treatment for contraception is a decision which a girl under 16 is not *competent* to make" (Lord Templeman, 1985, p. 41).

Lord Templeman's use of 'infant' commonly referred to someone below the age of majority (21 years old in the United Kingdom) at the time of the Gillick case, however contemporary terms such as minor are becoming more common (Olson, 1999). The words immature and irresponsible were used to describe a child lacking competence and the words understanding, intelligence, maturity and discipline were used to describe a competent child. Hence in this formative document, the identity of a competent child is constructed as one who is intelligent, mature, disciplined and able to understand the nature and consequences of treatment. Nature of treatment and age were also cited by the Lords and are two additional factors that are irrespective of the child's personal attributes but still contribute to their identity.

The influence of historical and social context can be seen in Lords Scarman, Templeman and Brandon's opinions on contraception and girls. Lord Scarman (1985) discussed the importance of the law staying abreast of the society in which they live and work with regards to the availability of contraception to women. His opinion on contraception was driven by the premise of health advice and treatment and the evolving capacities of children. He takes an enlightened stance on the law regarding

contraception and women's access to a more autonomous and independent lifestyle. Contrary to this Lord Templeman (1985) took a more moral stance and judged the participation of a girl in sexual intercourse as a practice that "offends basic principles of morality and religion" (p. 41). Lord Brandon (1985) quotes section 5 of the Criminal Law Amendment Act 1885 to have been passed "for the purpose of protecting women and girls against themselves" (p. 34); indicating a paternalistic view point. Lords Templeman and Brandon connected contraception with sexual intercourse and women and children's position in society at that time. The different viewpoints of each Lord result in different meanings being attributed to the same words. The majority of the Lords discussed maturity as a main attribute of a competent child, but with their different points of view in mind, the connotations they attribute to maturity could be different. Hence, when health professionals discuss the competence of a child in today's world and they look for intelligence, maturity and understanding, as dictated by the Medical Council of New Zealand and the Health and Disability Commission, what they are actually measuring cannot be verified. With their own meanings attributed to these words, health professionals, as the Lords did, are making personal and independent judgements of children's competence.

Competence as a binary or continuum

Within the Gillick case there are the competing discourses of competence as a binary versus competence as a continuum. Lords Fraser, Scarman and Bridge's arguments of what constitutes a competent child's identity includes the evolving capacity of children and the diminishing duties of parents. This suggests the child competence discourse could be based on a continuum. However the Lords also discussed the need for a doctor to make a finite clinical judgement of competence or incompetence in order for the child to be allowed to decide on important health matters that affect them. Lord Scarman (1985) further illustrated these competing discourses;

The law relating to parent and child is concerned with the problems of the 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 (Lord Scarman, 1985, p. 23).

This quote illustrates that although the Lords discussed the evolving capacities of a child and the diminishing guardianship of a parent, a precedence of competent or incompetent was established. This may have been because it was based on the outcome of whether or not a child could make their own legal decisions rather than participate on a continuum ranging from mostly dependent, to shared decision making, and finally to autonomous decision making. Alderson (2007) discussed four different levels of decision making; to be informed, to express an informed view, to have that view taken into account when decisions are made and to be the main decision maker about proposed interventions. If decision making can be viewed on a sliding scale from simply being informed to making an autonomous decision, whilst keeping in mind the requirement of competence to make a decision, then it might be possible that competence too may be viewed on a sliding scale. This scale may begin with simply being present and informed about intended interventions, to participating in the decision making in association with parents and health professionals (otherwise known as shared decision making) and finally to being competent to give legally binding consent.

A personal account

Kendall and Wickham (1999) encouraged researchers to look for contingencies, rather than causes while reading texts and conducting the historical component of a Foucauldian discourse analysis. Looking for contingencies relates to Foucault's notion of a 'history of the present' where historical rules can still be found operating and influencing us today. One contingency identified in the Gillick case is the 'lawful' statements that place the word of the law at the ultimate position of power within our societies; both as the foundation of a lawful society and the dictator of future societal movement. Reflexively, I realised in the review of literature I found law, and policy to a certain extent, to be the 'official' statements of what child competence is and what personal attributes and components construct a competent child's identity. Just as in 1985 when the rule of the Lords introduced the competent child discourse as an entity, determined their identity and enforced their version of this discourse as a factor in children's healthcare, I believe this same level of power is exerted by the law today to maintain the 'Gillick' version of the child competence discourse. This is clearly depicted

in literature from the United Kingdom where competent children are often referred to as 'Gillick competent' children (Griffith, 2013).

The universalisation of the child competence discourse: UNCRC

The United Nations Convention on the Rights of the Child (UNCRC) is the most highly ratified convention of all United Nation Conventions. As noted earlier, all nation states, excluding the USA and Somalia, have committed to the principles outlined in this document. Some countries, such as Sweden, have gone so far as to propose its introduction in legislation. The evidence or manifestation of the power this document exerts is experienced in the fact that this is one of the most widely accepted documents in the world. Its principles have enabled most nation states to identify common ground with each other and vice versa, these child welfare principles have identified common ground with most nation states. The UNCRC is both a facilitator and a product of a universal childhood; the UNCRC was influenced by and subsequently disseminates the concept that all children from all cultures develop along the same linear biological, emotional and psychological pathway toward adulthood (Twum-Danso Imoh, 2012). This is indicative of a foundation based on a westernised conceptualisation of childhood (Twum-Danso Imoh, 2012). For example, this convention urges children's need for special care and assistance, for family as the fundamental group of society and in particular, for the individual life of the child in society; "brought up in the spirit of peace, dignity, tolerance, freedom, equality and solidarity" (United Nations General Assembly, 1989, p. 1). Individualism and family as the fundamental group of society are both westernised concepts that originated prior to this convention and that are further communicated by this convention. Acknowledging that this convention also relates to children living in exceptionally difficult conditions and that the intention of the UNCRC is to improve the wellbeing of these children, it is also important to understand the UNCRC's global effects on both developing and developed countries.

A product of universalisation

The UNCRC was the result of a movement towards the recognition of children's rights and their need for protection. This movement began in the enlightenment period with the introduction of the Apollonian and Dionysian child discourses resulting

in children being progressively separated from the sophistications of the adult world. These child identities were further standardised and solidified by reformers in the nineteenth and early twentieth century, most notably in the education sector (Twum-Danso Imoh, 2012). Educational facilities can be seen as a form of surveillance and mode of discipline to tailor and mould children towards adulthood; emulating the Dionysian child wrought with original sin. It can also be seen as a system dedicated to the protection and nurturing of children; emulating the Apollonian child. Initially the abstract concept of school was open to all ages, however over the years it was redefined by age and scholarship, divided by gender and ultimately resulted in the exclusion of adults as a social norm. Children began to occupy a separate social space to adults and were categorised by immaturity, innocence and physical weakness, hence requiring special protection and rights. One of the first formalising documents of children's position in society was the 1870 Education Act which called for and made provisions for children's rights to education in the United Kingdom. By the early twentieth century children were banned from public houses and gambling, and institutions such as welfare agencies and correctional facilities forged "a new age of consent" (p. 21) which further separated children from the adult world (Twum-Danso Imoh, 2012). This contributed to the development of the 1924, 1959 and finally the 1989 United Nations Declaration of the Rights of the Child. The principles laid out in the UNCRC are indicative of a universal child who follows a particular developmental trajectory with particular requirements and entitlements (Twum-Danso Imoh, 2012).

The right of the child to express their views and feelings on all matters affecting them is one of the four main principles in the Convention. However according to Twum-Danso Imoh (2012) this principle goes against beliefs and values of many societies making it one of the most controversial principles. It is upon this principle (cited in Articles 12, 13, 14 and 15) that the autonomy to participate and consent to important health matters is based. The prescription of age laid out in the UNCRC, of children being defined as those below the age of 18 years, is also relevant to the child competence discourse. "The idea of a single (gender neutral) age of legal maturity reflects the western juridical tradition and concepts of citizenship built around the universal franchise and eligibility for conscription into the army" (de Waal as cited

inTwum-Danso Imoh, 2012, p. 26). Hence the Convention is a product of westernisation and ultimately resulted in the imitation of the 'universal childhood'.

A facilitator of universalisation

The UNCRC has been a major driver of law reform and establishment of national independent human rights institutions for children (Santos Pais & Bissell, 2006). In over 50 countries the UNCRC has been incorporated and adopted into national legal frameworks (Twum-Danso Imoh, 2012). However through the process of review and surveillance by international and national watchdogs, once ratified each country has been expected to assimilate and harmonise with the principles set out in the UNCRC. The introduction of children requiring additional rights and protection has created a change in societal perceptions of children and recognition as subjects of rights (Twum-Danso Imoh, 2012). For example, Lansdown and Karkara (2006) cite a growing recognition of children's capacities for informed decision-making to be the second most important outcome of the UNCRC; the first being adults gaining a better understanding of the nature of children's lives.

The UNCRC has contributed to adults appreciating the benefits from direct engagement of children in policies and services that affect their lives (Lansdown & Karkara, 2006). Children's position in society is moving from passive victims to social actors "capable of advocacy and action to challenge rights abuses, development of strategies for change, and participation in the implementation of programmes to promote their rights" (Lansdown & Karkara, 2006, p. 692). However these authors still believe that respect for children's participation in important decisions is still missing in many countries. In contrast Arce (2012) writes

The hegemonic children's rights discourse, crystallized in the UNCRC, is anything but child empowering because it is indebted to specific Euro-American adult understandings which picture the child as ignorant, innocent and needy and the child's human rights as a concession granted by adults. (p. 365).

New Zealand's adaptation of the UNCRC

General measures of the implementation of the Convention includes law reform, establishment of national independent human-rights institutions for children, national plans of action, coordinating bodies, allocation of resources for children, monitoring mechanisms on implementation of the Convention, awareness raising and advocacy and measurement of the involvement of civil

society, including children, in the realisation of children's rights (Santos Pais & Bissell, 2006, p. 689).

This quote was taken from an article published by the UNICEF Innocenti Research Centre which undertook a three year study on the implementation of the UNCRC in 62 ratified countries, including New Zealand. New Zealand's implementation of the UNCRC can be seen in its changes to law and policy and its introduction of children's rights institutions, action plans and monitoring mechanisms of children's rights. The Care of Children Act 2004, the Vulnerable Children's Action Plan and the UNCRC public consultation on the Fifth Periodic Report under the UNCRC (2015) are some examples of New Zealand's assimilation with the UNCRC principles. There are inconsistencies however in the definition of child, as seen in the use of different ages in different statutes, and insufficient mechanisms for ensuring the views of children and young people are captured during the policy and legislative process (Ministry of Social Development, 2015). In addition, the UNCRC has been seen by many as the 'last word' on children's rights however some authors such as Bernie Carter (2014) believe even a seminal document such as the UNCRC needs the addition of child advocates' voices for children's rights to be acted upon.

Summary

The social, historical and political speaking position of the House of Lords allowed them to impose their version of the child competence discourse as authoritative. Subsequently the UNCRC, influenced by the 'universal childhood' and emulating a similar position as the House of Lords on child competence, facilitated the universalisation of the westernised legal version of the child competence discourse.

In conjunction with health professionals, the Lords and the UNCRC dictated the identity of the competent child that best served those of the dominant social group, arguably themselves and health professionals, and through the use of specialised knowledge imposed their version of this discourse as the 'truthful' version. Contributing to this was women and children's position in society at the time. The Lords disseminated their authoritative power to health professionals in the form of 'clinical judgements'. Although, there was some disagreement as to whether or not the parent or the health professional was the most appropriate person to make child

competence judgments. Children were neither present nor allowed to participate in the construction of the identity of the competent child.

Important findings from this analysis also include adult's control of children through the premise of protection and the Lord's conflict of competence as a binary versus as a continuum. Access to contraception and children's requirement of competence to participate in health discussions and decisions can both be seen as forms of control through protection. The rigidity of competence as a binary contributes to adult's control by protection of children. The competence assessment could be understood as a more flexible and changing sliding scale in the form of children being mostly dependent and requiring protection to having the ability to make autonomous decisions. This may result in more accurate competence assessments for individual children.

The meanings attributed to the language the Lords used to construct the identity of the competent child may have been different in 1985 United Kingdom society compared to 2016 New Zealand society. In addition, the Lords may have attributed personal meanings to these words prior to the Gillick case, influenced by their experiences and contexts. As per the Medical Council of New Zealand, Gillick competence principles have been incorporated into guidelines for health professionals to conduct these assessments. However, words such as maturity and intelligence may have had different meaning for the House of Lords in 1985 and health professionals in 2016. With different meanings attributed to the same words, health professionals may make personal, subjective and independent judgements of children's competence.

Chapter 7: Assessing child competence

Child competence to consent to health advice and treatment is currently not assessed in a standardised manner (Hein, Troost, Broersma, et al., 2015). It has been proposed that health professionals' judgements of the level of children's competence may have an effect on the level of participation children are allowed in important health matters (Lansdown, 2005). The possible benefits of participation in healthcare may not be realised due to the subjectivity of the child competence assessment. Child competence is dynamic, ever changing and depends on the child's context; in particular on the judgements of health professionals (Alderson, 2007; Hein, Troost, Broersma, et al., 2015; Lansdown, 2005). However as previously discussed, words such as maturity and intelligence may have different meanings to different people depending on their experiences and contexts. In addition to the ambiguity of the words used to describe a competent child, health professionals' perceptions of childhood, children's position in society and the ill-defined guidance from New Zealand health legislation and policy (status versus maturity approach) may contribute to possible inconsistencies in health professionals' assessments of child competence. Lastly, health professionals' speaking position and power relations may further contribute to these possible inconsistencies.

Health professionals versus children's subject position

Health professionals in New Zealand are currently in the position to dictate and promote children's access to participation and autonomous decision making in healthcare. However with ambiguous instructions on which rule to follow (maturity or status rule) and how to assess child competence if the maturity rule were to be followed, their judgements may be highly influenced by their perspectives on children's position in society as vulnerable and in need of protection and their own experiences, values and training. The power health professionals may exert to enact their judgements, contributed to by their specialised knowledge, results in children having little influence on whether or not they may exercise their right to autonomous decision making and freedom of expression.

The existence of power can be seen in its particular manifestations in specific contexts. In the context of modern society and its health system, health professionals manifest power to determine the competence of children. They also dictate the involvement of the child's parents and the level of participation a child is allowed. If the child is deemed incompetent, the parent may decide for the child. However if the parent disagrees with the doctor, it is the health professional's obligation under the 'best interest' rule to apply for the child to become a ward of the court (*Care of Children Act*, 2004; United Nations General Assembly, 1989). Hence the manifestation of power can be seen in the health professionals' ability to have the final say on important health matters and it is Judges enacting the law who disseminate this power to doctors, as seen in the Gillick case. An example of this is the application for Liam William Holloway to become a ward of the court after his parents disagreed with the conventional medical options offered to treat him. When he later died, Liam's parents were found guilty of not providing the necessities of life and were given jail sentences. Tovia Laufau on the other hand was not made a ward of the court due (in part) to the controversy following Liam's case, and his parents were given suspended sentences for not providing the necessities of life. These cases were fuelled by relational powers between the parents, the media (especially in the Liam William Holloway case), and the legal and health systems. It is not the purpose of this work to discuss the ethical dilemmas presented in these cases, but to highlight the powers at play; those of the health professional, parents and the law.

In contrast to the powers of the health professional, parents and the law, it is important to consider the powers of the child and how New Zealand legislation allows social constructions of childhood to affect children's position in the health system. Section 36 of COCA that specifies children's legal rights to consent to or refuse healthcare only pertains to those over the age of 16 years. With regards to children less than 16 years old, Section 6 simply states "a child must be given reasonable opportunities to express views on matters affecting the child; and any views the child expresses (either directly or through a representative) must be taken into account" (*Care of Children Act*, 2004, s 6). This section has implications for the relational power of those younger than 16 years to enact their rights to participating in and

autonomously consenting to healthcare. The absence of the notion of child competence in COCA is misaligned with the Code that states “Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent” (Health and Disability Commission, 1996, Right 7(2)). As children are consumers of healthcare, this document instructs providers of healthcare to presume children are competent to give informed consent. Similar to COCA, the Code has implications on children’s relational power and their position in society. Simply being a child may be ‘reasonable grounds’ for health professionals to judge them as incompetent. Westernised versions of children’s position in society portray them as vulnerable, in need of protection, incompetent in comparison to their adult counterparts and requiring education and moulding to grow into the socially accepted version of a model adult citizen. Hence while COCA does not specifically mention those below 16 years of age, the Code allows for societal and historical assumptions of children to contribute to the ‘reasonable grounds’ health professionals require for determining a child as incompetent to participate in or consent to important health matters that affect them. This is evidenced by the presumption in healthcare that children are first incompetent and need to prove their competence to consent to health treatment (Alderson, 2007; Christensen, 1998; Wyse & Hawton, 2000). This presumption does not align with New Zealand legislation but may align with New Zealand healthcare practise. Some researchers and child health advocates believe that this presumption is so ingrained that it has become the norm; simply being a child creates, as the Code would say, “reasonable grounds for believing that the consumer is not competent” (Alderson, 2007; Christensen, 1998; Health and Disability Commission, 1996, p. 5). The presumption of children’s incompetence contributes to their subject position and is a stark contrast to the subject position and speaking powers of the healthcare professional and parent.

Children’s position in society and their speaking position in relation to that of health professionals and parents is further demonstrated in the language used by the Health and Disability Commission detailing the latest instructions to health professionals on the matter of child competence, which emulates language used in the

1985 Gillick case and the 1989 UNCRC document. The Health and Disability Commission (2014) released a Fact Sheet in an attempt to resolve some of the ambiguity surrounding children's competence to consent to healthcare in New Zealand. It stated "a child may consent themselves if and when the child achieves sufficient *understanding* and *maturity* [emphasis added] to understand fully what is proposed" (p. 1), and that the legal position held by Gillick reflects that of New Zealand (Health and Disability Commission, 2014). The principles of the Fact Sheet are also reflected by the New Zealand Medical Council and the Auckland District Health Board legal department (Auckland District Health Board, 2010; Medical Council of New Zealand, 2011). Hence the principle of children requiring protection, as stipulated in the UNCRC, and the language used in the Gillick case, that of maturity and understanding, which constructs the identity of a competent child, has been emulated by New Zealand legislation, policy and guidelines on child competence. The individual meanings attributed to the words used to describe, measure and assess the competence of a child and the influence of children's position in society as incompetent and in need of protection further contributes to the relational powers exuded by health professionals and children. Health professionals subsequently maintain their subject position to differentiate between those who are competent and those who are not. Consequently, this power exerted by health professionals disseminates and reinforces the dominant discourse of child competence and incompetence as a binary throughout the New Zealand health system.

The dominant legal version of the 'child competence' discourse

Grimwood (2009) suggests there have been two specific New Zealand cases that openly declare Gillick has been applied to New Zealand. *Hawthorn v Cox* [2008] details a mother who appealed to the High Court to have her guardianship reinstated (Grimwood, 2009). The presiding judge, Heath J, used Gillick principles in order to recognise the diminishing role of a parent as a child grows and matures (Grimwood, 2009). In *Re SPO* [2005], Judge Ullrich presided over a 14 year old boy who wanted to continue his course of MENZ B vaccinations against his mother's will. Judge Ullrich stated "sufficient understanding and intelligence has become known as the Gillick principle and has been applied to New Zealand" (Grimwood, 2009, p. 745). The

Medical Council of New Zealand (2011) stated in its footnotes pertaining to the section 'Consent of minors' that "In the absence of clear legislative direction it is likely that the principles set out in Gillick ... will be followed by New Zealand Courts" (p. 4). The Ministry of Health (1998) described the ability of a child to consent to health treatment as being "based on the child's individual capacity to consent, and that this decision is generally accepted as binding for New Zealand courts" (p. 14). The Health and Disability Commission (2014) recent Fact Sheet publication stated:

The House of Lords [Gillick v West Norfolk and Wisbech Area Health Authority 1985] decided that whether or not a child can give effective consent to medical treatment depends on the child's individual capacity to make an informed decision. That legal judgement is generally accepted as reflecting the legal position in New Zealand. (p. 1).

Skegg (2006) stated,

Minors' common law capacity to consent to medical treatment has not been extinguished by the New Zealand legislation, and that the consent of those under the age of 16 will sometimes be effective in law, be it for the purpose of the criminal law, the law of torts, or the Code of Rights. (p. 195).

New Zealand case law, the Medical Council of New Zealand, the Ministry of Health, the Health and Disability Commission, and leading expert on medical law in New Zealand, Professor Peter Skegg, gives evidence to the application of Gillick to New Zealand legislation and case law. Hence the measure for children consenting to health care is no longer clearly based on the status rule (age), rather it may be based on the maturity approach, otherwise known as the evolving capacities rule or Gillick competence. Unfortunately without a clear indication from New Zealand health legislation as to which rule (maturity or status) to follow and with meagre information available to health professionals on how to assess children for competence, a grey and ill-defined area remains, which may lead to inconsistencies in practice.

New Zealand's increasing support of Gillick competent children in its health policies shows the maturity approach or evolving capacities rule is gaining momentum. However, the contents of New Zealand's governing health legislation pertaining to child competence to participate in and consent to health treatment, particularly COCA and the Code, indicate that since the UNCRC was ratified by New Zealand 1993, there has been some neglect of much that has been learnt about children's capabilities (Alderson, 2007; UNCROC Monitoring Group, 2013; UNICEF New Zealand, 2013). The

lack of acknowledgement of the different facets of children's competence, such as its dynamic nature and the effects of children's context, contributes to our understanding of the magnitude of the dominance of the legal version of the child competence discourse. This version asserts its authoritative position by dictating what information can be said (and not said) about the dominant discourse that best serves the most dominant group. In this case it is easier to understand who this dominant group is by defining who the most marginalised group is; children. Research has indicated that the maturity approach based on evolving capacities should be the foundation of the child competence assessment (Hein, Troost, Broersma, et al., 2015). Further research is required to more fully comprehend what contributes to children's competence; what has been learnt to date has not been incorporated into health legislation or policy. This is evidenced by the misalignment of health legislation on this topic and the lack of guidance for health professionals from health policies.

Competence versus Compliance

It may be difficult for health professionals to assess the difference between compliance with proposed health treatments and making a competent health decision. Locke in 1690 and Kant in the 1780 talked about how the rational man [sic] capable of reasoning should be able to make autonomous decisions (Alderson & Goodwin, 1993). However at the time of Locke and Kant, women and children were denied this right as they were assumed to be irrational (Alderson & Goodwin, 1993). This is no longer the case for women in the modern world but remains so for children. Children's position in society suggests they are still regarded as irrational, physically weak, vulnerable and in need of protection (Smith, 2013). Some believe this position is nearing the adult realm again as children's rights gain momentum through easier access to adult censored information via the World Wide Web and increasing accessibility to a disposable income (Postman, 1994). The former notion however of children as incompetent beings requiring protection remains dominant in the health system, simply evidenced by the requirement for children to prove their competence rather than incompetence to participate in important decisions. Incompetence remains synonymous with childhood and competence with adulthood.

Compliance, the manifestation of surveillance

Surveillance, overseeing or observation, induces the effects of power and consequently invisible coercion (Foucault, 1977). Surveillance as a means of control is applicable to the child competence discourse where there is disagreement with treatment suggestions. Children, primarily viewed by health professionals as irrational beings as a result of their position in society, may agree with the rational adult's views and consequently may be perceived by health professionals as competent and exercising their right to free expression and autonomous decision making. Compliance however may be the manifestation of children's self-discipline as a result of the competence assessment, emulating Foucault's notion of surveillance and its affects on less dominant groups. Children who enact self-discipline in the form of compliance early in the consent process could cause health professionals to misinterpret the appropriate level of information they require for their understanding, which may subsequently affect their competence to participate in health discussions. This form of self-discipline may affect the level of autonomy children exercise, health professionals perceived levels of children's intelligence or maturity and consequently the level of competence and participation children are allowed. To avoid compliance as a form of self-discipline in the consent process children require an appropriate environment, information and support to be able to enact their rights to voluntary and autonomous participation and decision making.

Summary

Health professionals wield the power to have the final say in important health matters concerning children and to dictate their involvement and the level of their parent's participation. They can judge a child competent or incompetent depending on their requirements, as the dominant social group. Their judgements are highly influenced by children's position in society, supported by New Zealand health legislation that is misaligned and open to misinterpretation, and by the subjective meanings they attribute to the words used in health legislation and policy to describe a competent child. This is contrasted with the powers of the child who is presumed to be incompetent and needs to prove their competence in order to practice their right to autonomous decision making.

It may be difficult however for health professionals to ascertain the appropriate level of participation and decision making for children if children enact self-discipline as a consequence of competence assessments. Foucault's notion of surveillance, enacted by a smaller dominant group in order to control the behaviours of larger groups, may produce the unintended behaviour of compliance by children in the health setting. This may cause difficulties for health professionals when attempting to convey adequate information at an appropriate level and with the appropriate manner in a bid to support their autonomous participation in health discussions and decisions.

Chapter 8: Discussion

Through an analysis of the history of childhood and a document analysis of New Zealand health legislation and policy, this research has identified additional critical aspects to the child competence discourse. These include historically situated conflicts and conditions required for this discourse to emerge, such as individualism and liberalism, the conflict between the Apollonian and Dionysian Child identities and adults' conflict of protecting children but also recognising children's right to autonomy. These foundational conflicts and conditions of existence remain present in the modern day and can be identified in New Zealand health legislation and policy. They also contribute to the construction of other complexities, such as competence as a binary rather than a continuum and life experience as a marginalised contributor to the child competence discourse.

Tacit rules and conditions of existence

The analysis section of this thesis indicates that, through a review of the history of childhood, there were three conditions of existence for the legal version of the child competence discourse to emerge; protection versus autonomy, the Apollonian Child versus the Dionysian Child and individualism and liberalism.

A conflict of ideals: Autonomy versus Protection

Within all discourses there are conditions required for them to exist and tacit rules that govern them in society. Foucault believed that the tacit rules and conditions of existence required for a discourse to initially emerge in earlier history still exist and function in the modern world. For example, *Madness and Civilisation* written by Foucault in 1961 was not a history of psychiatry but rather an investigation of the conditions that made possible the eventual development of such a discipline (McHoul & Grace, 1993). However, for discourses to develop and be positioned as dominant over more silent or marginalised versions, subject positions, knowledge and power are required to exercise the power of the tacit rules and conditions of existence over those of the more silent or marginalised discourses. The oscillation of children's inclusion/exclusion in the adult world throughout history and history's contradicting

explanations for this pattern is an example of the effects of power on a subject position. For example, it is argued that in the Middle Ages childhood did not exist and children did not occupy a separate social space to adults; they were included in the adult realm through the requirement for them to work as soon as they were physically able and they were privy to adult information and discussion (Aries, 1978). In the Early Modern Period however children began to be seen as vulnerable, innocent, in need of protection and requiring discipline in order for them to grow successfully to adulthood; they were separated from the adult realm especially through the establishment of schools and the rise of Puritanism (Duschinsky, 2013; Gittins, 2009).

There is however little consensus between researchers as to what initiated the 'invention of childhood'. With the heightened need for labour, children during the industrialisation period were expected to work, earn a wage and contribute to the family's income; they were again included in the adult realm especially through the requirement of independence (Bellingham, 1988; van Nederveen Meerkerk & Schmidt, 2008). Notions of childhood as a vulnerable stage in a person's life were mostly irrelevant during this time. Towards the end of the industrialisation period however, children's rights started becoming prominent through certain pieces of legislation such as the Factory Act 1833 and the requirement for compulsory schooling (Wyse & Hawton, 2000). This again resulted in children populating a separate social space to adults and being the subjects of dependency and ignorance (Wyse & Hawton, 2000). This oscillation can also be seen in the construction of children's identity, or more accurately the construction of children's multiple identities throughout history as a consequence of the effects of power. For example, the Apollonian Child and Dionysian Child of the Early Modern Period and the Evangelical Child, Factory Child and Delinquent Child of the industrialisation period.

The oscillation of children in and out of the adult realm is still present today in the form of the child competence assessments conducted by health professionals. If found competent a child may participate in the adult world, but if found incompetent they remain separated and unable to practice their right to autonomy. The conflict between children's rights to autonomy and adult's desire to protect them may be one of the conditions of existence for the child competence discourse. Competence

assessments (maturity approach) can be viewed as tools to promote participation in health discussions and autonomous decision making by younger children rather than remaining with the static age based measure of competence (16 years). However, competence assessments can also be viewed as a measure to ensure those who are 'incompetent' are protected and their best interests are seen to. The conflict of autonomy versus protection is evident in the inconsistent inclusion/exclusion of children in the adult realm throughout history depending on adult's needs and agendas. This is relevant to Foucault's 'history of the present' where tacit rules that were present during the emergence of a discourse still remain in effect in the modern day. During the Early Middle Ages a recognition for the *protection* of the innocent child developed and children began to occupy a separate social space to adults. However, during the industrialisation period children were expected to participate in adult work, make independent *autonomous* decisions and be responsible for (formerly) adult duties. Children vacillated between adults' need to either protect them or to encourage their autonomy. This tacit rule, or more aptly this tacit conflict that health professionals may experience, is still present today in the form of the child competence assessment.

Power is known from the strategies and practices in and through which the force relations take effect. Marginalization is the process by which non-dominant discourses are not eliminated, but tolerated as alternative speaking positions of resistance that provide the target and therefore the tension to sustain the dominant discourse (Powers, 2007, p. 28).

It may be possible that through the marginalization of children as vulnerable and in need of protection that the discourse of child competence to participate in the adult world is continually supported.

Apollonian Child versus the Dionysian Child

Apollonian Child, represented as little 'angels' and the Dionysian Child filled with original sin and represented as little 'devils' inform much of the economic and social growth pertaining to children since the late nineteenth century (Jenks, 2005). This growth is evidenced by the provision and regulation of childcare services, education and interventionist welfare services (Jenks, 2005). For modern day children,

‘good’ and ‘bad’ behaviour is assumed to be a natural part of being a child which requires shaping and tailoring by adults (Jenks, 2005).

During the 1980’s the historical constructions of children’s identities and their place in society influenced the socio-political position of the House of Lords’ with regard to child competence to participate in and consent to health treatment. The conflict between the identity of the romantic child (Apollonian) and the identity of the child as the inheritor of original sin (Dionysian) is evident in the House of Lords discussions on the positioning of children in society. Lord Fraser and Lord Scarman believed children’s abilities evolved and developed as they grew which is congruent with Rousseau’s notion of supporting and guiding a child to a state of maturity (adulthood) and protecting their innocence. However the majority of the Lords also discussed girls less than 16 years of age being irresponsible and immature which is congruent with a girl possessing qualities that are not acceptable in the adult realm and which need to be corrected before she can safely rear a child. Again, tacit rules that governed children’s position in society in the Early Modern Period, such as the requirement for discipline to align them with the will of God, and their protection as an innocent and vulnerable population requiring protection, remain present in the modern day.

Individualism and liberalism

The emergence of the autonomy discourse began with the challenging of the power relations previously established under religious monarchies (Powers, 2007). Individuals began to consider themselves as autonomous beings capable of making decisions independent of feudal or religious orders. This form of individualism and liberalism is correlated with the realisation that people have the opportunity to make choices for themselves. Liberalism may have been a condition of existence for the child competence discourse to emerge, and is still a tacit rule that continues to govern modern society. In order for adults to question whether or not children were competent they first needed to understand that it might be possible for children to act as independent individuals and make choices for themselves. Prior to the emergence of liberalism, adults may have not considered children’s independence from themselves an option, just as they had not considered themselves independent of

feudal or religious orders. There is however still some way to go with regard to child autonomy as children are still held within the familial and societal hierarchies for their 'protection' and may only enact their right to liberalism (and autonomy) when adults allow it (Lansdown, 2005). Hence the opportunity for children to prove their competence in the health environment and have autonomy over their own body's will only come about if health professional realise this opportunity for children. There is no research in New Zealand that indicates whether or not health professionals are currently aware of and/or putting into practice the possibility of children participating in and consenting to important health matters.

Life experience, a marginalised discourse?

It has been suggested that experience has more significant affect on the level of a child's competence than their age or ability (maturity, intelligence and understanding) (Alderson et al., 2006). Experience however has not been mentioned as a criteria in most of New Zealand's health legislation and policy that pertains to child competence, whereas age and ability have. Children have been proven to be competent at younger ages than was previously thought and measures of competence according to physical development have been shown to be inaccurate (Alderson, 1990; Alderson et al., 2006; Coyne & Gallagher, 2011; Bates et al., 2002). It is possible however that life experience is a subcategory of children's 'abilities'. Children gradually come to know and understand the world through their own activities in communication with others, and a continual process of learning generates development (Smith, 2013). The greater the richness of the activities and interactions in which children participate, the greater their understanding and knowledge will be (Smith, 2013). Hence it is possible that the greater a child's experience the greater their abilities and subsequently their competence. Yet in the questions posed by Lord Fraser (1985) and the Ministry of Health (1998) guiding health professionals on how to assess the competence of children, they simply note the case by case nature of the assessment rather than highlighting the importance of considering life experience.

Competence on a continuum

The binaries of competent/incompetent rather than competence on a continuum are factors in the child competence discourse. Power is supported by force relations or tensions (Powers, 2007); for example the notion of competence is sustained by the definition of incompetence, just as the definition of patriarchy was partially sustained by the definition of women as not-men in the 17th century. If competence were to be a binary and that it is achieved at the age of 16 years then it could be suggested that a person's competence is static throughout their 'adult' (>16 years of age) lifespan. Assuming a sound mind, the competent adult would not evolve in their maturity or intelligence. Life experience alone has a large impact on the maturity and intelligence of a person as it accumulates and informs their life. If maturity, intelligence and understanding are indeed the definition of the maturity approach to child competence then by default competence changes and evolves as a person grows and experiences life. Hence a binary framework for competence is less appropriate than a framework that considers competence on a continuum.

Individualism vs collectivism in New Zealand

A particular issue may be present in the New Zealand child competence discourse as it is applied to the New Zealand context. Chapter 5 of this thesis put forward the possible conditions required for the child competence discourse to emerge, some of which were individualism and liberalism. However, Māori and Pasifika culture are founded on collectivism rather than individualism. Again, conflicting discourses highlight the power exerted by different subject positions, and in this case that of differing cultures. If there is to be a review of the child competence discourse in New Zealand health policy then specific attention is required to the appropriateness of this dominant discourse for all New Zealand children. The call for children's independent and autonomous participation in health care decision making in combination with the collective nature of the Māori and Pasifika cultures will need to be reviewed in New Zealand, with specific attention to the affects of this version of participation on the lives of Māori and Pasifika children.

Limitations

As knowledge is legitimised and power is exerted to position the legal version of the child competence discourse as the dominant discourse, what can and cannot be said within this discourse is dictated by the legal system. Hence a document analysis of New Zealand legislation and health policy has limitations in its ability to identify silent or marginalised child competence discourses. As there is a limited amount of New Zealand literature written on behalf or from the perspective of health professionals, parents and children. Further collaboration and research with these groups are required to inform a deeper analysis of the child competence discourse.

Recommendations

The effect of the power exerted by the 'official' documents concerning child competence on the micro-practices of health professionals on a day to day basis when dealing with children is not known. Further research is required to identify which approach, if any, health professionals are currently utilising to assess child competence; the maturity approach versus the status based rule. If these assessments are being conducted then research is required to identify the process and extent of these assessments. It is important to establish a baseline of practice which health professionals are currently performing to understand the reasoning behind opinions and/or actions pertaining to child competence to participate in and consent to health treatment. In addition, identifying whether or not health professionals require clarification on what child competence is, how to assess it and its implications for them and their clients will add new information to this body of knowledge.

Research is required to develop a working definition of 'child competence' to participate in and consent to health advice and treatment in New Zealand. With ambiguity in the New Zealand health legislation and policy, and unknown levels of competence assessments being conducted by health professionals, having a working definition of this discourse will assist in the communication and regularity of its use. Language used in the House of Lords to describe a competent child, such as intelligent and mature predisposed this case. Each Lord attributed their own meaning to these words prior to utilising them in the Gillick case. As language is also a result of the social

and historical context in which it is used, the interpretation of the words could be different in today's health system. Hence, as per the Health and Disability Commission (2014) and the Medical Council of New Zealand (2011) the statement of having the 'maturity and intelligence to understand the nature, purpose and consequences of treatment and non-treatment' may be difficult for health professionals to understand. It is important that the meanings attributed to these words are clarified to avoid misinterpretation. This will assist in developing clearer explanations as to how health professionals assess a child's maturity, intelligence and understanding.

Health professionals are a dominant social group in child healthcare and their knowledge and skills largely inform how health services and its delivery are implemented (Manful & McCrystal, 2010). Focused training for health professionals and health policy makers on matters pertaining to child competence to participate in and consent to health treatment, may be an effective method for improving child health service delivery, and consequently improving child welfare (Manful & McCrystal, 2010). This suggestion aligns with the recommendations of the Committee on the Rights of the Child for systematic education and training on the UNCRC principles for all New Zealand health professionals working with children (UNCROC Monitoring Group, 2013).

The subject position and power of the House of Lords influenced the dominant version of the child competence discourse. The dominant discourse is further substantiated by women's position in society at the time of Gillick and the positioning of the medical professional as the expert. Children did not have the opportunity to participate in or contribute to the construction of the dominant version of this discourse. It is important to call on the more silent discourses, and in this case to call on children to have a say in who they are and what they can and cannot do/say. Further, and most relevant to this thesis, what children think they are capable of, how adults assess their capabilities and how adults promote their participation in important health matters that affect them are important considerations. Theories on childhood argue that children have a unique perspective or point of view, which in the past has often been ignored. This marginalisation of children comes about because they are considered to lack competence, rationality, independence and experience, and their

view points on the world are thought to be merely a reflection of what their parents or teachers think (Smith, 2013, p. 17). However children are able to be active citizens. The Committee on the Rights of the Child have suggested that child rights awareness campaigns, which are aimed specifically at children, could be introduced to better align New Zealand with its obligations to the UNCRC and to promote children as active citizens. Hence, children should contribute to the development and clarity of the child competence discourse.

Cave (2013) suggested that competence assessments or judgements conducted at the end of the informed consent process are biased due to the child's decision having a large impact. She propositioned that children are more likely to be deemed incompetent if they disagree with a recommended course of treatment (Cave, 2013). Hence, it may be beneficial for research to consider the effectiveness of competence assessments being conducted prior to a final decision or the use of an independent consultant to assess the competence of a child where there may be a dispute regarding the treatment plan.

Conclusion

Much of what has been learnt about child competence to participate in and consent to health treatment through research has not been used to inform New Zealand health legislation and policy, especially competence as a dynamic attribute that changes with different contexts. Competence versus incompetence as a binary maintains the status based approach (age as a measure of competence) which has clearly been proven to be an inaccurate measure of children's abilities. Inconsistencies in New Zealand health legislation and policy, health professionals speaking position versus children's relatively silent speaking position and the assumption of children's incompetence have contributed to competence assessments being a grey and ill-defined area for health professionals. A lack of information for health professionals on how and when to consider and assess child competence may have contributed to potential inconsistencies in practice and ultimately, the overlooking of possible health benefits children could gain from their participation in and consent to healthcare. There is a dearth of research pertaining to the use and regularity of competence assessments, the process or methods used to conduct these assessments and the reliability or effectiveness of the outcomes of these assessments.

The purpose of this thesis was to contribute to a better understanding of the child competence discourse and to highlight its innate complexities. Its goals were to better inform healthcare practice and policy with regard to child competence assessments, to highlight the meagre information currently available to health professionals and policy makers, and to indicate the requirement for children's participation in the further construction of this discourse. Ultimately, it may serve to improve children's participation in and consent to health treatment and its subsequent benefits may contribute to enhancing New Zealand children's welfare and health outcomes. Research, health professional training and changes to health policy and practice however are required to further realise this goal.

References

- Agger, B. (1991). Critical theory, poststructuralism, postmodernism: Their sociological relevance. *Annual Review of Sociology*, 17, 105-131.
- Alderson, P. (1990). Consent to children's surgery and intensive medical treatment. *Journal of Law and Society*, 52, 58.
- Alderson, P. (1992). In the genes or in the stars? Children's competence to consent. *Journal of Medical Ethics*, 18(3), 119-124. doi: 10.1136/jme.18.3.119
- Alderson, P. (2007). Competent children? Minors' consent to health care treatment and research. *Social Science and Medicine*, 65(11), 2272-2283. doi: 10.1016/j.socscimed.2007.08.005
- Alderson, P. (2013). *Childhoods, real and imagined*. NY, USA: Routledge.
- Alderson, P., & Goodwin, M. (1993). Contradictions within concepts of children's competence. *The International Journal of Children's Rights*, 1(3-4), 303-313. doi: 10.1163/157181893X00179
- Alderson, P., Sutcliffe, K., & Curtis, K. (2006). Children's competence to consent to medical treatment. *The Hastings Center Report*, 36(6), 25.
- Alderson, P., Sutcliffe, K., & Curtis, K. (2006). Children as partners with adults in their medical care. *Archives of Disease in Childhood*, 91(4), 300-303. doi: 10.1136/adc.2005.079442
- Appelbaum, P. S., & Grisso, T. (1988). Assessing patients capacities to consent to treatment. *New England Journal of Medicine*, 319, 1635-1668.
- Arce, M. C. (2012). Towards an emancipatory discourse of children's rights. *The International Journal of Children's Rights*, 20(3), 365-421. doi: 10.1163/157181812X637127
- Archard, D., & Skivenes, M. (2009). Balancing a child's best interests and a child's views. *The International Journal of Children's Rights*, 17(1), 1-1. doi: 10.1163/157181808X358276
- Aries, P. (1978). The family, sex and marriage in England, 1500-1800 (Vol. 83, pp. 1221-1224): The American Historical Association.

- Ariès, P. (1962). *Centuries of childhood: A social history of family life*. New York: Vintage Books.
- Atwool, N. (2006). Participation in decision-making: The experience of New Zealand children in care. *Child Care in Practice*, 12(3), 259-267. doi: 10.1080/13575270600761727
- Auckland District Health Board. (2010). Patients, clients, residents (Section 5) *Legal issues relating to children* (pp. 1-30). Auckland, New Zealand: Auckland District Health Board.
- Auckland University of Technology Ethics Committee. (2012). Exceptions to activities requiring AUTECH approval. Retrieved May 15, 2014, from <http://www.aut.ac.nz/researchethics/guidelines-and-procedures/exceptions-to-activities-requiring-autec-approval-6>
- Bainham, A. (1986). The balance of power in family decisions. *The Cambridge Law Journal*, 45(2), 262-284. doi: 10.1017/S0008197300120963
- Ballinger, C. (2012). *The House of Lords 1911-2011: A century of non-reform* (Vol. 1.). Oxford: Hart Publishing.
- Bartholomew, T. P., & Teoludzka, A. (2010). Queensland general practitioners' applications of the "mature minor" principle: The role of patient age and gender. *Journal of Law and Medicine*, 18(2), 390-401.
- Baxter, J. E. (2008). The archaeology of childhood. *Annual Review of Anthropology*, 37, 159.
- Beauchamp, T., & Childress, J. (1994). *Principles of biomedical ethics* (4th ed.). UK: Oxford University Press.
- Bell, D. (2014). What is liberalism? *Political Theory*, 42(6), 682-715. doi: 10.1177/0090591714535103
- Bellingham, B. (1988). The history of childhood since the "invention of childhood": Some issues in the eighties. *Journal of Family History*, 13(1), 347-358. doi: 10.1177/036319908801300121
- Bernard, J. (1963). "Centuries of childhood. A social history of family life", Philippe Aries (Book Review) (Vol. 25, pp. 503).

- Billick, S. B., Burgert III, W., Friberg, G., Downer, A. V., & Bruni-Solhkhah, S. M. (2001). A clinical study of competency to consent to treatment in pediatrics. *The Journal of the American Academy of Psychiatry and the Law*, 29, 298–302.
- Billick, S. B., Edwards, J. L., Burgert III, W., Serlen, J. R., & Bruni, S. M. (1998). A clinical study of competency in child psychiatric inpatients. *The Journal of the American Academy of Psychiatry and the Law*, 26, 587–594.
- Boy refused treatment: Mother. (2000). *Waikato Times*. Retrieved from <http://search.proquest.com.ezproxy.aut.ac.nz/docview/313659256/fulltext?accountid=8440>
- Brandon, S., Clarke, D., George, A., Jensen, J., Interns, T., & Paul, C. (2001). A survey of attitudes to parent-doctor conflicts over treatment for children. *The New Zealand medical journal*, 114(1145), 549.
- Brook, G. (2000). Children's competency to consent: A framework for practise. *Paediatric Nursing*, 12, 31-35.
- Burckhardt, J. (1860). *The civilisation of the Renaissance in Italy*. London, UK: Phaidon.
- Cahill, P., & Papageorgiou, A. (2007). Triadic communication in the primary care paediatric consultation: A review of the literature. *British Journal of General Practice*, 57(544), 904-911.
- Campbell, J. (2005). When patients refuse treatment. *New Zealand Doctor*, 14.
- Care of Children Act*. (2004). New Zealand.
- Carpenter, D. M., Stover, A., Slota, C., Ayala, G. X., Yeatts, K., Tudor, G., . . . Sleath, B. (2014). An evaluation of physicians' engagement of children with asthma in treatment-related discussions. *Journal of Child Health Care*, 18(3), 261-274. doi: 10.1177/1367493513489780
- Carter, B. (2014). Advancing health and well-being through children's rights. *Journal of Child Health Care*, 18(3), 205-206. doi: 10.1177/1367493514546587
- Carter, B., Stickley, T., Inglis, S., & Laxon, A. (2002). Science, religion and a dying baby. November 18, 2015, from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=2045181
- Cave, E. (2013). Goodbye Gillick? Identifying and resolving problems with the concept of child competence. *Legal Studies*, 34(1). doi: 10.1111/lest.12009

- Charlton, K. (1974). Children in english society II, from the eighteenth century to the Children Act 1948, a book review (Vol. 22, pp. 227-228).
- Children's Hospitals Australasia and Paediatric Society of New Zealand. (2010). Charter on the Rights of Tamariki Children & Rangatahi Young People in Healthcare Services in Aotearoa New Zealand. Retrieved November 15, 2014, from <http://www.paediatrics.org.nz/files/Charter%20on%20the%20rights%20of%20Children%20and%20Young%20People%20in%20NZ%20final%20version.pdf>
- Christensen, P. H. (1998). Difference and similarity: How children's competence is constituted in illness and its treatment. In I. Hutchby & J. Moran-Ellis (Eds.), *Children and social competence: Arenas of action* (pp. 187-201). UK: The Falmer Press.
- Citizen's Advice Bureau. (2015). Legal ages and ID. Retrieved November 2, 2015, from <http://www.cab.org.nz/vat/gl/roi/pages/legalagesandid.aspx>
- Cox, R. (1996). *Shaping childhood: Themes of uncertainty in the history of adult-child relations*. London, UK: Routledge.
- Coyne, I. (2006). Consultation with children in hospital: Children, parents' and nurses' perspectives. *Journal of Clinical Nursing*, 15(1), 61-71. doi: 10.1111/j.1365-2702.2005.01247.x
- Coyne, I., & Gallagher, P. (2011). Participation in communication and decision-making: children and young people's experiences in a hospital setting. *Journal of Clinical Nursing*, 20(15-16), 2334-2343. doi: 10.1111/j.1365-2702.2010.03582.x
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St Leonards, Australia: Allen & Unwin.
- Crowe, M. (1998). Discourse analysis: Towards an understanding of its place in nursing. *Journal of Advanced Nursing*, 51(1), 55-63.
- Curtis, K., Liabo, K., Roberts, H., & Barker, M. (2004). Consulted but not heard: A qualitative study of young people's views of their local health service. *Health Expectations*, 7(2), 149-156. doi: 10.1111/j.1369-7625.2004.00265.x
- Darbyshire, P. (2007). 'Childhood': Are reports of its death greatly exaggerated? *Journal of Child Health Care*, 11(2), 85-97. doi: 10.1177/1367493507076056
- Debski, S., Buckley, S., & Russell, M. (2008). Just who do we think children are? New Zealanders' attitudes about children, childhood and parenting: An analysis of

- submissions on the bill to repeal Section 59 of the Crimes Act 1961. *Social Policy Journal of New Zealand*(34), 100-112.
- DeMause, L. (1976). The evolution of childhood. In N. Frost (Ed.), *Child welfare: Major themes in health and social welfare*. Oxon, UK: Routledge.
- Demos, J. (1970). *A little commonwealth: Family life in Plymouth Colony*. NY, USA: Oxford University Press.
- Dickinson, A., Wrapson, W., & Water, T. (2014). Children's voices in public hospital healthcare delivery: intention as opposed to practice. *The New Zealand medical journal*, 127(1405), 24.
- Downing, L. (2008). *The Cambridge introduction to Michel Foucault*. Cambridge, UK: Cambridge University Press.
- Doyle, C., Lennox, L., & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *British Medical Journal open*, 3(1), 1570. doi: 10.1136/bmjopen-2012-001570
- Drake, C. (2001). Review: Informed consent? A child's right to autonomy. *Journal of Child Health Care*, 5(3). doi: 10.1177/136749350100500302
- Duschinsky, R. (2013). Augustine, Rousseau, and the idea of childhood. *The Heythrop Journal*, 54(1), 77-88. doi: 10.1111/j.1468-2265.2009.00562.x
- Elliott, A. (2006). Postmodernism. In B. Turner (Ed.), *Cambridge Dictionary of Sociology*. Cambridge, United Kingdom: Cambridge University Press.
- Ferguson, L. (2013). Not merely rights for children but children's rights: The theory gap and the assumption of the importance of children's rights. *International Journal of Children's Rights*, 21(2), 177-208. doi: 10.1163/15718182-55680015
- Fiks, A. G., & Noonan, K. G. (2013). Shared decision making in pediatrics. *Health Affairs*, 32(4), 822.
- Fillingham, L. A. (1993). *Foucault for beginners*. NY, USA: Writers and Readers.
- Foucault, M. (1963). *The birth of the clinic: The archaeology of medical perception*. NY, USA: Routledge Classics London and New York
- Foucault, M. (1972). *The archaeology of knowledge*. NY, USA: Pantheon Books.
- Foucault, M. (1977). *Discipline and punish: The birth of the prison*. London, United Kingdom: Allen Lane.
- Foucault, M. (1980a). *Power and knowledge*. Sussex: United Kingdom: Harvester Press.

- Foucault, M. (1980b). *Power/Knowledge: Selected interviews and other writings, 1972-1977*. London, United Kingdom: Harvester Press.
- Foucault, M. (1983). Afterword: The subject and power. In H. L. Dreyfus & P. Rabinow (Eds.), *Michel Foucault, beyond structuralism and hermeneutics*. IL: USA: Chicago University Press.
- Foucault, M. (1991). Governmentality. In G. Burchell, Gordon, C., Miller, P. (Ed.), *The Foucault Effect: Studies in Governmentality*. London, UK: Harvester Wheatsheaf.
- Foucault, M. (2004). *Sécurité, territoire, population, Cours au Collège de France, 1977-1978*. G. Burchell (trans.). Basingstoke: UK.
- Frijhoff, W. (2012). Historian's discovery of childhood. *Paedagogica Historica*, 48(1), 11. doi: 10.1080/00309230.2011.644568
- Gallagher, M. (2006). Foucault, power and participation. *International Journal of Children's Rights*, 16, 395-406.
- Gane, M. (2008). Foucault on governmentality and liberalism. *Theory, Culture & Society*, 25(7-8), 353.
- Gerison, L. (1994a). Seen but not heard, *The Guardian (1959-2003)*, p. A12. Retrieved from http://aut.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMw1V1LS8NAEB5EQQQPDWp8k5MXSWyzSbM9eKjiA7SnViheyMYfINS0xs3_d3bTJmm1P8DJEthMZoZ5fJkHgIc5jyCKpzTIURqTWLU5jUUio4pRQW2rWAPPrXYOrhWRbpDyzX8R89AUWaWFvs5m2kR9-crizaYS2JFMBo4zhWINAObJlmsIX9FpCczJaxygHOHL_LJV10quuswYR6s25k8P-6NPaoE4JQ2z1V-UMq9OnsZUKaZmg2Z4ZeaQf4oPrm9I5r8N0eV1MDRE85GM7yrHtwZpJb_cm_XZoxa0DI1zNpe51y8Z58CWzA7AMUzzkGkeMs2zTDuEy8eH0f2zv7xqlqbTSU0aOYJ9ZpoBMm2bBoULOWpFKI3jTV18pwu7494LHbyHg_LoLI_Bt-1sC760i99gNcKpg-gYvLagPOSKxN2IR92ox3hElMJckmEKyEJ2Au4Gek43PjmDvVpu57Ct80JeYExU6B-bQfeD
- Gerison, L. (1994b). Seen but not heard: A government report to the UN on children's rights fails to mention many disturbing facts, *The Guardian (pre-1997 Fulltext)*, p. NOPGCIT. Retrieved from

http://aut.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMwnV1NS8NAEB3UggiCLdb4UWFunhLznc1JqlgEqRcVipeSZJMipEnbbP6_s5umiNGLxw057GYn7-3MzpsBQPJ5uJMIMYsTN_YcLzMT5vEgtbKlcaakYt_iudCWgNhubYuICqZ5mcgl-S2Rkuvb5HPfrda6bBklr1a3_TP2oWcRjUkjD2b3Oxj-EWAJOmCrGGRyAm0yaDdzpFOY8b9T7ENfYtYqWqUbHDcmMYC9tDiF_JX8VYxrgUUpUHax5jjGxa7RLjZ3ByhKpBMhvr9gWWAr9L6pUPnwFWbRZ17Jl5ZNliQuCUuQk6nUG3KxFyh1EtUQRpPHt4cnvV3BnOf53A9dj8kSDmdwHMM8-klo_R3XoJfRT5Bqkpg0-mAaHM7CZzb9sKfNcNAOjUqJxly10GgD1KJ1z3DPAW03IVNgse8ksracH4XElqYThJZLOGvyCxj-OpvLP55fwVFTz9jRbWcEB2JTp9d0tKjFF0Jyu6w

Gillick vs West Norfolk Area Health Authority (House of Lords 1985).

Gittins, D. (2009). The historical construction of childhood: *An introduction to childhood studies by M Kehily*. NY, USA: Open University Press.

Graham, L. J. (2005). *Discourse analysis and the critical use of Foucault*. Paper presented at the Australian Association for Research in Education, Sydney, Australia.

Grant, B. M., & Giddings, L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary nurse*, 13(1), 10-28.

Gray, A. (2002). Increasing the participation of children, young people and young adults in decision making: A literature review. New Zealand: Ministry of Social Development and Ministry of Youth Affairs.

Griffith, R. (2013). Nurses must be more confident in assessing Gillick competence. *British Journal of Nursing*, 22(12), 710-711.

Grimwood, T. (2009). Gillick and the consent of minors: Contraceptive advice and treatment in New Zealand. *Victoria University of Wellington Law Review*, 40, 743.

Grisso, T., Appelbaum, P. S., & Hill-Fotouhi, C. (1997). The MacCAT-T: A clinical tool to assess patients' capacities to make treatment decisions. *Psychiatric Services*, 48, 1415-1419.

Hagger, L. (2009). The law and children's autonomy *The child as vulnerable patient: Protection and empowerment* (pp. 13-54). UK: Ashgate Publishing Limited.

- Health and Disability Commission. (1996). The HDC Code of Health and Disability Services Consumers' Rights Regulation. Retrieved December 8, 2014, from <http://www.hdc.org.nz/the-act--code/the-code-of-rights>
- Health and Disability Commission. (2014). *Fact Sheet 3: The age of consent and informed consent for children*. Retrieved from www.hdc.org.nz.
- Hein, I. M., Troost, P. W., Broersma, A., de Vries, M. C., Daams, J. G., & Lindauer, R. J. L. (2015). Why is it hard to make progress in assessing children's decision-making competence? *BMC Medical Ethics*, 16(1), 1-6. doi: 10.1186/1472-6939-16-1
- Hein, I. M., Troost, P. W., Lindeboom, R., Christiaans, I., Grisso, T., van Goudoever, J. B., & Lindauer, R. J. L. (2015). Feasibility of an assessment tool for children's competence to consent to predictive genetic testing: A pilot study. *Journal of Genetic Counseling*, 1-7. doi: 10.1007/s10897-015-9835-7
- Henaghan, M. (2012). What happens when trust breaks down? *Health professionals and trust: The cure for healthcare law and policy* London, UK: Falmer Press.
- Hendrick, H. (1997). The constructing and reconstructing of British childhood: An interpretative survey 1800 to the present. In A. James & A. Prout (Eds.), *Constructing and reconstructing childhood: Contemporary issues in the sociological study of childhood*. UK: The Falmer Press.
- Hewitt, M., & Pinchbeck, I. (1969). *Children in English society. Vol. 1: From Tudor times to the eighteenth century*. London, UK: Routledge & Kegan Paul.
- Human Rights Commission. (2015a). New Zealand's fifth periodic report under the United Nations Convention on the Rights of the Child: A summary. Retrieved January 15, 2015, from <http://www.hrc.co.nz/2014/12/19/uncroc-public-consultation-have-your-say/>
- Human Rights Commission. (2015b). The rights of children and young people Nga tika o nga tamariki, rangatahi. Retrieved January 20, 2015, from <http://www.hrc.co.nz/report/chapters/chapter04/children01.html#tro>
- Humphries, J. (2013). Childhood and child labour in the British industrial revolution. *The Economic History Review*, 66(2), 395-418. doi: 10.1111/j.1468-0289.2012.00651.x

- Illick, J. E. (1974). Child-rearing in seventeenth-century England and America. In L. deMause (Ed.), *The history of childhood*. MD, USA: Rowman & Littlefield Publishers.
- Janofsky, J. S., McCarthy, R. J., & Folstein, M. F. (1992). The Hopkins Competency Assessment Test: A brief method for evaluating patients' capacity to give informed consent. *Hospital and Community Psychiatry*, 43, 132–136.
- Jenks, C. (Ed.). (2005). *Childhood: Critical concepts in sociology* (Vol. 1). London, United Kingdom: Routledge.
- Kertzer, D. I. (1987). Childhood and industrialisation in Italy. *Anthropological Quarterly*, 60(4), 152-159.
- Kroll, J. (1977). The concept of childhood in the middle ages. *Journal of the History of the Behavioral Sciences*, 13(4), 384-393. doi: 10.1002/1520-6696(197710)13:4<384::AID-JHBS2300130411>3.0.CO;2-Y
- Lake, L. (2014). Children's rights education: An imperative for health professionals. *Curationis*, 37(2), 1-7.
- Lansdown, G. (2005). The evolving capacities of the child: UNICEF Innocenti Research Centre.
- Lansdown, G. (2011). Every child's right to be heard. London, UK: UNICEF, Save the Children.
- Lansdown, G., & Karkara, R. (2006). Children's right to express views and have them taken seriously. *The Lancet*, 367(9511), 690-692. doi: 10.1016/S0140-6736(06)68268-8
- Lewis, C. E., Lewis, M. A., Lorimer, A., & Palmer, B. (1977). Child initiates care: The use of school nursing services by children in an adult free system. *Pediatrics*, 60, 499.
- Liebel, M. (2004). *Will of their own: Cross-cultural perspectives on working children*. Berlin, Germany: Zed Books.
- Lipstein, E. A., Brinkman, W. B., & Britto, M. T. (2012). What is Known about parents' treatment decisions? A narrative review of pediatric decision making. *Medical Decision Making*, 32(2), 246-258. doi: 10.1177/0272989X11421528

- Lord Brandon. (1985). *Gillick v West Norfolk & Wisbech Area Health Authority*. Retrieved December 15, 2014, from <http://www.bailii.org/uk/cases/UKHL/1985/7.html>
- Lord Bridge. (1985). *Gillick v West Norfolk & Wisbech Area Health Authority*. Retrieved December 15, 2014, from <http://www.bailii.org/uk/cases/UKHL/1985/7.html>
- Lord Fraser. (1985). *Gillick v West Norfolk & Wisbech Area Health Authority*. Retrieved December 15, 2014, from <http://www.bailii.org/uk/cases/UKHL/1985/7.html>
- Lord Scarman. (1985). *Gillick v West Norfolk & Wisbech Area Health Authority*. Retrieved December 15, 2014, from <http://www.bailii.org/uk/cases/UKHL/1985/7.html>
- Lord Templeman. (1985). *Gillick v West Norfolk & Wisbech Area Health Authority*. Retrieved December 15, 2014, from <http://www.bailii.org/uk/cases/UKHL/1985/7.html>
- Lowden, J. (2002). Children's rights: A decade of dispute. *Journal of Advanced Nursing*, 37(1), 100-107. doi: 10.1046/j.1365-2648.2002.02049.x
- Ludbrook, R. (2000). Victims of tokenism and hypocrisy: New Zealand's failure to implement the United Nations Convention on the Rights of the Child. In A. B. Smith, M. Gollop, K. Marshall & K. Nairn (Eds.), *Advocating for children: International perspectives on children's rights* (pp. 109-125). Dunedin, New Zealand: University of Otago Press.
- Manful, E., & McCrystal, P. (2010). Conceptualisation of children's rights: What do child care professionals in Northern Ireland say? *Child Care in Practice*, 16(1), 83-97.
- Marshall, G. (1998). Affective individualism: A dictionary of sociology. Retrieved from <http://www.encyclopedia.com/doc/1O88-affectiveindividualism.html>.
- Martenson, E. K., & Fagerskiold, A. M. (2007). A review of children's decision-making competence in health care. *Journal of Clinical Nursing*, 17, 3131-3141. doi: 10.1111/j.1365-2702.2006.01920.x
- May, H. (1997). *The discovery of early childhood*. Auckland, New Zealand: Bridget Williams Books Ltd.
- McAliley, L. G., Hudson-Barr, D. C., Gunning, R. S., & Rowbottom, L. A. (2000). The use of advance directives with adolescents. *Pediatric Nursing*, 26, 471-482.

- McHoul, A., & Grace, W. (1993). *A Foucault Primer: Discourse, power and the subject*. New York: New York University Press.
- McLean, K. (2000). Children and competence to consent: Gillick guiding medical treatment in New Zealand. *Victoria University of Wellington Law Review*, 31(3), 551.
- McMurdo, M., & Gillett, G. (2013). Consent, competence and lies to children: Veracity in paediatric care. *Journal of Law and Medicine*, 21(2), 265-271.
- McPherson, G., & Thorne, S. (2000). Children's voices: Can we hear them? *Journal of Pediatric Nursing*, 15(1), 22-29. doi: 10.1016/S0882-5963(00)80020-2
- Medical Council of New Zealand. (2011). Information, choice of treatment and informed consent.
- Miller, F. (2011). Wake up COCA! Give children the right to consent to medical treatment. *New Zealand Family Law Journal*, 7(4), 1-9.
- Mills, S. (2003). *Michel Foucault*. London, United Kingdom: Routledge.
- Ministry for Culture and Heritage. (2013). Minnie Dean. Retrieved 10 August, 2015, from <http://www.nzhistory.net.nz/culture/baby-farmers/minnie-dean>
- Ministry of Health. (1998). Consent in child and youth health: Information for practitioners. Retrieved December 15, 2014, from www.moh.govt.nz
- Ministry of Social Development. (2015). *Summary of public consultation on New Zealand's Draft Fifth Periodic Report under the United Nations Convention on the Rights of the Child*. New Zealand: Ministry of Social Development.
- Mintz, S. (2012). Why the history of childhood matters. *Journal of the History of Childhood and Youth*, 5(1), 17.
- New Zealand Bill of Rights Act*. (1990). New Zealand.
- O'Leary, Z. (2007). *The social science jargon buster: A no-nonsense dictionary of key terms*. London, United Kingdom: Sage.
- October, T. W., Fisher, K. R., Feudtner, C., & Hinds, P. S. (2014). The parent perspective: "Being a good parent" when making critical decisions in the PICU. *Pediatric critical care medicine: A journal of the Society of Critical Care Medicine and the World Federation of Pediatric Intensive and Critical Care Societies*, 15(4), 291-298. doi: 10.1097/PCC.0000000000000076

- Office of the Minister for Social Development. (2014). *United Nations Convention on the Rights of the Child work programme*. New Zealand: Ministry of Social Development.
- Olson, K. C. (1999). *Legal information: How to find it, how to use it*. USA: Greenwood Publishing Group.
- Orr, F. E. (1999). The role of the paediatric nurse in promoting paediatric right to consent. *Journal of Clinical Nursing*, 8(3), 291-298. doi: 10.1046/j.1365-2702.1999.00223.x
- Paltridge, B. (2012). *Discourse analysis: An introduction* (2nd ed.). London, United Kingdom: Bloomsbury Academic.
- Parker, I. (1992). *Discourse dynamics: Critical analysis of social and individual psychology*. NY: USA: Routledge.
- Parkinson, P. (1992). Children's rights and doctors' immunities: The implications of the High Court's decision in Re Marion. *Australian Journal of Family Law*, 101-125.
- Payne, D. (2010). Foucauldian discourse analysis. In L. S. Giddings & L. Smythe (Eds.), *Qualitative research: A guide for novice researchers*. Auckland, New Zealand: Auckland University of Technology.
- Penticuff, J. H. (1990). Ethics in pediatric nursing: Advocacy and the child's "determining self". *Issues in Comprehensive Pediatric Nursing*, 13(3), 221-229. doi: 10.3109/01460869009009037
- Pollack, M. E., & Billick, S. B. (1999). Competency to consent to treatment. *Psychiatric Quarterly*, 70(4), 303-311. doi: 10.1023/A:1022038215986
- Pollard, A. F. (1964). *The evolution of parliament* (2nd ed.). NY, USA: Russell & Russell.
- Pollock, L. A. (1986). *Forgotten children: Parent-child relations from 1500 to 1900*. United Kingdom: Cambridge University Press.
- Pool, I. (2010). Review article: British immigration 1800-1945 and New Zealand social morphology (Vol. 25, pp. 150). Hamilton: Sociological Association of Aotearoa New Zealand.
- Postman, N. (1994). *The disappearance of childhood*. NY, USA: Vintage Books.
- Powers, P. (1996). Discourse analysis as a methodology for nursing inquiry. *Nursing Inquiry*, 3(4), 207-217.

- Powers, P. (2007). The philosophical foundations of Foucaultian discourse analysis. *Critical Approaches to Discourse Analysis across Disciplines*, 1(2), 18-34.
- Purvis, M. (2011). House of Lords reform: Chronology 1900-2010. United Kingdom: House of Lords Library.
- Radbill, S. X. (1974). A history of child abuse and infanticide. In R. E. Helfer & C. H. Kempe (Eds.), *The battered child* (2nd ed.). Chicago, USA: University of Chicago Press.
- Re C (Adult: Refusal of Treatment), 1 290-296 (Family Division 1994).
- Re J (An Infant). (1996). Re J (An Infant): B and B v Director-General of Social Welfare. *New Zealand Law Reports*, 2(134), 146.
- Sandin, B. (1995). *"The Century of the Child" On the changed meaning of childhood in the twentieth century*. Sweden: Linköping University.
- Santos Pais, M., & Bissell, S. (2006). Overview and implementation of the UN Convention on the Rights of the Child. *The Lancet*, 367(9511), 689-690. doi: 10.1016/S0140-6736(06)68267-6
- Shorter, E. (1976). *The making of the modern family*. London, England: Collins.
- Skegg, P. D. G. (2006). Capacity to consent to treatment. In P. D. G. Skegg & R. Paterson (Eds.), *Medical Law in New Zealand* (pp. 191-195). Wellington, New Zealand: Brookers Ltd.
- Skegg, P. D. G. (2015). Capacity to consent to treatment. In P. D. G. Skegg & R. Paterson (Eds.), *Health law in New Zealand*. Wellington, New Zealand: Thomson Reuters.
- Smalley, L. P., Kenney, M. K., Denboba, D., & Strickland, B. (2014). Family perceptions of shared decision-making with health care providers: Results of the national survey of children with special health care needs, 2009–2010. *Maternal and Child Health Journal*, 18(6), 1316-1327. doi: 10.1007/s10995-013-1365-z
- Smith, A. B. (2013). *Understanding children and childhood: A New Zealand perspective* (5th ed.). Wellington, New Zealand: Bridget Williams Books Ltd.
- Stearns, P. N. (2011). *Childhood in world history*. London, UK: Routledge.
- Stone, L. (1977). *Family, sex and marriage in England, 1500-1800*. NY, USA: Harper and Row.
- Strauss, S., & Feiz, P. (2013). *Discourse analysis: A multi-perspective and multi lingual approach*. NY, USA: Routledge.

- Sutherland, D. (2000). Peeresses, parliament and prejudice: The admission of women to the House of Lords, 1918-1963. *Parliaments, Estates and Representation*, 20(1), 215-231. doi: 10.1080/02606755.2000.9522108
- Tates, K., Meeuwesen, L., Bensing, J., & Elbers, E. (2002). Joking or decision-making? Affective and instrumental behaviour in doctor-parent-child communication. *Psychology & Health*, 17(3), 281-295. doi: 10.1080/08870440290029548
- Thomson, L. (2001). Whose right to choose? A competent child's right to consent to and refuse medical treatment in New Zealand. *Canterbury law Review*, 8(1), 145-186.
- Titlestad, P. (2010). Liberalism. *English Academy Review*, 27(2), 94-100. doi: 10.1080/10131752.2010.514989
- Todres, J. (2014). Independent children and the legal construction of childhood. *Southern California Interdisciplinary Law Journal*, 23(2), 261.
- Twum-Danso Imoh, A. (2012). The Convention on the Rights of the Child: A product and facilitator of a global childhood. In A. Twum-Danso Imoh & R. K. Ame (Eds.), *Childhoods at the intersection of the local and the global* (pp. 17-33). N.Y., USA: Palgrave Macmillan.
- UNCROC Monitoring Group. (2012). Monitoring the implementation of the United Nations Convention of the Rights of the Child in New Zealand. Retrieved from www.occ.org.nz
- UNCROC Monitoring Group. (2013). Monitoring the implementation of the United Nations Convention of the Rights of the Child in New Zealand: UNCROC Monitoring Group final submission. Retrieved from www.occ.org.nz
- UNICEF New Zealand. (2011). United Nations Convention on the Rights of the Child: Education and training for professionals working with and for children. Retrieved from www.unicef.org.nz
- UNICEF New Zealand. (2013). Kids missing out. Retrieved from www.unicef.org.nz
- United Nations General Assembly. (1989). *Convention on the Rights of the Child*. Retrieved from <http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf>.

- van Nederveen Meerkerk, E., & Schmidt, A. (2008). Between wage labor and vocation: Child labor in Dutch urban industry, 1600-1800. *Journal of Social History*, 41(3), 717-736. doi: 10.1353/jsh.2008.0041
- van Rooyen, A., Water, T., Rasmussen, S., & Diesfeld, K. (2015). What makes a child a 'competent' child? *The New Zealand medical journal*, 128(1426), 88-95.
- van Staa, A. L., Sattoe, J. N. T., & Strating, M. M. H. (2015). Experiences with and outcomes of two interventions to maximize engagement of chronically ill adolescents during hospital consultations: A mixed methods study. *Journal of Pediatric Nursing*, 30(5), 757-775. doi: 10.1016/j.pedn.2015.05.028
- Weedon, C. (1997). *Feminist practice and poststructuralist theory*. Oxford, United Kingdom: Blackwell Publishers.
- Weithorn, L., & Campbell, S. (1982). The competency of children and adolescents to make informed treatment decisions. *Child development*, 53, 1589.
- Wilson, S. R., Strub, P., Buist, A. S., Knowles, S. B., Lavori, P. W., Lapidus, J., & Vollmer, W. M. (2010). Shared treatment decision making improves adherence and outcomes in poorly controlled asthma. *American Journal of Respiratory and Critical Care Medicine*, 181, 566-577. doi: 10.1164/rccm.200906-0907OC
- Woods, M. (2007). *A discursive analysis of parental resistance towards medical treatment for a seriously ill child*. (Doctor of Philosophy), Massey University, Palmerston North, New Zealand.
- Wyse, D., & Hawton, A. (Eds.). (2000). *Children: A multi-professional perspective*. UK: Arnold.