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Question&Answer

MEDICAL LAW

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Question&Answer

MEDICAL LAW

treatment of under 16s. This is a different legal framework to that which applies to an adult (18 and over) or young person aged 16 or 17.[2]

For an under 16 there is no statutory provision which provides for the child to give consent.[3] However, in the case of ***Gillick*** it was held that a child could consent where they were competent; this is known as '***Gillick*** competence'. Legal authority for treatment may also come from the consent of the parent, where they have parental responsibility (PR) for the child, from the court or in emergency circumstances from the common law doctrine of necessity. It is possible for there to be 'concurrent' consent providers.[4]

We need to consider if Sasha is ***Gillick*** competent and the implications if not. We need to identify who may have PR and whether they can provide the necessary authority. We need to consider a possible application to the High Court and the position should Sasha's treatment become urgent.

2. *Gillick* competence

Even though Sasha is refusing treatment at present, the question of whether she is ***Gillick*** competent still needs to be considered. The notion of ***Gillick*** competence is primarily derived from the judgments of Lord Frazer and Lord Scarman in the House of Lords' decision.[5] The concept is a developmental one, whether Sasha is sufficiently mature of understanding to be able to understand the purpose and effect of the proposed treatment and consequences of not having it. Increasingly the components of the MCA may be considered[6] to assess whether the child is able to understand, retain and use or weigh up the relevant information. There is no presumption of competence and the courts seem to set the bar high, particularly where the treatment may be life sustaining (see ***Re E (A Minor) (Wardship: Medical Treatment)*** [1993] 1 FLR 386).[7]

The court has held that ***Gillick*** competence is a developmental concept, not one gained then lost as mental health fluctuates (see ***Re R (A Minor)*** [1992] Fam 11). This makes it more difficult to apply where there is the potential for mental health issues to complicate the assessment.[8]

Although Sasha is 15, an age at which a child may be expected to be ***Gillick*** competent to consent to having a wound treated, she has a

[2] It is helpful to show the examiner that you know a different legal framework applies for adults and 16–18-year-olds, but it is enough to mention this in passing. You don't need to go into details, unless this is relevant to the actual question, for example if you are asked to consider how the position would change if Sasha was 16 or 18.

[3] For 16–17-year-olds the Family Law Reform Act does convey such provisions. Again, it is sufficient to mention this in passing.

[4] Remember, the Mental Capacity Act 2005 (MCA) does not apply to treatment of an under 16. You need to stay focused on the relevant legal regime that does apply.

[5] The *Gillick* case is a key case. Although detailed references may not be practicable in exam conditions, you need to be familiar with it and the key judgments.

[6] See, e.g. the suggested approach to capacity assessment of a child in the Code of Practice to the MHA, which you could incorporate into your answer.

[7] There are a number of cases you could include references to here if time allows – see *Re R* (also referred to above) and *Re L* [1998] 2 FLR 810.

[8] Make it clear in your answer that you are not assuming that Sasha lacks competence solely because she has self-harmed.

history of self-harming behaviour and is very distressed. It may well be that she would not be found to be ***Gillick*** competent of making the treatment decision.

3. Refusal of *Gillick* competent child

In any event, it appears that Sasha is not prepared to consent. Her competence may still be relevant, however, to the question as to whether her refusal could be overridden by someone with parental responsibility. In the case of ***Re R*** (referred to above) and ***Re W (A Minor)*** [1993] Fam 64), it was held that even where a child could give a valid consent to their treatment, this did not mean their decision to refuse was decisive. Instead such refusal may be overridden by the consent of someone with parental responsibility. It is suggested (see, for example, guidance in chapter 36 of the MHA Code of Practice) that it would be unwise to rely on such consent where the child were ***Gillick*** competent and refusing. The position has not been tested post-Human Rights Act 1998.[9]

[9] The lack of recent case law and commentary makes this a difficult legal area to provide clear authorities at times. It is helpful to acknowledge this in your answer.

4. Parental responsibility consent

In relation to a child there may be more than one 'consent giver'. A person with parental responsibility may provide a consent to treatment in the best interests of the child (Children Act 1989).[10] Here Debbie will have PR but it seems unlikely Mike will, so he cannot provide consent. If Debbie can be contacted she may consent to the treatment and in theory this could be provided. However, she may not be prepared to consent to Sasha having any blood products.

[10] Remember, this right is only one to act in the child's best interests. Only one consent is required. Make this clear in your answer.

5. Role of the court

The High Court has an inherent jurisdiction[11] that it may exercise in relation to a child to make decisions about whether a child should be treated, in particular where the child and/or parents disagree with healthcare professionals as to whether treatment should be given.[12] On a number of occasions the courts have been asked to determine whether a child should have blood products following the child and parents' refusal for religious reasons (see ***Re E*** and ***Re L (Medical Treatment: Gillick Competency)*** [1998] 2 FLR 810). The court tends to approach the decision on the basis that a child 'should not be allowed to martyr himself' (***Re E***) and to order the treatment be given.

[11] There are many examples and you will need to be familiar with the key cases, such as *Glass* v *UK,* so you can select relevant ones to support/illustrate your answer.

[12] You may wish to refer to the fact that applications may also be made under the Children Act 1989 to decide specific issues. However, don't try to include too much detail on the procedural elements.

6. Emergency

In an emergency, treatment could be given without consent under the common law doctrine of necessity (see ***Gillick***). There would have to be a genuine emergency. Where the treatment is contrary to the wishes of the child and those with parental responsibility an application to court should be made where there is time to do so (see ***Glass* v *UK*** (App. No. 61827/00)).

7. Summary of advice to Dr Smith

If Dr Smith cannot persuade Sasha to consent, and assesses her as being ***Gillick*** competent, then he will need to assess the urgency of the situation and need for treatment. He should consider whether there are any alternative treatments that Sasha may agree to. If, as seems likely, Sasha is not ***Gillick*** competent, then if Dr Smith can obtain Debbie's consent, he could proceed on that basis. If he cannot obtain a valid consent from Sasha and or Debbie, then if the situation is genuinely urgent Dr Smith could treat on the basis of the common law doctrine of necessity, and should do so if Sasha's life is at risk. Otherwise the safest legal option may be to make an application to the High Court for an order that it is lawful to treat. The court will balance the various considerations but is almost certainly going to conclude that a child should be given life-sustaining treatment even where parent and child objects.

✓ Make your answer stand out

- Demonstrate throughout a clear focus on the applicable legal framework and actual question.
- Introduce key case references and quotations to support your arguments.
- Demonstrate clear understanding of how the legal components fit together and their practical application.
- Show you have an appreciation of the potential for challenge in this area from a human rights context.

! Don't be tempted to . . .

- Simply recite the overall legal framework for consent, including adults and 16–17-year-olds. Although some compare and contrast may be appropriate.
- Start your answer without a clear answer plan. This is a tricky legal area with overlapping and sometimes conflicting provisions. Failure to plan a sound structure from the start will lead to a confused rambling answer.
- Waste too much time (or word limit, if applicable) on the facts of the cases. Your answer will just read like a case summary.
- Get too 'bogged down' in the procedural aspects of the possible court applications.

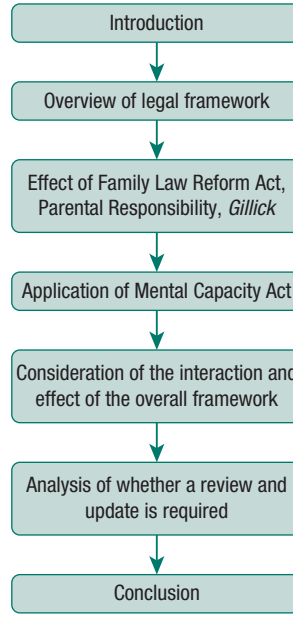
Question 5

The introduction of the Mental Capacity Act 2005 and its application to 16- and 17-year-olds, highlights the need for a review and update of the legal framework which governs the medical treatment of young people aged 16 or 17. Discuss.

Answer plan

- Introduce the relevant legal framework that applies to the treatment of 16–17-year-olds.
- Consider the effect of the Family Law Reform Act, Parental Responsibility and *Gillick*.
- Detail the application of the Mental Capacity Act 2005 (MCA).
- Consider how this 'sits alongside' the surrounding legal framework.
- Analyse to what extent this highlights the need for a review and update.
- Conclude your answer.

Diagram plan



A printable version of this diagram plan is available from **www.pearsoned.co.uk/lawexpressqa**

Answer

It is suggested that the introduction of the Mental Capacity Act 2005 (the MCA) highlights the need for review and update of the legal framework relating to the medical treatment of young people aged 16 and 17 (referred to as young people). In order to determine to what extent this may be the case, we need to consider the overall legal framework, including the effect of the MCA, and analyse to what extent this has indeed highlighted such a need.[1]

[1] Remember to introduce your answer to the actual question.

1. Legal framework

As with a person of any age, any medical treatment needs to be 'legally authorised'. The overall legal framework is complex, with arguably overlapping and at times apparently inconsistent provisions. The framework is made up of the Family Law Reform Act 1969 (the FLR), Parental Responsibility (PR)[2] and more recently the MCA. The High Court has an inherent jurisdiction to authorise treatment. Where the

[2] You may wish to include more detail as to PR and relevant provisions of the Children Act 1989, but take care to stay focused on the treatment aspects.

young person requires treatment for mental disorder then the Mental Health Act 1983 may apply, although detailed consideration of this is outside the scope of this essay.[3]

Unlike an under 16,[4] a young person is statutorily able to provide consent for treatment by the FLR, which provides that the consent of a young person is as valid as if they were an adult. This is an age-based concept.[5]

The full effect of the FLR has been subject to considerable debate and was considered in the case of ***Gillick* v *West Norfolk and Wisbech AHA*** [1985] J All ER 402 and subsequently ***Re R (A Minor)*** [1992] Fam 11) and ***Re W*** [1993] Fam 64. The main issue raised is the question whether its effect is to confer exclusive authority to determine whether to have treatment[6] on the young person. It was ultimately held in the ***Re R*** and ***Re W*** cases that it did not, but that it simply permits the young person to provide their legal authority for the treatment. It does not impact on the authority of the person with PR, who has a 'concurrent' right to authorise the treatment. The validity of such a conclusion that a capable young person may consent but not refuse treatment has been much debated and criticised. In *Mason & McCall Smith's Law and Medical Ethics* it is suggested that the level of understanding required to refuse a treatment is not necessarily on a par with that required to consent to treatment (Mason, J.K. and Laurie, G.T. (2006) *Mason & McCall Smith's Law and Medical Ethics* 7th edn. Oxford: Oxford University Press, para. 10.52). However, many other commentators share John Harris's view that 'the idea that the child . . . might competently consent to a treatment but not be competent to refuse it is a palpable nonsense . . . ' (Harris, J. (2003) Consent and end of life decisions. *Journal of Medical Ethics*, 29: 10–15).

In certain circumstances the application of the FLR may be limited[7] in which case the case of ***Gillick*** may have an application to the young person, requiring an assessment of whether they are ***Gillick*** competent to consent to the proposed 'treatment'. Although the application and relevance of ***Gillick*** to a young person will not be considered in any detail here, the possibility of the decision falling outside the FLR adds a further complication.

The authority of the person with PR to consent to treatment on behalf of a young person is not removed by the FLR, but relying on PR consent where the young person is capable is controversial. Even where the young person lacks capacity relying on PR consent may no longer be necessary or justifiable since the introduction of the MCA.[8]

[3] The extent to which the MHA should be considered as part of your answer may depend upon the scope of the question and answer, the time and/or word limit and the extent to which it has formed part of the syllabus.

[4] Where *Gillick* applies. Take care not to deal in any detail with the position in relation to under 16s as this is not relevant to the question. Some comparisons between the different legal regimes may be appropriate.

[5] The law recognises that the young person is old enough to consent. This is in contrast to the MCA which is mental capacity based. You need to make sure your answer is clear on this point.

[6] In other words, be clear in your answer that this means whether to consent to and refuse treatment.

[7] You may wish to include an example, such as the young person consenting to being a blood donor.

[8] Try to keep the actual question in mind throughout your answer and refer back to it as appropriate throughout your answer.