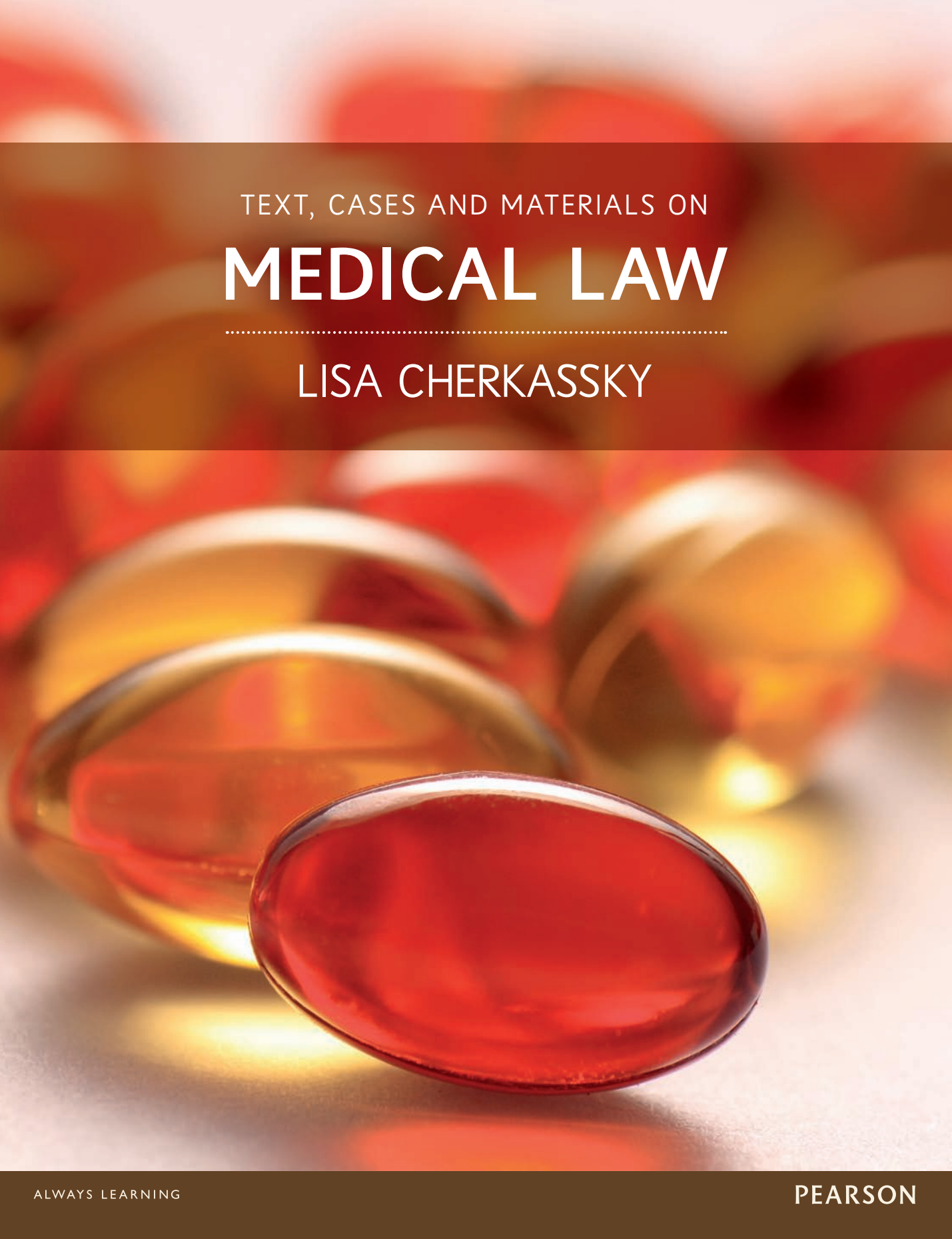
TEXT, CASES AND MATERIALS ON
MEDICAL LAW
LISA CHERKASSKY
ALWAYS LEARNING
PEARSON

Text, Cases and Materials on Medical Law

Children Act 1989

Section 1: Welfare of the child

(3) a court shall have regard in particular to –

(a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding);

(b) his physical, emotional and educational needs;

(c) the likely effect on him of any change in his circumstances;

(d) his age, sex, background and any characteristics of his which the court considers relevant;

(e) any harm which he has suffered or is at risk of suffering;

(f) how capable each of his parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs;

(g) the range of powers available to the court under this Act in the proceedings in question.

The General Medical Council provides additional guidance to doctors.

EXTRACT

General Medical Council, Explanatory Guidance, 0–18 years: Guidance for all Doctors (2007):

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Section 12: An assessment of best interests will include what is clinically indicated in a particular case. You should also consider:

a. the views of the child or young person, so far as they can express them, including any previously expressed preferences;

b. the views of parents;

c. the views of others close to the child or young person;

d. the cultural, religious or other beliefs and values of the child or parents;

e. the views of other healthcare professionals involved in providing care to the child or young person, and of any other professionals who have an interest in their welfare;

f. which choice, if there is more than one, will least restrict the child or young person's future options.

Cultural, social and religious views are clearly important, but they do not automatically decide the issue. The courts can also authorise the use of force against child patients, but, as with incompetent adults, only if it is in their best interests. *DB* (1997) is the accepted authority for this rule.

CASE EXTRACT

***Wolverhampton MBC* v *DB (A Minor)* [1997] 1 FLR 767**

Facts: A teenager (B) was a cocaine addict and she was pregnant. She experienced serious complications but had a phobia of needles. She wanted to discharge herself from hospital.

Held: B had a right to refuse to give consent to medical treatment as she was over 16 years (she was 17 and so had not reached the age of majority), but that right could be overridden by the court or a person with parental responsibility for her. B's refusal was an important factor, but it carried little weight as it had been demonstrated that she could neither comprehend and retain information about her treatment, nor believe such information, and was unable to make a reasoned choice about her treatment. The local authority and her mother having parental responsibility could take steps to protect her best interests, which could permit the use of reasonable force in order to administer the correct treatment. An order would be made that the local authority was entitled to administer such treatment as was medically required with the use of reasonable force necessary to prevent her death or serious deterioration of health.

It is an uncomfortable thought that reasonable force can be used against a refusing teenage patient, but if the age of majority has not been met, and the teenager is showing signs of incompetence, it may be in her best interests to restrain her in order to save her and her unborn child.

THINKING POINT

Do you think that the courts are well equipped, in terms of common law rules and professional regulations, to fairly judge the best interests of a child?

Children: competent

Despite the age of majority being widely accepted at 18, it was still not clear in law just how old a teenager could be before a consent to treatment could be acted upon by a doctor.

This is the issue in *Gillick* (1986), a case which radically changed the law. As a result of the judgment in *Gillick*, a minor aged 15 years or under, who is deemed to be competent, can *consent* to medical treatment without their parent's knowledge or permission.

CASE EXTRACT

***Gillick* v *West Norfolk and Wisbech AHA* [1986] AC 112**

Facts: Mrs Gillick had several daughters under 16. She became aware of a Memorandum of Guidance, issued from the Department of Health and Social Security (DHSS), which allowed a doctor to give contraceptive advice and treatment to her daughters without her consent. She wrote to the local health authority seeking assurance that no contraceptive advice or treatment would be issued to her daughters without her knowledge or consent, and they refused. Mrs Gillick sought a declaration from the courts that the memorandum was unlawful.

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Held: The Court of Appeal supported Mrs Gillick, but the House of Lords allowed the DHSS appeal.

Lord Fraser (at pages 169, 174): 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. Of course the consent of the parents should normally be asked, but they may not be immediately available. Provided the patient, whether a boy or a girl, is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises. [...] The only practicable course is to entrust the doctor with a discretion to act in accordance with his view of what is best in the interests of the girl who is his patient. He should, of course, always seek to persuade her to tell her parents that she is seeking contraceptive advice, and the nature of the advice that she receives. [...] But there may well be cases, and I think there will be some cases, where the girl refuses either to tell the parents herself or to permit the doctor to do so and in such cases, the doctor will, in my opinion, be justified in proceeding without the parents' consent or even knowledge provided he is satisfied on the following matters: (1) that the girl (although under 16 years of age) will understand his advice; (2) that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice; (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.

Lord Scarman (at pages 188–9): I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances.

The case of *Gillick* consolidated several principles: a competent patient under 16 can consent to medical treatment without the knowledge or consent of her parents; it may be in a competent minor's best interests to consent to treatment without the knowledge or consent of her patents; there is a five-part test in order to ascertain '*Gillick* competence'; a doctor will not face criminal charges if he advises or treats a competent patient under the age of 16; and there may be social ramifications if a teenager could not visit her doctor in confidence and receive contraceptive advice and treatment. Lord Fraser's five-part test is as follows:

(1) the girl will understand the medical advice;

(2) the doctor cannot persuade her to inform her parents or allow him to inform the parents that she is seeking contraceptive advice;

(3) she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment;

(4) unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer;

(5) her best interests require him to give her contraceptive advice, treatment or both without the parental consent.

This test is quite strict at first glance. It does not give a doctor a green light to simply dish out contraceptives for no apparent reason. The competent minor must be likely to suffer if she does not receive the advice or treatment and it must, of course, be in her best interests. This test is not completely new: case law has already shown that a court will put the best interests of a child over the views of the parents.

In 2006, the *Gillick* competence test was applied to abortion.

CASE EXTRACT

***R (on the application of Axon)* v *Secretary of State for Health* [2006] QB 539**

Facts: This was a judicial review sought by parents of Department of Health Guidelines which allowed doctors to advise people under the age of 16 on contraception, sexually transmitted diseases and abortion. Mrs Axon, who had five children, claimed that the guidance was unlawful because it would permit a doctor to perform an abortion on one of her daughters without her knowledge. She also claimed that it was a breach of her family life under Article 8 of the European Convention on Human Rights.

Held: The procedure of abortion may have been more intrusive, but there was no reason why Lord Fraser's *Gillick* competence criteria could not be applied to another medical procedure.

Silber J (at page 569): The speeches of Lord Fraser, Lord Scarman and Lord Bridge [in *Gillick*] do not indicate or suggest that their conclusions depended in any way upon the nature of the treatment proposed because the approach in their speeches was and is of general application to all forms of medical advice and treatment.

Silber J in *Axon* was clearly persuaded by Lord Scarman's strong words in *Gillick* that a parental right to consent *terminates* when the child becomes competent because of the far-reaching consequences that could result (i.e. secrecy and teenage pregnancy) if their confidentiality was not respected. Mrs Axon's contention that her right to family life was breached was thrown out by Silber J, who concluded that the autonomy of a young person must undermine any Article 8 rights of a parent to family life.

How far does Gillick competence stretch?

The medical profession have recognised *Gillick* competence and enshrined it into all the relevant medical guidelines. For example, the General Medical Council states that when it comes to gleaning a competent consent from a child, the doctor must use the correct communication tools to achieve an honest answer. The following provisions are clearly derived from the criteria in *Gillick*.

EXTRACT

General Medical Council, Explanatory Guidance, 0–18 years: Guidance for all Doctors (2007):

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Paragraph 14: Effective communication between doctors and children and young people is essential to the provision of good care. You should find out what children, young people and their parents want and need to know, what issues are important to them, and what opinions or fears they have about their health or treatment. In particular you should:

(a) involve children and young people in discussions about their care;

(b) be honest and open with them and their parents, while respecting confidentiality;

(c) listen to and respect their views about their health, and respond to their concerns and preferences;

(d) explain things using language or other forms of communication they can understand;

(e) consider how you and they use non-verbal communication, and the surroundings in which you meet them;

(f) give them opportunities to ask questions, and answer these honestly and to the best of your ability;

(g) do all you can to make open and truthful discussion possible, taking into account that this can be helped or hindered by the involvement of parents or other people;

(h) give them the same time and respect that you would give to adult patients.

The General Medical Council places a duty upon on the doctor to ensure that the child patient can communicate effectively. These guidelines recognise that even competent children may need to be put at ease and encouraged to be honest before they can issue their consent. There should not, therefore, be an assumption that just because a child cannot express their views, they are automatically unable to consent for themselves. A procedure may be so overwhelming and confusing for the child that it is only until he or she sits down with a doctor who uses effective methods of communication that the child can reveal their honest thoughts about it all. Once the doctor has had an opportunity to talk to the child, he must be convinced that the child is *Gillick* competent.

EXTRACT

General Medical Council, Explanatory Guidance, 0–18 years: Guidance for all Doctors (2007):

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Paragraph 24: You must decide whether a young person is able to understand the nature, purpose and possible consequences of investigations or treatments you propose, as well as the consequences of not having treatment. Only if they are able to understand, retain, use and weigh this information, and communicate their decision to others can they consent to that investigation or treatment. That means you must make sure that all relevant information has been provided and thoroughly discussed before deciding whether or not a child or young person has the capacity to consent.

The *Gillick* judgment is clearly far-reaching and throws a lot of support behind minors who have 'sufficient understanding and intelligence' (as per Lord Scarman) to consent to their medical treatment. However, case law since *Gillick* has revealed that there are limits to *Gillick* competence. Minors do not have as much freedom as first thought:

- *Gillick* competence applies to issues of *consent* only: it will support a consent that is in the *best interests* of the minor.
- Refusals are *not* covered by *Gillick* competence: they will probably be deemed as proof of *incompetence*.

To put it another way, if a minor refused treatment, a competent parent (or a court) will simply consent on his behalf.[8] This is because, if a minor makes a foolish decision, it will be viewed as evidence that he or she does not have sufficient understanding or intelligence. These principles have come to light in a string of controversial cases concerning minors and life-saving treatment.

CASE EXTRACT

Re E (A Minor) (Wardship: Medical Treatment) [1993] 1 FLR 386

Facts: A 15-year-old patient was suffering from leukaemia (a cancer of the blood), and wanted to refuse his blood transfusion because he was a Jehovah's Witness. His parents supported this. The minor was clearly intelligent and met the *Gillick* criteria. The local authority made him a ward of court because he was in a critical condition.

Held: The *Gillick* criteria was not enough when making a decision this grave: an understanding of the manner of death and the extent of his family's suffering was required. It was in his best interests to have a blood transfusion.

Ward J: I find that A is a boy of sufficient intelligence to be able to take decisions about his own wellbeing, but I also find that there is a range of decisions of which some are outside his ability fully to grasp their implications. Impressed though I was by his obvious intelligence, by his calm discussion of the implications, by his assertion even that he would refuse well knowing that he may die as a result, in my judgment A does not have a full understanding of the whole implication of what the refusal of that treatment involves. I am quite satisfied that A does not have any sufficient comprehension of the pain he has yet to suffer, of the fear he will be undergoing, of the distress not only occasioned by that fear but also – and importantly – the distress he will inevitably suffer as he, a loving son, helplessly watches his parent's and his family's distress. They are a close family, and they are a brave family, but I find that he has no realisation of the full implications which lie before him as to the process of dying. He may have some concept of the fact that he will die, but as to the manner of his death and to the extent of his and his family's suffering I find he has not the ability to turn his mind to it nor the will to do so. If, therefore, this case depended upon my finding of whether or not A is of sufficient understanding and intelligence and maturity to give full and informed consent, I find that he is not. One has to admire – indeed one is almost baffled by – the courage of the conviction that he expresses. He is, he says, prepared to die for his faith. That makes him a martyr by itself. But I regret that I find it essential for his wellbeing to protect him from himself and his parents, and so I override his and his parents' decision.

[8] This was confirmed in *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 CA.