

Key developments in case law: assessing competence in minors

YOUNG, Andy

Available from Sheffield Hallam University Research Archive (SHURA) at:

<http://shura.shu.ac.uk/24213/>

This document is the author deposited version. You are advised to consult the publisher's version if you wish to cite from it.

Published version

YOUNG, Andy (2019). Key developments in case law: assessing competence in minors. *Practice Nursing*, 30 (3), 140-142.

Copyright and re-use policy

See <http://shura.shu.ac.uk/information.html>

Key developments in case law: assessing competence in minors

Introduction

In this article, Andy Young discusses the complicated legal structure of medical consent for minors. When patients are minors, it is important for the health professional to be aware of what the law requires to treat and manage these patients

Abstract

Primary care is fundamentally about first-contact healthcare accessible to all. It is undifferentiated by age, gender or disease modality, and it is about the continuity of a clinical relationship over time, coordinated across sectors, and interventions that focus on both the individual and the wider population and community. Conveying relevant information about treatment and risk can be problematic, particularly in relation to minors, but it is nevertheless vital that health professionals promote autonomy in decision-making. This requires effective and sensitive communication, with consideration as to how information is framed and presented to patients and their families, as the communication process has a strong influence on how people understand, remember and evaluate information (Brown, 2006).

Key words: Medical competence, Adolescents, Medical consent, Minors, Legal

Alasdair, a 14-year-old boy, has had asthma since he was a young child and regularly uses beclomethasone and salbutamol inhalers. He occasionally gets teased at school, where he boards, because he cannot join in the sports that are being played due to cold weather and extreme exercise exacerbating his asthma.

Despite this, he adheres to his medication and has only had to be admitted to hospital once when his inhaler ran out. Alasdair comes to see Jess, a practice nurse, for a routine asthma review and a flu jab. He tells her that everyone at school is suffering with flu and he thinks that he has caught it from the student who shares a bedroom with him. He feels terrible but his main worry is that his asthma has become much worse. By the end of the history taking he is struggling to catch his breath and has to take a couple of puffs of salbutamol. Jess speaks to her GP colleague, Dr Singh, who listens to Alasdair's chest and diagnoses a chest infection. He suspects that Alasdair may benefit from intravenous antibiotics but Alasdair tells him that he has an important examination coming up and does not want to go to hospital. Dr Singh gives Alasdair a choice of taking oral antibiotics and steroids, but tells him that he has to stay in the sick bay for a few days to get some rest.

When is a young person considered competent to make health decisions? 16–17-year-olds

According to the Children Act 1989, Section 105, legally, a child is someone under the age of 18 years old. Consent means the same in regards to the treatment of children as it does in the treatment of adults. Just as with an adult, medical treatment given to a child in the absence of consent may be a criminal offence, as well as a civil wrong and/or a professional disciplinary matter.

Children of 16 or 17 years old are presumed capable of giving valid consent to medical treatment as if they were adults, as stated in the Family Law Reform Act 1969, Section 8(1). However, even though a child aged 16 or 17 may give consent to medical treatment, their 'refusal' will not be binding. If the treatment is in the child's 'best interests', such a refusal may be overridden by someone with parental responsibility or by the Court.

The limitations to capacity that apply to children over 16 are the same as those that apply to adults. However, where a child of 16 or 17 is incapable, consent to any medical treatment of that child should be obtained from someone with parental responsibility. This means that practitioners should not ordinarily proceed to treat children on their own assessment of the child's best interests.

Under 16s

Many children under 16 are capable of giving consent to medical treatment on their own behalf because they are sufficiently mature to understand the nature, purpose and implications of the procedure in question. Those children fulfil the Fraser Guidelines and are described as 'Gillick competent' (Care Quality Commission (CQC), 2018). Although they must be given the opportunity to consent to medical treatment, their refusal to consent may still be overridden by anyone with parental responsibility. However, practitioners will often wish to obtain a court order before seeking to impose medical treatment on an unwilling teenager solely on the basis of parental consent.

What is the role of the parents?

Where it is proposed to give medical treatment to a child under 16 who is not 'Gillick competent', consent must be sought from someone with parental responsibility. The Children Act 1989, Section 3(1), defines parental responsibility as:

'All the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property.' Significantly, the parent's right is to act in the best interests of the child. Therefore, a parent has no right to act contrary to the best interests of the child. It follows that practitioners should not act on the basis of parental consent where they do not believe that the proposed course is in the child's best interests. Parental responsibility is gained automatically by a mother, when she gives birth to the child, and by a natural father if he is married to the mother. Where parents share parental responsibility, they will continue to do so after they divorce. If the parents are not married to each other when the child is born, the father will not have parental responsibility automatically.

However, it may be acquired by:

- Becoming married to the mother after the child's birth
- Becoming registered as the child's father on the child's birth certificate
- Making a Parental Responsibility Agreement with the child's mother.

Consent may be taken from someone else where that person has had parental responsibility delegated to them or urgent treatment is required; where that person cares for the child; and when those with parental responsibility cannot be contacted. Where consent is needed from someone with parental responsibility, it will usually be sufficient to obtain it from one such person.

There is a small group of medical treatments for which it might be necessary to obtain the consent of everyone with parental responsibility for a child. If such consent cannot be obtained, it might be necessary to make an application to the Court. The group of medical treatments includes sterilisation, non-therapeutic male circumcision and some immunisations. Although those with parental responsibility can give consent to treatment on a child's behalf, they cannot veto treatment if it is in the child's best interests.

Occasionally, therefore, it might be necessary to treat a child against their parents' wishes. In such circumstances, and if time permits, a Court declaration should be sought as to the child's best interests. In an emergency where there is no time to go to Court, health professionals should take any action that is immediately necessary to save the life or preserve the health of the child.

Are there limitations on what treatments a young person can consent to?

The ability to consent depends on competence, not age, although clearly experience of life and perhaps particularly of illness itself, will point towards the ability to weigh issues in the decision-making process and to predict outcomes.

Competence is functional, i.e. it depends on the nature of the decision to be taken, and a high level of understanding would be expected for an invasive procedure. However, in such cases, the parents of a young person will normally be involved in the decision-making process. The assessment of competence is a matter for the health professional conducting the examination or providing the treatment. If there are doubts about the young person's capacity then a second opinion should be sought.

How much information is 'enough' for the purposes of consent?

It is vital that consenting minors are given sufficient information as part of the consent process, and have an opportunity to ask relevant questions. In terms of how much information to give, practitioners are advised to err on the side of caution, and consider all significant information that a prudent patient might expect to receive. Clearly explaining the

nature and purpose of care/ treatment is vital. The recent case of Montgomery v Lanarkshire Health Board 2015 has clarified legal expectation in relation to consent and adults, and arguably this new threshold must now also be considered in relation to consenting minors. This landmark ruling, concerning a pregnant woman who was not informed of the serious risks associated with a natural birth by her obstetrician, emphasised that all patients are entitled, as a matter of right, to decide what risks to undertake. Consequently, doctors and other health professionals must warn their patients of all 'material' risks and of the availability of alternative treatments. In the Montgomery case, the court defined a material risk as one that a reasonable person in the patient's position would be concerned about and attach significance to.

Conclusion

Practice nurses have a key role in ensuring that relevant information is presented in such a way that the patient (older or younger) can use it meaningfully. The Montgomery test has already been applied in several cases, and suggests a shift towards a more cooperative approach in healthcare consultation (Herring, 2018). Although the ruling has not radically changed the process for gaining consent, it has given appropriate recognition to patients as decision makers, and this has implications for all nurses working with children and their families in primary care.

References

Brown B, Crawford C, Carter, R. Evidence-based health communication. 1st edn. Oxford: Oxford University Press; 2006

Care Quality Commission. Nigel's surgery 8: Gillick competency and Fraser guidelines. 2018. <https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-8-gillick-competency-fraser-guidelines> (accessed 12 February 2019)

Herring J. Medical law and ethics. 7th edn. Oxford: Oxford University Press; 2018.

Key Points

- Children under 16 years old have the legal capacity to consent to medical examination and treatment if they can show sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, the alternatives and the risks involved
- The nature and amount of information provided can influence capacity
- Consenting minors must be made aware of 'material' risks and be given sufficient information to allow them to make an informed decision
- Where a minor is not competent to give or withhold informed consent, a person with parental responsibility may give permission for investigations or treatment that are in the minor's best interests. This is the case whether the minor is 17, 16 or younger than 16 years

Box 2:

'Children of 16 or 17 years old are presumed capable of giving valid consent to medical treatment as if they were adults, as stated in the Family Law Reform Act 1969, Section 8(1). However even though a child aged 16 or 17 may give consent to medical treatment, their 'refusal' will not be binding. If the treatment is in the child's 'best interests', such a refusal may be overridden by someone with parental responsibility or by the court.'

Box 1: The landmark case of Gillick

The expression 'Gillick competence' or 'Fraser competence' came from the *Gillick v West Norfolk and Wisbech Area Health Authority* 1986 case involving Victoria Gillick, in which one of the judges, Lord Fraser, set out guidelines by which a child's capacity is to be determined.

The guidelines relate to contraceptive advice, but they may be adapted to most other areas of treatment.

They state that a child under 16 years old may give valid consent to medical treatment – and no one with parental responsibility need be told about the treatment or invited to consent if:

- The child understands the health professional's advice
- The health professional cannot persuade the child to inform either parent, or allow the doctor to inform the parents, that they are seeking contraceptive advice
- The child is very likely to begin or continue having intercourse with or without contraceptive treatment
- Unless they receive contraceptive advice or treatment, the child's physical or mental health (or both) are likely to suffer
- The child's best interests require the health professional to give contraceptive advice, treatment, or both without parental consent.

The level of 'Gillick competence' required will vary according to the treatment proposed. For example, a 10-year-old may be sufficiently competent to consent to the treatment of a minor cut but not to orthopaedic surgery. Even if children are undoubtedly 'Gillick competent', it is good practice to encourage them to involve their parents in decision making. However, any request for confidentiality must be respected unless disclosure without the child's consent can be justified in their 'best interests'.

It might be necessary to ask the Court to grant a declaration to treat a child under 16 if there is doubt or disagreement as to their 'Gillick competence'; they are not 'Gillick competent' and no one with parental responsibility will give consent to treatment that is believed to be in his best interests; or it is not possible to determine who has parental responsibility for him. If in doubt, ask.

The rules about consent and the medical treatment of children are more complex than those concerning adults. It is not uncommon for there to be confusion about parental responsibility, particularly where parents are unmarried or where, following divorce, they have found new partners. Practitioners should not hesitate to seek expert advice, for although children may disagree with their parents when it comes to medical treatment, and though the parents may sometimes disagree among themselves, the basic rules are logical and, once understood, relatively easy to apply and the courts are willing to adjudicate in difficult cases.