the child and refusal of medical treatment

by Stuart Clubb

introduction

It is an inevitable fact of life that as children grow up, especially as they enter their teens, they become more capable of forming their own opinions, expressing these views and evaluating the advantages and disadvantages of certain courses of action for themselves. The law on consent to medical treatment reflects this. However, the law is less clear on the ability of a mature, competent child to *refuse* medical treatment. Here there is a potential clash between three competing interests: the rights of the child, the parent, and of the state; and the law in Scotland is unclear as to whether the rights of the child prevail in such a conflict.

This essay will evaluate the capacity of a *"s2(4) competent"*[1] child to refuse medical treatment and will then examine the extent to which the child's refusal can be overcome by either those with parental responsibility or by the courts. I will then consider, in light of this evaluation, whether any changes in the law could usefully be made.

a child's ability to consent to treatment

In 1985 the infamous case of Victoria Gillick's daughter blew open the hitherto unexplored issue of a minor child's ability to consent to medical treatment. The English decision of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority*[2] held that children under 16 could, exceptionally, consent to receiving medical treatment, provided that the child had reached a sufficient understanding and intelligence to understand what was proposed. This decision was one of the most important cases in the area of children's rights and would subsequently become one of the most controversial due to the failure to decisively state the criteria for what would become known as *"Gillick competence".*

The importance of this case lies in the fact that until it was decided it was generally believed, in both Scotland and England, that the right to consent to medical treatment was a right invested in the parents and one which continued until the child reached the age of 16. This case decided otherwise in English law, although the position in Scotland remained speculative and unclear. The decision is also of importance in recognising the reality of the growing maturity of children as they get older and of their increasing ability to decide important issues affecting them.

The position in Scots law as regards the capacity of children under the age of 16 years to consent to medical treatment was clarified by s2(4) of the Age of Legal Capacity (Scotland) Act 1991 which stated that:
"A person under the age of 16 years shall have legal capacity to consent on his or her own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment".

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[1] s2(4), Age of Legal Capacity (Scotland) Act 1991
[2] [1985] 3 All E.R. 402

This provision essentially lays down the essence of the decision in Gillick in statutory form in Scotland, making it plain that someone under the age of 16 *can* consent to medical treatment. However, the question remains as to whether a "Gillick competent" child, or in Scotland a "s2(4) competent" child, can *refuse* medical treatment.

the "s2(4) competent" child's capacity to refuse treatment

What if the child is deemed to be capable by a qualified medical practitioner of understanding the nature and possible consequences of the proposed treatment yet refuses to consent? This raises a number of important and largely unresolved legal questions: Can the parents override their child's refusal? ; Can the courts override the refusal? ; Or is the child free to decide what is to happen to him or her regardless of whether or not their refusal is in their best interests? In examining these issues I will look at the ability of the parents, and the ability of the courts to override the refusal separately.

- the parent's ability to consent in the face of a competent child's refusal

It is now well established that parents have various parental responsibilities in relation to their children and that they are given various rights in order to fulfil those responsibilities[3]. One such responsibility is the responsibility to *"safeguard and promote the child's health, development and welfare"*[4]. The parent also has the right to *"act as the child's legal representative"*[5]. It is this which gives parents, or those with parental responsibility, the right to consent to medical treatment on behalf of a minor. These responsibilities and rights last until the child reaches the age of 16[6]. Of course, as we have seen this right must be viewed in conjunction with s2(4) of the 1991 Act.

When a child is deemed to have s2(4) capacity there are two possible views as to what happens to the parent's right to consent on behalf of a child:

1. the parents lose their right to consent as this right is no longer needed;
2. there now exist *two* possible rights of consent, either of which can be used to give consent.

Both viewpoints can be traced back to the judgments in the Gillick case, but determining what would happen in the situation whereby a competent child refuses consent while a parent is willing to give consent depends upon which viewpoint prevails in the law of Scotland, and it is this which remains speculative.

In Gillick, there was a difference of opinion between Lords Fraser and Scarman. Although both agreed that in some circumstances a child could give effective consent to medical treatment, there was dissension between the Law Lords as to whether a child could only be regarded as competent if he or she were acting in his or her best interests.

Lord Scarman took the view that once the minor child *"achieves a sufficient understanding and intelligence to enable him or her to understand fully what is*

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[3] contained in Part 1 of the Children (Scotland) Act 1995
[4] s1(1)(a), 1995 Act
[5] s2(1)(d)
[6] s1(2)(a) and s2(7)

proposed"[7] then the parental right to determine whether or not the minor child will have medical treatment terminates or *"yields to the child's right to make his own decisions"*[8]. This clearly suggests that in a clash between the rights of the parents and those of the child, the rights of the child will prevail. Lord Scarman is also seemingly indicating the possibility that competent children would be free, like adults, to make mistakes as well as wise choices in deciding questions of medical treatment[9].

Lord Fraser, on the other hand, took the view that in determining whether or not a child was competent to consent to treatment, the doctor must be satisfied that the proposed course of treatment is in the child's *"best interests"*[10]. This clearly differs from the opinion of Lord Scarman who made no requirement that the treatment be in the best interests of the child. Indeed, on the view of Lord Fraser, if refusal of treatment was not in the best interests of the child then the child would not be deemed competent and, therefore, the parental right remains and the parent could give a valid consent.

As mentioned earlier, s2(4) of the 1991 Act effectively put the holding in Gillick on a statutory footing and it is my opinion that in doing so, s2(4) supports the judgment and reasoning of Lord Scarman. s2(4) tells us that all that is required by the qualified medical practitioner is an assessment of the child's capability of understanding the nature and consequences of the treatment. A requirement that the treatment be in the best interests of the child is clearly not necessary. Indeed, the Scottish Law Commission in their report, *Report on the Legal Capacity and Responsibility of Minors and Pupils*[11] came to the conclusion that if the child was deemed to have sufficient maturity then, logically, it should not matter whether the treatment was for his or her benefit or not.

Following this thread of reasoning, it would seem to be a false dichotomy to say that a child can consent to a procedure which may not be in his or her best interests, yet cannot refuse to undergo treatment, the refusal of which may equally be against his or best interests. All of this points towards the adoption of the view of Lord Scarman whereby once the child is deemed competent, it does not matter whether the course of action is in the best interests of the child or not, the parent's right to consent still terminates.

There is, therefore, a very strong argument to suggest that if a child refused treatment in Scotland, the parent would be unable to consent and the child would have a right of refusal. However, this is a question which has yet to be determined by the Scottish courts. It may, therefore, be useful to look at how the law of England has dealt with this controversial issue.

- the position in England

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[7] [1985], 3 All E.R. 402, at 423
[8] p.422

[9] Edwards and Griffiths, 'Family Law', p.94
[10] Lord Fraser, p.413
[11] SLC No.110, 1987, paras 3.61-3.83

Re R[12] was the first case to consider the concept of the 'Gillick competent' child and although it was widely assumed prior to this case that 'Gillick competence' carried with it the right to refuse[13], the comments of Lord Donaldson MR suggest otherwise.

The case concerned a 15 year old girl who was suffering from severe mental health problems and who refused the administration of anti-psychotic drugs. Although the Court of Appeal held that the girl lacked 'Gillick competence', Lord Donaldson took the opportunity to express a view as to the ability of a person with parental responsibility to override the refusal to consent by a competent child.

He took the view that even if a 'Gillick competent' child refused treatment, someone with parental responsibility could still consent, as the parent's right to consent did not completely disappear but rather was simply no longer able to defeat any consent given by the child. In reaching this view, he felt that when Lord Scarman talked in Gillick about rights *"terminating"* and *"yielding"* he was referring to the parental right to *determine* whether or not a child should receive medical treatment and not their concurrent right to consent. Lord Donaldson adopted a "key holder" analogy, whereby both the parent and the competent child hold a "key", and either of them can use this "key" to "unlock the door" – ie. give a valid consent to treatment. Therefore, if one "keyholder" chooses not to "unlock the door", there is nothing to stop the other from lawfully doing so.

Re W[14] in 1992 concerned a 16 year old girl who was suffering from anorexia nervosa and who was refusing all treatment. Although the concept of 'Gillick competence' was not relevant to the case, Lord Donaldson once again chose to express obiter views as to the capability of a minor child to refuse medical treatment. He stated that *"No minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor"*[15].

He also expressed regret at his use of the "keyholder" analogy as he said that keys can lock as well as unlock. He, therefore, adopted the analogy of the legal "flak-jacket" instead, saying that the doctor may acquire this from either the competent patient or someone having parental responsibility. Under this analogy, *"anyone who gives him a flak-jacket (ie.consent) may take it back, but the doctor only needs one and so long as he continues to have one he has the legal right to proceed"*[16].

- ***the Scottish position***

It must, however, be remembered that the comments of Lord Donaldson MR are only obiter comments and, in any event, these are English cases and as such are, at most, only persuasive in Scotland. However, it is felt by many that the dicta in Re R and Re W must call into question any assumption in Scotland that 'Gillick competence' carries with it the right to refuse[17].

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[12] [1991] 4 All ER 177
[13] Houston (Applicant) 1996 SCLR 943 per the comments of the editor, Sheriff Kelbie at p.946
[14] [1992] 4 All ER 627
[15] p.639
[16] p.635
[17] 1996 SCLR 943, per the comments of Sheriff Kelbie at p.946

There is, however, no reason why Scotland could not take a different stance than that of Lord Donaldson MR. Indeed, as I have suggested above, all of the evidence points towards a different stance being taken in any event. The position adopted in Re R and Re W would also give rise to the alarming possibility of mature children being subjected to medical treatment against their will, despite having the competence to make their own choices. Such treatment could range from the simple administration of drugs to hospitalisation or even the removal of organs. The law does not interfere to this extent with adults so why with competent, mature children?

Indeed, Re R and Re W seem to be a step backwards from the progress made in Gillick as to recognising the autonomous rights of children. Whereas Gillick quite clearly recognised the growing maturity of children and their increasing ability to make informed decisions for themselves, the comments in those two cases put a clear limit on the extent to which the law will recognise this maturity. However, the obiter views of Lord Donaldson MR may have been largely superseded by an increase in the recognition of children's rights since those cases, most notably by the Children (Scotland) Act 1995.

s90 of the 1995 Act deals with the consent of a child to certain procedures and states that, without prejudice to s2(4), where a child is required under certain provisions of the Act to submit to any examination or treatment but the child has the capacity mentioned in s2(4), then the examination or treatment shall only be carried out if the child consents. In his commentary on the 1995 Act Professor Norrie, in relation to s90, makes the point that *"Capacity to consent to medical treatment necessarily includes capacity to refuse consent".* Sheriff Kelbie in his commentary on Houston[18] is, however, more cautious and states that in his opinion the matter is still far from clear but that it can be argued from s90 that s2(4) does includes the right to refuse[19].

s15(5), however, provides further evidence that the child has the right to refuse in the face of consent from someone with parental responsibility. s15(5) tells us that a person acting as a child's legal representative[20] can only act or give consent *"where the child is incapable of so acting or consenting on his own behalf"*[21]. Although Wilkinson and Norrie state that the effect of this provision *"could have been expressed more clearly"*[22], it would evidently seem to have the effect of the parent's rights terminating, as envisaged by Lord Scarman in Gillick, provided the child is capable of consenting.

These statutory provisions, therefore, suggest that the competent child does have the right to refuse. This is consistent with the present NHS guidelines which recommend that the refusal of treatment by *"competent young people"* under 16 *"must be respected"*[23]. The case of Houston[24] is the only Scottish case on the issue of a child's right of refusal and Sheriff McGowan in that case made comments to the

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[18] ibid.
[19] p.948
[20] which, as we have seen above, a parent does by virtue of their rights and responsibilities under the 1995 Act
[21] s15(5)(b)
[22] Wilkinson and Norrie, Parent and Child, p.261
[23] 'A Guide to Consent to Examination, Investigation, Treatment or Operation', NHS in Scotland para 14
[24] 1996 SCLR 943

effect that the refusal of a competent child could not be overruled by the consent of a parent. He said that *"it seems to me illogical that on the one hand a person under the age of 16 should be granted the power to decide upon medical treatment for himself but his parents have the right to override his decision. I am inclined to the view that the minor's decision is paramount and cannot be overridden."*[25]

The evidence would therefore, in my opinion, point to the viewpoint of Lord Scarman being adopted in Scotland and consequently the termination of the parent's right to consent once the child becomes competent. Indeed, it is my belief that this is the position the law ought to adopt if it is to recognise the increasing maturity of children as they grow older. However, there are a number of commentators who believe that it should always be open to the parent to consent on behalf of a child despite that child's refusal.

It has been argued that there is a clear practical distinction to be made between consent to and refusal of medical treatment in that consent involves acceptance of what is an experienced medical view whereas refusal rejects that experience from a position of limited knowledge[26]. Consequently, it is argued that the implications of refusal may be more serious. This, however, presupposes that consent is 'always good' while refusal will always be 'dangerous'. But what of the less clear 'grey' cases where treatment may be just as dangerous as doing nothing? This is still refusal and places doubt upon the above dichotomy.

- the court's ability to consent

I will turn now to the ability of the court to override a refusal by a competent child. Once again, there are two competing views as to whether it is competent for the wishes of the child to be overridden. Under s11 of the 1995 Act, an application can be made to the court in relation to parental responsibilities and parental rights[27]. Such an application can be made either by a person having parental responsibilities or rights, or by a person who does not have such responsibilities or rights but who *"claims an interest"*[28]. The latter category could include doctors, an unmarried father or perhaps a grandparent. In relation to the question of medical treatment, the application to be made would be for a specific issue order[29], as this regulates any 'specific issue' which arises in relation to parental responsibilities and rights.

When asked to make a s11 order the court is required to bear in mind the principles contained in s11(7) of the 1995 Act. These principles are that the welfare of the child is paramount; the court should not make any order unless it considers it better than making no order at all; and that, as far as is practicable, the court should have regard to the views of the child, taking into account the child's age and maturity.

It is, therefore, arguable that where the welfare of the child is the paramount consideration to be taken into account, the court would be required to make a specific issue order where treatment would clearly be in the best interests of the child despite the child's refusal. Indeed, it is stated by some academics that the courts

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[25] p.945
[26] Mason and McCall Smith, 'Law and Medical Ethics' (4th ed), p.229
[27] s11(1)
[28] s11(3)(a)
[29] s11(2)(e)

ability to override the wishes of a "s2(4) competent" child is not even open to question[30].

However, Wilkinson and Norrie suggest that any application to the court for a specific issue order should be dismissed as incompetent once the child is deemed to be competent under s2(4)[31]. They submit that an application under s11 is only competent in relation to, amongst other things, parental responsibilities and parental rights. If the child has capacity under the 1991 Act to perform a legal transaction on his or her own behalf then s15(5) of the 1995 Act tells us that the parent has no right to act in that transaction as the child's legal representative. Therefore, in my opinion, Wilkinson and Norrie quite correctly submit that the dispute is not one relating to parental responsibilities and parental rights and consequently not one to which s11(7) applies.

conclusion

It may be true that the implications of refusing treatment may be serious and perhaps even dangerous but the same can be said of adults who refuse treatment. Once it is established that a child is competent and mature enough to have sufficient understanding to make decisions what justifications are there for the parent overriding the decision of the child? Indeed, making a 'wrong' choice is one of the consequences of judging someone to be competent and mature enough to make their own decisions. The decisions of competent children may be misguided but again so may those of adults.

However, the law in Scotland on the question of whether a "s2(4) competent" child can refuse medical treatment remains, despite the strong arguments in favour of recognising such a right, speculative and unclear. What is therefore needed is explicit statutory recognition of the existence of a right of refusal. The existence of NHS guidelines 'respecting' the refusal of a competent child have done little to clarify the situation and end the speculation and, therefore, in the absence of any case dealing directly with the question, the amendment of s2(4) is required. This would greatly clarify the law and as a result be beneficial for the medical profession, the parents, and more importantly those most affected by the uncertainty – the children who are competent and mature enough to make their own decisions.

[30] Edwards and Griffiths, p.96
[31] Wilkinson and Norrie, p.262