Minors and consent to treatment law medical essay

Law

INTRODUCTION

English law contains a rebuttable presumption that parents act in the best interests of their children. When it comes to making medical decisions for their sick child, it has been accepted that parents know best since they are emotionally connected with their child. However, cases have revealed that parental decision-making over their sick children has been declining. The onus in determining the best medical interests of a child could shift to the child's doctor. Ultimately, in proceeding to administer treatment or in making a decision to refuse to treat, a doctor must act with consent of the patient or in the case of a child, his parents or the court. To borrow the words of Lord Woolfe in his inaugural lecture in the new Provost Series, delivered in London in 2001, the phrase ' doctors know best' should now be followed by the qualifying words ' if he acts reasonably and logically and gets his facts right'. The most difficult cases arise when parents and doctors disagree about what amounts to ' best interests' of the child. When this happens, the courts will step in and act as the ultimate arbiter in determining the ' best interests' of the child.

THE ENGLISH POSITION

The Family Law Reform Act 1969 reduces the age of majority from 21 to 18. Any persons below the age of 18 would therefore be recognized as a child under the law. Section 3(1) Children Act 1989 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'. Since parents are empowered by law by this wide and all-encompassing

provision, their decisions made in respect of their children must accordingly be respected.

RELIGIOUS BELIEFS

Article 8 read together with Article 9 of the European Convention on Human Rights (" ECHR") which was incorporated in England by way of the Human Rights Act 1998 accords respect to family life and would include the right of a parent to determine the religious affiliation of his child. Doctors and indeed, the courts, have not always been comfortable with this interpretation of rights and will intervene when they are of the view that the imposition of such rights on the child will conflict with the child's best interests. The fundamental principle governing withholding life saving treatment from young children was settled in Re B[1]in 1981. The parents of Alexandra, an infant girl born with Down's syndrome refused to consent to surgery for an intestinal obstruction. Her parents argued that God or nature had given their child a way out. However, the Court of Appeal allowed the doctors to proceed with the operation as it was in the child's best interest. In the case of the conjoined twins from Manchester[2], Jodie and Mary, the devout Roman Catholic parents of the twins believed that separating the twins would be a sin and against the will of God. The Court of Appeal held that it would be in both the twins' best interest that the surgery be performed. Margaret Brazier said that there are 2 factors which play a vital role in the decision as to whether to treat an acutely ill child; first, what do her parents desire? and second, what is the practice of the medical profession in the management of her kind of illness and disability?[3]. It is submitted that Brazier's first factor seems to be in contrary to the principle of " proxy consent". It is submitted

that the factor Brazier writes about could just a way of comforting the parents of the sick child. It can be clearly gauged from the case of Re B that where the views of the parents conflict with medical views, the courts would ultimately be called upon to make a decision based on the child's best interests.

BEST INTERESTS

In Re C[4]baby C was made a ward of court after her parents expressed inability to care for their severely ill infant. Among her many conditions, she appeared to be blind and virtually deaf. Her prognosis was poor and it was medically opined that she would die in a matter of months. The issues put before the court were these[5]. If it became impossible to go on feeding her by syringe, must she be fed naso-gastrically or intravenously? If she developed an infection, must she be treated by antibiotics? At the outset, it must be observed that there was no conflict in the views of the parents and the doctors of baby C. Absent any views from the parents, her doctors sought an order to refuse treatment to baby C should the above situations materialise. The High Court ordered that leave be given to ' treat the ward to die' which caused a public outcry for the unsavory choice of phrase used. The Court of Appeal affirmed the decision but took the diplomatic course to remove the phrase and ordered that:-" The hospital authority be at liberty to treat the minor to allow her life to come to an end peacefully and with dignity..." It is submitted that the Court adopted a humane approach in attempting to relieve baby C of her sufferings. The Court also acknowledged the principle of quality of life; that if she was resuscitated to continue living, her quality of life would be compromised and she will not be able to enjoy

the kind of life other children her age were capable of enjoying. Since Re C (supra), the Courts have shown a willingness to authorise a refusal to treat where medical evidence proves that the child would not be able to enjoy a reasonable quality of life. It is submitted that the Courts have adopted a paternalistic approach towards sick infants. Instead of playing the role of a neutral arbiter, the role of the Court has now been widened to decide if a child can or cannot enjoy a certain quality of life, thereby usurping the role of parents, who by law are the child's proxy decision-makers. In another case also called Re C[6], the Court authorised the removal from life-support from a baby who survived only with the support of a ventilator. Interestingly, both the baby's parents and the doctors wished to withdraw the life-support. However, the case set an excellent precedent in that notwithstanding the agreement between parents and doctors that a child should be refused treatment which would artificially keep her alive, a Court order is necessary to authorise the refusal to treat and to finally determine whether it would be in the best interest of the child to live or die. Therefore, it can be seen from the above cases, the best interests of the child may be determined by his or her parents, doctors or the court. It is submitted that at the end of the day, a balancing exercise should be performed in assessing the course to be adopted in the best interests of the child. Another case that warrants discussion is Re J. J was born severely brain damaged and suffered near death experiences several times. In all those times, he was saved by medical skill. His doctors were of the view that he was likely to develop paralysis, blindness and probable deafness. Nevertheless, he was expected to live till his late teens. There was no disagreement between J's parents and his

doctors and both agreed that J ought not to be resuscitated if he suffers and infection. The Court was called upon to decide on whether J ought to be resuscitated and held that he need not. It is submitted that the Court attempted to place heavier emphasis on baby J’s quality of life over the sanctity of life. The reason why the Court could only have ‘ attempted’ to do so was that baby J could have lived a happy and fulfilling life notwithstanding his medical conditions. The Court’s decision therefore sets an unhealthy precedent on how the Court’s view those born with abnormalities such as baby J’s. It is an indication of the view that the disabled do not enjoy the same quality of life as other normal human beings when in reality, they could be enjoying the same quality of life as any other human being. Quality of life was therefore judged based on the physical aspects of a human being and the child’s possible emotional happiness which he was capable of enjoying was disregarded. Nevertheless, the Court was careful not to offend against Article 6 of the United Nations Convention on the Rights of the Child (" UNCRC") which recognises every child’s inherent right to life and to the maximum extent possible the survival and development of the child:-" But in the end there will be cases in which the answer must be that it is not in the interests of the child to subject it to treatment which will cause increased suffering and produce no commensurate benefit, giving the fullest possible weight to the child’s and mankind’s desire to survive." It is submitted that where there is an agreement between a sick child’s parents and doctor not to resuscitate him, the Courts are more willing to respect that decision. The difficulty arises in the event of conflict where the parents demand for treatment to be administered but the doctors refuse on the grounds that

additional treatment would be futile. Such was the scenario in Re Wyatt[7]where 2 ½ year old Charlotte Wyatt was born with severe brain damage, respiratory difficulties and poor kidney function. Unanimous medical evidence held that continued intervention was futile whilst her parents on the other hand were ‘ hoping for a miracle’[8]. The Court’s decision reflects the paternalistic approach adopted by the Courts in being the final arbiter of determining the fate of a child after a consideration of the medical evidence and the ‘ assumed’ view of the child. Hedley J stated:-" In reaching that view I have of course been informed by the medical evidence as to the prospects and costs to her of aggressive treatment. I hope, however, that I have looked much wider than that and seen not just a physical being but a body, mind and spirit expressed in a human personality of unique worth who is profoundly precious to her parents. It is for the personality of unique worth that I have striven to discern her best interests. It is my one regret that my search has led to a different answer than sought by these parents." [emphasis added]From the above passage, it may be gleaned that though her parents’ desires were considered, the Court’s ultimate decision was based on the views of the doctors. It was indeed a decision where the ‘ doctors know best’ as such decision was affirmed by the Court. In most instances of conflicting views, it is submitted that the courts usually defer to the views of the sick child’s doctors. However, the case of Re T[9]is an aberration of sorts because the Court allowed the views of the parents of baby T to prevail and they were therefore entitled to withhold life-saving treatment from their child. Interestingly, it must be noted that baby T’s parents were both health professionals who were of the view that the

proposed transplant operation would not be in their son’s best interest. Ironically, later decisions have seen the unwillingness of Courts to override parental views. In An NHS Trust v B[10], the Court refused to authorise doctors to remove the life-support from 18 month old baby MB against the objections of his parents. However, in attempting to balance the best interests of the child’s right to live against his interests to die a dignified death, the Court also refused the parents’ request for an order for further invasive treatment to prolong the baby’s life. In Glass v United Kingdom[11], the European Court of Human Rights allowed David Glass’ mothers views to prevail over that of his doctors. The doctors believed that David should not be resuscitated if he stopped breathing and that he should be administered diamorphine to relieve any distress. The mother was strongly opposed to the doctor’s proposed actions. The European Court of Human Rights allowed the mother’s appeal stating that the administering of diamorphine to David against the wishes of his mother violated Article 8 of the ECHR. It is submitted that the Courts would usually defer to medical opinion. In Glass (supra) and An NHS Trust (supra) however, the doctors were of the view that the children should not continue to receive treatment. It is submitted that the act of switching off a ventilator as was proposed to the parents of baby MB and the proposed course of ‘ treating’ David Glass to diamorphine to relieve him from distress could be viewed as a means of euthanasia which the courts were weary of sanctioning especially in the light of objections from the child’s parents.

THE MALAYSIAN POSITION

In Malaysia, Section 2 of the Child Act 2001 defines a ‘ child’ as a person under the age of 18 years. Medical law in Malaysia is not as developed as its English counterpart. Therefore, in assessing the law on minors and consent to treatment, it is likely that courts would lend guidance from the family law principles which are applicable to children.

JURISDICTION & POWERS OF THE COURT

Section 11 of the Guardianship of Infants Act 1961 (" GIA") provides that the Court shall, in exercising its powers under the Act, have regard primarily to the welfare of the infant and shall, where the infant has a parent or parents, consider the wishes of such parent or both of them, as the case may be. The inherent jurisdiction of the High Court is also laid out in Section 24(d) of the Courts of Judicature Act 1964 and includes the jurisdiction to appoint and control guardians of infants and generally over the person and property of infants. Section 88(2) of the Law Reform (Marriage and Divorce) Act 1976 (" LRA") provides for the matters to be considered by the court when deciding in whose custody a child should be placed. The section also makes it mandatory for the court to consider the welfare of the child as being paramount, and subject thereto, the wishes of the parents and of the child, where he or she is of an age to express an independent opinion. Sections 92 and 93 of the LRA make it clear that parents cannot oust the protective jurisdiction of the court over their children in matters of custody or maintenance. Although the sections do not expressly refer to a parent’s consent to or refusal of medical treatment, it is submitted that the courts may be guided by their protective jurisdiction laid out in these sections. With

the Child Act 2001, a child may also be taken into temporary protective custody by the Department of Social Welfare or a police officer, who may authorise medical investigations and treatment for the child to diagnose the child's condition[12]. The Act also takes into consideration the principle of proxy-consent under Section 24(2)(b) where written consent of a parent or guardian is required before a child can be authorized to undergo surgical treatment. However, where the parent has " unreasonably refused" consent, a Protector may authorize treatment without obtaining such consent where there is an " immediate risk" to the health of the child[13].

PARAMOUNT CONSIDERATION

We have discussed above how the Courts interpret and apply the ' best interest' test to determine the best possible treatment for a child. In Malaysia, the ' paramount consideration' test is the applicable test in granting custody of a child. As was observed in the myriad of cases in England, the term ' best interest' is one which is difficult to define. A similar difficulty arises in attempting to define ' paramount consideration' although the term has been judicially considered in a number of cases. Dr. Puteri Nemie Kassim had, in her article[14], opined that the common law cases in Malaysia have been instrumental in many consent to medical treatment cases. In Mahabir Prasad v Mahabir Prasad[15], the Federal Court considered ' paramount consideration' vis-à-vis the welfare of the child under the LRA and said that:-" The phrase ' first and paramount consideration' does not mean that one should view the matter of the children's welfare as first on the list of factors to be considered, but rather that it must be the overriding consideration." The Federal Court observed that among the factors that must

be taken into account are the claims and wishes of the parents of the child but the overriding consideration must be the welfare of the child. Raja Azlan Shah CJ in delivering judgment of the Court said:[16]-"...In short the learned judge had given the overriding consideration of the welfare of the children uppermost in his mind. That, we think, is the correct approach. We would state categorically that that must be first and paramount consideration and other considerations must be subordinate. The mere desire of a parent to have his children must be subordinate to the welfare of the children, and can be effective only if it coincides with their welfare." It is submitted that a wide definition ought to be accorded to the term ‘ welfare’ and should include the physical and mental well-being of a child. It is also submitted that consideration ought to be given to the ability of the sick child’s parents to care for their child. Authors on the subject of family law are of the view that in determining the welfare of a child, the question before the court is to assess the best interest of the child[17].

CONCLUSION

In the final analysis, paternalism is no longer the order of the day. Parents and more importantly doctors, play an equally important role in medical decision-making of minors. When there is a conflict between the wishes of the parents and the doctors, the court will act as the final arbiter of justice. It is observed that in medical decision-making, courts are often more comfortable to defer to the views of the doctor rendering medical opinion the most vital piece of information before the court. To the courts, the doctor indeed knows best and with this mind-set, the autonomy of the child patient or the status of his parents as the child’s proxy decision-makers often takes

a back-seat. It is submitted that justice can only be served if a balancing exercise is carried out between the views of the parents and the doctor. In the event of a deadlock, however, justice would be best served if the balance is tipped in favour of the child patient who would be forced to live with the consequences of whatever decision made.

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