

Can children withhold consent to treatment?

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A dilemma exists when a doctor is faced with a child or young person who refuses medically indicated treatment. The Gillick case had been interpreted by many to mean that a child of sufficient age and intelligence could validly consent or refuse consent to treatment. Recent decisions of the Court of Appeal on a child's refusal of medical treatment have clouded the issue and undermined the spirit of the Gillick decision and the Children Act 1989. It is now the case that a child patient whose competence is in doubt will be found rational if he or she accepts the proposal to treat but may be found incompetent if he or she disagrees. Practitioners are alerted to the anomalies now exhibited by the law on the issue of children's consent and refusal. The impact of the decisions from the perspectives of medicine, ethics, and the law are examined. Practitioners should review each case of child care carefully and in cases of doubt seek legal advice.

A 16 year old boy with diabetes lies in hospital refusing the necessary treatment required to save his arm. Septicaemia is likely to result, which might threaten his life. Though the primary efforts will naturally be targeted towards discussion with the young person with the aim of overcoming all of the underlying issues that seem to be preventing him from agreeing to what most of us would regard as the reasonable approach, what is the current state in law if the crisis worsens? Would the refusal of a 16 year old person without mental illness be binding on the professionals? Or would the parents' agreement to treatment carry greater weight?

Every case will have its own unique features, but in this article we search for the presence of pointers and themes in recent case law and provide a medicoethical commentary on the present state of the law. We also examine the implications of the cases for practitioners.

The Children Act 1989 came into force on 14 October 1991, bringing the law relating to children and families into one piece of legislation.¹ In seeking to redefine the balance between securing children's safety and the responsibility and rights of parents to bring up

children within their own families, the act adopts as its guiding principle the welfare of the child.

One aspect of the importance of the child's welfare is the act's concern that children's wishes and feelings are incorporated into decision making. Indeed, the act's welfare checklist has as its first item "the ascertainable wishes and feelings of the child considered in the light of his age and understanding." The act has incorporated the Gillick principle that the child's full consent to examination, assessment, or treatment is required under the various protection, supervision, and care orders if he or she is "of sufficient understanding to make an informed decision."² The guidance accompanying the act states that "this is for the doctor to decide,"³ but quite on what basis is not further discussed.⁴ The act does not distinguish between consenting to have a treatment on the one hand and refusing consent on the other.

Since the act's inception, however, there have been several important cases in the Court of Appeal, which, while purporting to base themselves on the same source as the Children Act—that is, the Gillick decision²—have reached different conclusions on a child's right to refuse treatment. Under the Children Act a child has a statutory right to refuse treatment proposed.¹ These Appeal Court cases hold that the right to refuse treatment does not extend to those children outside the Children Act. The purpose of this article is to alert professionals to the anomalies that the law now reveals.

The cases

The cases of *Re R*⁵ and *Re W*⁶⁻⁸ concerned the intersection of three pieces of law. The first of these was the decision of the House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority*,² briefly referred to earlier. The second was section 8 of the Family Law Reform Act 1969, which provides that the consent of a person aged 16 or 17 to medical treatment "shall be as effective as if he were of full age."⁹ The final area of law was the power of the court in exercising its inherent (or wardship) jurisdiction. Could the court in exercising this latter jurisdiction override the wishes of a competent minor? Academics have expressed conflicting views on the question.^{10 11}

CASE OF RE R

Re R concerned a 15 year old girl who had voluntarily entered the care of the local authority after a fight with her father.⁵ R had been known to social services for 12 years as a possible victim of emotional abuse. After leaving care she absconded from her parents' home, damaged property, threatened suicide, and attacked her father. R was admitted to the psychiatric unit of a hospital and then to a specialist adolescent care unit. The unit sought to give her antipsychotic drugs. The local authority initially gave permission for the administration but withdrew the consent on the basis that they thought R was competent to express her own wishes on the subject. The unit made it clear that it required freedom to administer treatment without consent if necessary, so the local authority started wardship proceedings to resolve the matter.

In the Court of Appeal Lord Donaldson, Master of

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The guiding principle of the Children Act 1989 is the welfare of the child

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the Rolls, and Lord Justice Farquharson (Lord Justice Staughton expressing no opinion) held that a child with fluctuating mental capacity could never be said to be competent even in her lucid moments. The court noted that its wardship powers were broader than parental powers. Wardship powers were theoretically unlimited and were said certainly to extend to overriding the wishes of a minor, whether "Gillick competent" or not. The cases cited by the court as authority for this view, however, were either decided before the Gillick case or concerned wards whose views happened to coincide with the court or related to wards who were not regarded as being mature.

It was surprising that the court did not go along with the spirit of the Gillick case and elect not to exercise wardship powers in respect of competent minors. This would have been permissible under the doctrine of *Re X* (a minor) (wardship jurisdiction),¹² which holds that the court may decline to exercise its wardship jurisdiction because of competing interests, notwithstanding possible harm to the ward.¹³

Lord Donaldson in *Re R* went one step further and stated that, notwithstanding the dictum of Lord Scarman in the Gillick case to the contrary, the right to consent which a competent child had did not include the right to veto treatment.⁵ Treatment could proceed on the consent of the parents or those in loco parentis. Lord Donaldson noted that, although Lord Scarman held that once a child became competent the parental right to determine what treatment be given to the child ended, the right to consent to treatment differed from determining the treatment. Arguably though, the right to determine includes the right to consent and is not an alternative to it.

CASE OF RE W

In *Re W* the young woman (aged 16) was suffering from anorexia nervosa.⁶⁻⁸ The local authority in whose care *W* was sought leave to have the court exercise its inherent jurisdiction over the child. An order was sought to permit compulsory feeding and movement of *W* to another treatment centre. Through her legal advisers *W* objected to both these proposals.

The Court of Appeal held that after *Re R*⁵ it could override the wishes of a minor, whether Gillick

competent or not. Lord Donaldson and Lord Justice Balcombe held that the Family Law Reform Act, though granting a 16 year old a right to consent, did not also deprive the parents (or a local authority) of their right to consent to medical treatment for their child. It followed that a competent child could never veto treatment if his or her parents had consented to it. The court was not persuaded by the fact that in other orders under the Children Act neither the court nor the parents could override the expressed wishes of a competent child to refuse assessment or treatment. Only one member of the appeal court (Lord Justice Nolan) was willing to hold that the welfare checklist from section 1(3) of the Children Act should guide the court's deliberations when exercising its inherent jurisdiction.

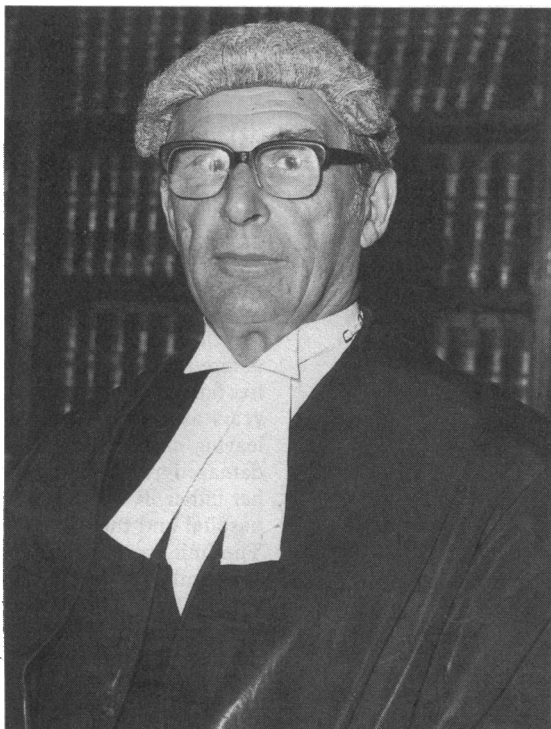
All members of the Court of Appeal held that the court's inherent jurisdiction had to be exercised in the best interests of the child. As the child got older, the court held, greater weight should be accorded to his or her wishes. In this sense the court in *Re W* made a concession to the Gillick principle.

We now comment on the court's rulings from the perspective of medicine, ethics, and the law.

Discussion

The cases of *Re R* and *Re W* adopt a different view of the Gillick case from that found in the Children Act generally. Some might argue that these cases merely codify common sense,¹⁴ but we think that they contradict the spirit of the Children Act. In so doing they implicitly set a higher "tariff" for refusing a medical examination or procedure than for consenting to one. A similar approach can be detected in the recent Court of Appeal decision in *Re T*. In that case the court held that a 20 year old's refusal of a blood transfusion was not valid because she was misinformed about possible substitutes for blood and did not foresee that her life was in danger. If *T* had made the decision to accept treatment on an equally misinformed basis, however, perhaps her consent to treatment would not have been called into question.

It seems obvious that a right to give consent must also mean the right to refuse consent. Otherwise the right to consent would seem to be no more than the right to agree with the medical practitioner. Many medical ethicists have commented wryly on the catch 22 by which patients whose competence is in doubt will be found rational if they accept the doctor's proposal but incompetent if they reject professional advice.¹⁵⁻¹⁸ Others argue that refusal of treatment should trigger an inquiry about the patient's competence, though not necessarily a finding of incompetence.¹⁹ As treatment is perceived to be in the patient's best interests they argue that we should impose a higher tariff for refusing than consenting because refusing would seem to the ethicists to be contrary to good sense. This assumes two debatable points: that the doctor is right about what is in the patient's best interests and that treating the patient even without the patient's consent will still help the patient. Although *W* accepted treatment after the court's decision, overriding her autonomy might well have harmed her as her main desire for most of the case seemed to have been to exert control. As was pointed out by the court, control is the essence of the struggle in cases of anorexia.⁶⁻⁸ Long term follow up studies of people with anorexia are salutary reminders of the lifelong struggles for control in a considerable minority, which follow initial intervention in adolescence.^{20,21} Hence there is at least room for debate concerning the clinical decision to override a youngster's expressed consent through such forcible means as a court of law. Naturally, in some cases the court option will be the



In Re R Lord Donaldson stated that a competent child's right to consent did not include the right to veto treatment

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only one available without risking the life of the young person, but in lesser cases there will be increasing room for debate on this question.

In conclusion, practitioners are advised to proceed cautiously in treating children and young people whose consent is in doubt. Given the anomalies, seeking legal advice may well be appropriate in difficult cases, particularly when a young person withholds consent and serious consequences, including death, may ensue unless treatment is forthcoming. Individual cases may need to be brought before the High Court so that the option of lifesaving treatment can be debated in full.

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- 6 Re W (1992) *Weekly Law Reports* 3,758-82.

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Tempting fate: control of communicable disease in England

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Recent changes in the NHS have left many defects in the systems for the control of communicable diseases and infection and their surveillance and the management of outbreaks. Clear, explicit legislation is needed, placing the responsibilities on health authorities. New teams led by consultants need to be set up to investigate and manage outbreaks of communicable diseases of all types.

"We have an unrivalled system in the UK" for dealing with communicable diseases. So said Baroness Hooper of our arrangements for early warning of outbreaks of communicable disease in a speech to the Institute of Health Service Managers in March 1991.¹ We believe that our unrivalled system is out of date and needs substantial reforms.

The current surveillance system has three main components. The first is notifications made by doctors attending patients suspected of having certain specified infectious diseases. Notifications are sent to the proper officer of the local authority, who in turn informs the Office of Population Censuses and Surveys. This system is notoriously inaccurate²; many doctors not only do not know which diseases are notifiable but also seem unaware of their statutory duty to notify.^{3,4} This was one of the anxieties of the committee of inquiry into the future development of the public health function (the Acheson Committee) in 1988.⁵ The current list of notifiable diseases is lamentably out of date.⁶ Single cases of diseases which have emerged recently as important problems in public health are not notifiable in England, although, depending on the judgment of individual proper officers about what constitutes a serious outbreak, numbers of cases of these diseases might be brought to the attention of the chief medical officer.⁷

The second source of information is reports of isolates from public health laboratories, hospital laboratories, and a small number of private laboratories. These are collated by the Public Health Laboratory Service/Communicable Disease Surveillance Centre (PHLS/CDSC). The recognition of newly emerging diseases like cryptosporidiosis and legionnaires' disease depends on diagnosis in a laboratory but

reporting is voluntary. Concern (so far unsubstantiated) has been expressed that the number of specimens submitted to laboratories might fall with the introduction of the internal market into the NHS, so this important source of epidemiological data might be severely compromised in future.

Thirdly, information about the incidence of communicable diseases is derived from the sentinel scheme run by the Royal College of General Practitioners for reporting disease in general practice. The main drawback of this scheme is that it is patchy.⁸ The best results come from districts in which public health medical staff have established local surveillance including the use of "spotter" general practices.

There are, in addition, separate reporting systems for sexually transmitted diseases,⁹ HIV, and AIDS,¹⁰ and for new or rare diseases which appear periodically and require the establishment of special surveillance systems.

Two spectacular failures in the investigation and control of outbreaks of communicable diseases in the 1980s at Stanley Royd and Stafford hospitals precipitated the Acheson report, the most comprehensive review of the public health system in England since 1871.

Public health in England: the Acheson report

The Acheson report made two very important recommendations about the control of communicable disease and infection. The first was that districts should consider appointing full time consultants responsible for communicable disease control who would cover a sufficiently large population to develop and maintain appropriate knowledge. This was commended to authorities in official guidance.¹¹

The second recommendation was that the law relating to infectious diseases should be revised "as a matter of urgency" and the Department of Health issued a consultation document in 1989,¹² but sadly no progress has been evident. A Department of Health circular issued after the Acheson report raised expectations¹¹ but the responsibilities it suggested still lack any statutory backing.¹³

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