Post-Webinar Reflections

Reading time:
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Consent to medical treatment when children are involved.

At the heart of the doctrine of informed consent, lies the principle of patient autonomy, whereby all individuals have the right to decide what is done and not done to their bodies. Healthcare providers must uphold the autonomous choices made by adult patients, who have capacity at law to make those decisions. Except in limited circumstances, clinical interventions must not be performed in the absence of a patient's legally valid informed consent. Treatment provided without consent may amount to assault or battery, while treatment provided without fully informed consent may amount to a claim in negligence, especially if there is an adverse outcome associated with the treatment[1].

When informed consent to medical intervention involves children (i.e., individuals under the age of 18), other critical considerations come into play.

Where a child under the age of 18 requires a clinical intervention, attention needs to be given to who may lawfully consent to the treatment. The consent may be provided by:

- The child - if they are Gillick competent.
- The child's parent or guardian – if the child is not Gillick competent.
- A court of law – in the case of certain special procedures.

As with adults, it is generally unlawful to provide clinical treatment to a child without the consent of the child, or the consent of a person with the relevant authority to provide that consent on behalf of the child. To do so exposes the health care practitioner to a civil claim and potential criminal charges. However, there exceptions:

- At common law, a healthcare provider may treat a child in an emergency where the child cannot consent, and the child's parent is not available to provide consent and may also do so if the child has been abandoned and the child is not in the care of a person who is acting in the place of a parent (in loco parentis).
- Medical treatment may be authorised by legislation in cases of emergency. For example, emergency medical treatment may be administered without a patient's consent if necessary as a matter of urgency to save the person's life, prevent serious damage to the person's health or to prevent the person from suffering or continuing to suffer significant pain or distress (Medical Treatment Planning and Decisions Act 2016 (Vic), s 53).

Age majority and informed consent

At law, issues may arise as to whether and when[2]:

- A child may consent to his or her own clinical treatment.
- Parental consent is required and what happens if parents disagree.
- Court authority is required.

Generally speaking, a child's parents will possess the right to consent to their child's clinical treatment up until the time that the child possesses "a sufficient understanding and intelligence to enable him or her to understand fully what is proposed". This point at which a child can consent to his or her own medical treatment is referred to as "Gillick competence" and is based on an English decision, the case of Gillick v West Norfolk & Wisbech Area Health Authority, which received approval in Australia in the High Court case of Secretary Department of Health & Community Services (NT) v JWB & SMB (Marion's case) (1992) 175 CLR.

Can very young children be deemed to be Gillick competent?

There are seldom issues regarding the assessment of Gillick competence for very young children. It can only come to be even considered in situations where the child's understanding and intelligence raises the question of whether he or she may have a sufficient understanding and intelligence to enable them to understand what is proposed.

Where a child is an infant or so young as to clearly not be Gillick competent, then the parents are empowered to provide consent for the child's clinical intervention.

When will a child be Gillick competent?

A parent's right to consent to treatment for the child ends if and when the child has the capacity to consent to the treatment. A child will have that capacity when he or she has "a sufficient understanding and intelligence to enable him or her to understand fully what is proposed".

When can a child give valid informed consent independently of their parents or guardians?

The test is whether a child has achieved sufficient understanding and maturity to enable him/her to understand fully what is proposed and that the treatment it is in the best interest of the child. There is limited guidance on how a clinical practitioner should assess the competence of older children to give informed consent. Broadly speaking, the more complex or risky the procedure, the greater the level of understanding and maturity required. A child's age and insights into the nature of the treatment and its possible side effects are relevant.

There also jurisdictionally relevant considerations. In NSW, for example, children between 14 and 16 years of age have a legal right to consent to their own treatment[2].

Is it sufficient to have the consent of only one parent?

Unless a clinician is specifically aware that the parents have opposing views about treatment, it is generally sufficient for one of the child's parents to provide consent. The situation can be more complex where the parents have separated and there is a shared parenting order in operation which requires parents to cooperate on major decisions regarding their child. However, even in these cases a doctor may still rely on the consent of one of the child's parents.

What should a medical practitioner do when asked to release a child's health records and divorced parents disagree?

Either parent has the right to access to the child's medical records, unless the child is Gillick competent and refuses access to their record. In addition, if there is a parenting order or Family Court Order that prevents one parent from having access to the child or removes their parental rights and responsibilities, then that parent is not entitled to a copy of the child's record. However, this can be a complex situation and we recommend that you contact MIPS if these circumstances arise. This is because parents may be unwilling to disclose relevant information or you may require assistance with the interpretation of any orders and their relevance to the issue about access to records.

There are some other points to consider. First, you should confirm the identity of the person requesting the record, to ensure that they are in fact the child's parent. Second, it is often helpful to ask the parent requesting access to the record to evidence their request in writing.

What should a medical practitioner do when one parent requests they be called every time the child is brought into the practice by the other parent, but the latter parent doesn't consent.

As immediately above, either parent has a right to access information about the child unless the exceptions above apply. Again, you check the identity of the parent requesting the information if you have not previously met them or checked their identity.

Does parental consent apply to all types of clinical intervention?

Parental power to consent to a child's medical treatment does not apply to every type of treatment or procedure. For example, parents are not able to give lawful consent to treatment that is deemed illegal (eg. female genital mutilation). In addition, there are some types of major complex medical treatment where parental consent will be insufficient and court authority is required (eg. sterilisation of a child with an intellectual disability, gender-affirming surgery, or termination of a pregnancy).

What are the limits of parental power to consent to a child's clinical treatment?

The High Court in Marion's case clearly stated that there are "controls" or limits on parental power to consent at common law. Parents may only exercise their authority to consent to, or refuse clinical treatment for their child if it is in their child's best interests.

Where does a general practitioner stand with an eleven-year-old girl brought in by a carer who is not a legal guardian, where there is a suspicion that the child has been sexually active several months ago with boyfriend of the same age. The practitioner has been told that the situation has been reported. Is it necessary to report it again? Can the carer who presents at the consultation, give consent to clinical intervention of any kind?

Again, this is a complex situation, and you really should be ringing MIPS for advice here. First, if the carer is not the legal guardian, then you may be unable to physically examine the child because the carer is not legally authorised to make decisions about the child. Legal guardians cannot delegate their duties to a carer. However, if you believe that might be an emergency situation because of the risk issues raised, then you may be able to obtain a limited history from the child in order to ascertain the level of risk. Based on your assessment, you may need to assess whether you have an obligation to report suspected child abuse. The issue of when to report child abuse is also complex and it is recommended that you contact MIPS to discuss your obligations and responsibilities in given circumstances.

Self-reflection questionnaire

The following is a useful resource: https://aifs.gov.au/sites/default/files/publication-documents/2006_mandatory_reporting_of_child_abuse_and_neglect_0.pdf

This reading material is for educational purposes only. MIPS would like to acknowledge the significant contribution of Barry Nilsson Lawyers in developing this content.

[1] Medical Law in Queensland 2021 Course Notes. Barry Nilsson Lawyers.

[2] ibid

[3] Children and Young Persons (Care and Protection) Act 1998 - Sect 174.

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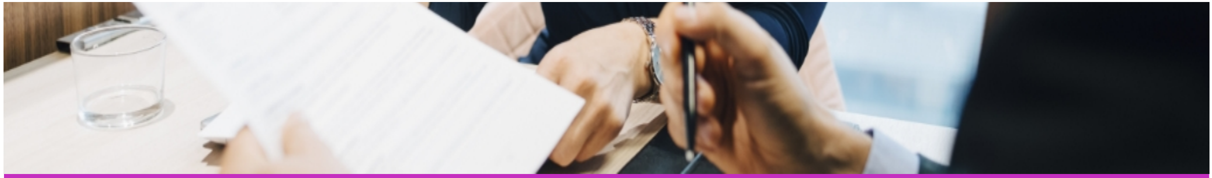

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