British Agencies for Adoption and Fostering

CONSENT TO MEDICAL TREATMENT FOR CHILDREN IN SCOTLAND

Note: References to

- *the 1991 Act mean the Age of Legal Capacity (Scotland) Act 1991*
- *the 1995 Act mean the Children (Scotland) Act 1995*

Introduction

This practice note is designed for use by staff in local authorities and others in Scotland, who are faced with the question: Who is entitled to consent to medical treatment for a child? This question, and other issues around it, frequently occurs in relation to children with whom the local authority is involved, whether or not the children are "looked after", at home or away from home. This is a very complex area of law and practice, and the practice note cannot provide all the answers to all the issues. However, it is hoped that it will be of assistance in many cases.

This practice note is concerned with children and young people under 16. Once a young person is 16, he or she has full adult legal rights to consent or not consent (see below, *Consent for young people of 16 and over*).

The question arises for *all* children, whether they are involved with a local authority directly, or not. The question may arise in a private law dispute between parents, or when a social worker is preparing a report, or providing some basic advice. The question may arise in relation to a child in school, with whom the social work department has no contact whatsoever. The practice note attempts to set out the general position for all children, and not just those "looked after" by a local authority.

Situations covered by the practice note therefore include:

- Children living at home with parents.
- Children living at home with non-parents.
- Children "looked after" at home (supervision requirement).
- Children "looked after" and placed away from home.
- Children placed for adoption.
- Children freed for adoption.

As stated, the practice note does *not* give all the answers. It is merely a starting point for the issues. It should also be borne in mind that the basic legal position of who can consent does not remove the general rule of good practice for all professionals, that it is important to work together with the child, parents and everyone else involved. One or other person may have the clear right to consent or refuse consent in relation to a child, but this in no way removes the need for all professionals to try to work with all family members, including the child, to carry through the necessary treatment, examination, etc. with the general agreement and confidence of everyone.

Finally, as will be seen from the detail below, the position for children and young people is different in Scotland from that in England. Different legislation applies and while some English cases may be relevant, such as Gillick v. West Norfolk and Wisbech Area Health Authority [1985] 3 W.L.R. 830, all the rules they lay down do not automatically apply in Scotland. There is little case law in Scotland in this area.

Children's views

In terms of the 1995 Act, courts, hearings and local authorities are obliged to take account of the views of children in making decisions about them. This can include decisions about medical treatment *but if* the child is the person who is entitled to consent (see below) then it is the consent that matters.

If the child is not entitled to consent, then, in good practice terms, and in terms of the 1995 Act, account should be taken of the child's views.

Medical consent in general

Medical treatment is lawful, either:

- with consent
- or in cases of urgent necessity (when consent cannot be immediately obtained).

It must be remembered that consent to medical treatment, whatever the age and capacity of the patient, is a matter that qualified medical

practitioners must always make a decision about. It is for the doctor or other practitioner to decide if he or she has the necessary, informed consent. The judgment is with the practitioner.

In some cases where emergency and necessary treatment is needed, the practitioner may decide that matters are so urgent that the treatment should not wait for the consent. Even then, however, it is the practitioner who is making a judgement: the treatment is so urgent that the consent is not necessary.

These points apply to all medical treatment including that for children and young people.

Consent for young people of 16 and over

For the purposes of medical consent, Scots Law treats the 16 year old as a full adult. He or she has the right to consent or refuse to consent to all medical, dental or surgical procedures or treatments, as any adult does. (See s1(1)(b) of the Age of Legal Capacity (Scotland) Act 1991).

The position is different from England and Wales, where parents have residual rights until the young person is 18.

Consent for young people under 16

The starting point for who is entitled to consent to medical treatment for an individual child is section 2(4) of the Age of Legal Capacity (Scotland) Act 1991. This says:

> *(4) A person under the age of 16 years shall have legal capacity to consent on his 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.*

This means that, for any child *under* 16, there is a right ('*shall* have legal capacity') to consent to any form of medical treatment and procedure, *if* the doctor, dentist or other medical practitioner takes the view that the child has capacity to understand

- *what* the treatment or procedure is
- *and* its possible consequences.

The understanding is in relation to the particular treatment or course of treatment. For example, a 10-year-old child may easily have the capacity to consent to the simple procedure of setting a broken arm, but not be considered capable of understanding all aspects of complicated treatments for leukaemia.

If a doctor, dentist or other medical practitioner takes the view that the child has the capacity to consent, then only the child can consent or not consent. The consent or refusal of someone else, such as the parent, is legally irrelevant, although good practice suggests involving the whole family in discussing issues and carrying the treatment forward if the child is in agreement with that approach. If the child has the capacity he or she is entitled to patient confidentiality.

If the doctor takes the view that the child does not have the capacity to understand the nature and consequences of the treatment, then it is necessary to consider who else has the right to consent or not consent (see below, *Who consents if not the child?*). But looking elsewhere for this consent is only an issue *if* the child does not have the necessary capacity.

The section says nothing about whether the right to consent includes the right to refuse to consent, but it is generally considered that this must be implicit in the provision:

> *In logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment.* (Balcomb L.J. in Re W. (A Minor) (Medical Treatment) [1992] 4 All E.R. 627).

The section appears to cover all types of medical treatment and procedures including examining children, diagnosis, treatments and all procedures which are not "treatments" in a strict legal sense. Further, the section applies to 'any surgical, medical or dental' type of treatment, and the phrase 'qualified medical practitioner' would appear to cover *all* practitioners duly authorised to carry out whatever the treatment or procedure is. It includes not only doctors and dentists, but also anaesthetists, nurses, chiropodists, midwives and all qualified health professionals.

Taking all this together, the test for the child under 16 is:

- Does the qualified medical practitioner think the child is able to understand the treatment, procedure, etc. *and* all the possible consequences or results?
- If the answer to that is "yes", then it is for the child to consent or not consent. The parental view is legally irrelevant.
- If the answer to the question is "no", then the medical practitioner must look further to see who has parental responsibilities and rights and/or the right to consent to medical treatment (see

below, *Who consents if not the child or young person?*).

The relatively clear (by legislative standards) statement in this section is often unknown to medical practitioners and other professionals working with children, as well as to parents. It is often assumed that parents automatically have the right to consent to medical treatment for the child at least until the child is 16, and many parents consider they have the right beyond then. In fact, this section makes it clear that the qualified medical practitioner must make an assessment of the child, in relation to capacity, for every treatment or course thereof; and, if the child has the capacity, it is the child who consents. Many parents find this very difficult to accept and may need support and help in allowing the child to exercise his or her rights. Further, many doctors, particularly those who do not regularly deal with children, may need to have the section drawn to their attention.

In practice, where the qualified medical practitioner, the child and the parents are all agreed on a course of action, it may not seem to matter whether the consent taken is that of the parent or the child, even where the child is clearly capable of understanding, and therefore consenting. However, all professionals working with children need to guard against overlooking children's rights and automatically proceeding on the basis that adults are the only people who have rights and whose views matter.

Who consents if not the child or young person?

The basic question, as always, is:

- Does the qualified medical practitioner think the child is able to understand the treatment, procedure, etc. *and* all the possible consequences or results?
- If the answer to that is "no", then the child is not legally capable of consenting, and it is necessary to look elsewhere for consent to treatment, examination, procedure, etc.

There may only be one person who can legally consent, or there may be a number of people.

Parents and others with parental responsibilities and rights

If the child has one or more birth parents, and the birth parent has not lost his or her parental responsibilities and rights through adoption, freeing or a Parental Responsibilities Order (PRO), then that birth parent has the right and responsibility to consent for the child who is not capable of doing so.

Apart from losing responsibilities in the above ways, a birth parent could also have the right to consent to medical treatment removed by a court order under section 11 of the 1995 Act, in which case he or she could not consent. This would be very unusual, however.

Assuming the birth parent still has some or all parental responsibilities, without full removal, then that birth parent is the person whose consent should be sought, both in terms of what the law says and good practice. If there are two birth parents with such parental responsibilities, it is not necessary to obtain the consent of both of them; the consent of one is sufficient (section 2(2) of the 1995 Act). If the views of the birth parents differ, then there is a difficult practice decision as to which consent to follow. Good practice would suggest that, if the treatment, examination, etc. is in the child's interests, and one of the parents is consenting to it, then the treatment should go ahead, but this could be a difficult area. There is really no right or wrong answer, although failure to treat and subsequent harm, because the qualified medical practitioner chooses to follow the non-consenting parent as opposed to the consenting one, could leave the practitioner open to a claim of failing to act in the child's best interests. However, this scenario of competing adults with parental responsibilities does not arise very often.

Unmarried fathers do *not* automatically have parental responsibilities. They may have acquired them:

- by agreement under section 4 of the 1995 Act;
- or because of a court order under section 11 of the 1995 Act.

As well as birth parents, other adults may have obtained parental responsibilities and rights, or some of them, under an order under section 11 of the 1995 Act. Again, if the doctor is satisfied that the person whose consent is given has the legal right to do so, that consent will be sufficient.

It is *not* necessary to get the consent of everyone who has parental responsibilities and rights. There may be competition between different people with parental responsibilities, as outlined above.

Carers

As well as people with parental responsibilities and rights, people who are normally "carers" of a child may also consent to medical treatment in certain circumstances. Under section 5 of the 1995 Act, any 'person who has attained the age of 16 years and who has care or control of a child under that age' but no parental responsibilities or rights may consent to

medical treatment if:

- the child him or herself is incapable of consenting; *and*
- the carer has no knowledge that a parent of the child would refuse to consent.

This second criterion is a relatively low test. The carer does not need to know positively that the parent would consent; the carer merely needs to state that he or she has no knowledge that the parent would refuse to consent.

This provision covers a wide variety of carers. For example:

- Unmarried father without parental responsibilities, but caring for a child either permanently, or merely for a few hours;
- Grandparent, etc. similarly caring for child;
- A babysitter;
- An approved foster carer or approved adopter;
- Anyone else looking after a child in the short or longer term.

It does not include school teachers or managers of schools or people under 16. Again, the consent of one person only is needed, and even if there is a birth parent with parental responsibilities and rights, the carer is able to provide consent, in terms of section 5.

There are obviously considerations of good practice. It is not always appropriate to take the carer's consent when the birth parents consent can easily be sought. However, if the birth parent is away, or unobtainable, or, in the situation of a child in foster care, does not keep regularly in contact with the local authority, the fact that the carer can consent may be useful, and avoid unnecessary delay until the parent is found.

"Looked after" children

If a child is "looked after" this does *not* normally give the local authority the right to consent to medical treatment on behalf of a child. Whether the child is at home or away from home, parental responsibilities and rights usually remain, more or less, with the parents. The local authority may have a signed general consent form from the parent, allowing medical treatment, but this is the parent's consent, used by the local authority, not the local authority themselves consenting. Most local authorities ask parents if they will sign such a form when a child is placed away from home. There is no obligation on parents to agree.

The only clear exception to the above is where the child is "looked after" because he or she is subject to a PRO under section 86 of the 1995 Act. In that situation, all parental responsibilities have been passed, by virtue of the PRO, from the parent to the local authority, except the right to consent or not to consent to adoption. In that circumstance, the local authority are the child's parents for almost every purpose, including giving of consent for medical treatment.

Another exception for "looked after" children is when the child is the subject of a Child Protection Order, a Child Assessment Order, a warrant or a supervision requirement *and* the order/warrant/requirement has a condition authorising medical treatment. In those situations, it is presumed to be safe for the doctor to take that authority in place of the consent from the parent. Such conditions have only been possible since 1 April 1997, and there is no case law as yet.

Such orders, etc are not likely to be granted unless *either*:

- the parent is completely refusing treatment etc. and the sheriff/hearing think treatment is necessary; *or*
- the parent is unavailable to give such consent. The granting of a Child Protection Order or Child Assessment Order, or the issuing of a warrant or supervision requirement, does *not* of itself transfer parental responsibilities and rights from the parent to the local authority. However, if these orders have the appropriate conditions attached, the parent's right to consent or refuse medical treatment is interfered with.

Child freed for adoption

If the child has been freed for adoption, in terms of section 18 of the Adoption (Scotland) Act 1978, then the local authority has *all* parental responsibilities and rights, and the birth parents have none. The child may or may not be "looked after" by virtue of other legislation, but a child who is freed is not, by virtue of the freeing order, "looked after". However, there is no doubt that it is the local authority who would consent to medical treatment on behalf of the child, and not the birth parent.

Specific issue orders

If it is necessary to seek an adult consent to medical treatment, and none of the above situations apply, an individual (*not* the local authority) can apply to the court under section 11 of the 1995 Act, for a specific issue order. A doctor, a foster carer, possibly even a health care trust, can apply for an order about a specific matter, including medical treatment (section 11 (2)(e)). Even if the birth parent or other person with a right to consent, including the local authority, has refused consent, it is possible for an application to be made under this section to override that

refusal, if the court sees fit. This has only been possible since 1 November 1996, and there is no case law. Scottish courts will not lightly rush into the making of such orders, but obviously, if a child's life is threatened in the long term, a court may be persuaded to give the necessary consent; or, indeed (as has happened in England), to give authority to withhold or withdraw treatment, even lifesaving treatment.

The Children (Scotland) Act 1995

This Act has already been referred to. The question is often asked: Did the Act change the position about medical consent for children? In many ways, it did not, except to make it clearer than before that the child, when he or she is capable of consenting, has the right to do so and that includes the right to refuse the consent. The Act does not interfere with a child's rights, but it does allow the parents' rights to be overruled if need be.

The basic legal provision for medical consent for children still remains the 1991 Act section 2(4) (see above). However, it is useful to list the provisions in the 1995 Act which deal with medical treatment, to put them in the context of the issues that arise.

Section 5

This is covered above under *Who consents if not the child or young person?*. This section allows any carer to consent to medical treatment for a child, if the child is not capable of consenting *and* the carer has no reason to believe the parent would refuse. See above for more information on this.

Section 11 orders

One of the orders able to be granted by a court is a specific issue order. In terms of section 11 (2)(e) the court can grant 'an order regulating any specific question which has arisen, or may arise in connection with' parental responsibilities and parental rights. Again, see above under *Who consents if not the child or young person?*.

Any person can apply for such an order, but the local authority is specifically prohibited from using section 11. These orders can relate to any topic, not just medical consent, but obviously one of their uses could be in this area.

Child Protection Orders, Child Assessment Orders, warrants and supervision requirements

These are dealt with by sections 57 & 58; section 55; section 66, 67 & 69; and sections 70 and 73 respectively. In terms of these provisions, the sheriff, when granting a Child Protection Order or Child Assessment Order, and the hearing, when issuing a warrant or making or varying a supervision requirement can add a condition about medical consent to examination, treatment, etc. Again, see above under *Who consents if not the child or young person?*.

Section 90

This section makes it clear that nothing in relation to the children's hearing system, local authority powers and duties or the powers and duties of the sheriff in granting orders, etc. interferes with the capacity of the child to consent to medical treatment, and to refuse to consent. The section goes on to say that, while an order or warrant or supervision requirement may require a child to submit to any examination or treatment, this cannot be carried out unless the child consents, if the child has capacity to consent. As indicated, it is not that this is a change from the 1991 Act, but it clearly emphasises that where the child has the capacity to consent, that consent is required.

A similar provision is to be found in the Arrangements to Look After Children (Scotland) Regulations 1996, regulation 13. This instructs local authorities to have medical examinations carried out for children before or just after they become "looked after" and placed. If the child is capable of consenting, such examinations can only be carried out with the consent of the child.

Confidentiality

The question of confidentiality is an extremely difficult one for all professionals, clients and parents. The 1991 Act does not talk about confidentiality of information, but only about the right to consent to medical treatment. However, it is safe to say that if a child is deemed capable of consenting to treatment, or refusing to consent, the child must also be deemed entitled to confidentiality on the matter. Best practice may attempt to bring the child and parents and others together, but this can *only* be done with the consent of the child, and the child's confidentiality must be respected. Generally speaking, not just in the area of medical consent, there is no legal obligation to tell a parent everything that a child says in all circumstances.

Best practice

While the legal position may or may not be clear cut in any given case, nothing in the legal provisions takes away from the duty of all professionals to deal with the case in the way best suited to the child and family, and involving all parties and other

professionals as much as possible. Just because the child has the right to consent does not mean that the parents' view should be excluded *if* the child is happy for matters to be discussed with them. (see above, *Confidentiality*). All professionals working in this area – medical, social work, legal, education and others – should work to keep or bring a family together on such matters, so far as is possible, bearing in mind the child's confidentiality. However, there is no *obligation* to consult with the parents of a child capable of consenting.

However, at the end of the day, if the child is capable of consenting and is consenting to something which the parent disapproves of, or is refusing to consent to something, then the child's right takes precedence and best practice has to work on that basis. Similarly, if a parent is refusing to consent to treatment which the professionals consider is appropriate, they need to consider whether they should take other steps to override that refusal.

Contraception and abortion

Particular questions about consent and confidentiality are often asked in relation to contraception and abortion. If a young person approaches a doctor for advice on contraception, whatever the outcome, that confidence should be respected, as with an adult, even if no treatment is given. It would be a breach of confidentiality for a doctor to tell a parent that his or her daughter had sought contraception advice, without the consent of the child.

The only exception to that, as with all other matters, is where the child is at risk and information may need to be disclosed in order to protect the child. Where the girl is under 16, it could be argued that, in seeking contraception, she is "at risk" of being a victim of a Schedule 1 offence. But it is not always appropriate to inform the local authority or the police. Medical practitioners have a right *not* a duty to inform the local authority of children "at risk". However, such disclosures would not normally be to the parent but to, for example, the local authority or the police.

Similarly with abortion. In all but the cases where a girl has serious learning difficulties, consent to abortion or refusal of such consent is a matter for the young person. Good practice dictates considerable support and counselling and reasonable attempts to involve the family *if* the child agrees. At the end of the day, however, it is for the girl to decide and not her parents.

Other issues

It is particularly difficult to decide the question of consent in relation to a young person who is under 16 and suffering from diabetes, anorexia nervosa or some other ultimately life-threatening condition. If such a young person requires treatment as a matter of urgency, that treatment can be given, as with any adult. On the other hand, if the young person is under 16 and refusing treatment, it is very difficult for medical practitioners and parents not to feel that the child's refusal should be overridden. This is a very difficult area to deal with but if the child has the capacity to consent or refuse to consent, the medical practitioner and the parents must consider:
is it proper to override that refusal just because the young person is under 16?

If the young person was 17 (and therefore clearly legally the person to consent or not) it would not be possible to override that refusal. Should physical age interfere with a test which is based on mental capacity?

Another difficult issue arises in relation to the attitude of parents. Many parents find it difficult to accept that their children have rights, even when they are 16, let alone when they are under 16. Even in straightforward cases where there is no real dispute between the parents and the child, it may be difficult for some parents to accept that it is the child's consent that is taken and not theirs. Best practice would suggest that work has to be done with such families, attempting to bring the parents round to a reasonable view of respecting the child's position generally, including their rights in this area.

Conclusion

This practice note covers the main legal points in this area, and attempts to look at a number of the issues that arise. As indicated already, this is a very difficult area of the law and practice and there are few easy answers.

As with all issues to do with consent to treatment, doctors may wish to seek advice from the British Medical Association and its Ethics Committee, the General Medical Council and other professional bodies. However, it must be remembered that the legal position in Scotland *is* different from England.

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