

Confidentiality and treatment of young adults

Proposals for amendments: the *Gillick* Proposition

Dr Ann Marie MANGION

ABSTRACT

The law does not determine between legal competency and actual competency of minors in medical issues. The objective of this paper is to put forward proposals to amend the legislation to redefine legal competency on the base that understanding should have more bearing than age.

The English landmark case of *Gillick* is used to analyse the Maltese situation. The Maltese legislation was examined and it resulted that there is no legal definition of what competency is. Various legislations use different ages to define competency. The Genito-Urinary (GU) Clinic was even given permission to assess a minor's competency itself and if it is determined by the medical professional that the minor is competent then such minor will be treated without the need for parental consent.

To substantiate the claim, in 2009 the researcher carried out empirical research using both qualitative and quantitative methods. Questionnaires were given to children aged between 6 and 18. Structured and semi-structured interviews were used to interview legal and medical professionals involved in the field.

By triangulating the results the conclusion reached is that minors do seek treatment without parental consent and that there are medical professionals who already treat minors without parental consent. There is the need for legal reforms to substantiate the reality of actual competency of minors.

Key words: competency; parental consent; *Gillick*; best interests; minors

INTRODUCTION

The main aim of this research was to determine whether age is more important than understanding when it comes to a minor's competency to consent to medical treatment. The law on competency is age-based. Therefore, the research question is whether understanding and maturity should form the basis of

determining a minor's competency to consent.

One can start off the discussion by defining what the legal definition of 'childhood' is. A quick look at the various Maltese legislative documents conclude that there is no such definition. The only terms used in the Maltese Civil Code to refer to the various stages of childhood are 'minors' and 'children'. Article 157 of the Civil Code (Chapter 16 of the Laws of Malta) defines a minor as 'a person of either sex who has not yet attained the age of eighteen years'. This reflects the United Nations Convention on the Rights of the Child (UNCRC), wherein a child is defined as 'every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier' (Part 1, Article 1). 'Juvenile' is used for children who have been caught up with the criminal justice system.

Minority and childhood has been artificially construed by society to give definition to such concepts as the age of majority. The age of majority has changed over time. In the past the age of majority was twenty-one which was then lowered to eighteen. Thus competency was attained at eighteen instead of at twenty-one. According to the UNCRC, the right of participation belongs to all children, and due weight to their opinion is given according to their age and maturity. Therefore, a new notion, has been introduced, that of maturity, in other words, understanding.

The Ministry of Health in New Zealand (Ministry of Health, 1998, p. 43) put forward two approaches to determine competency:

(1) The 'status' rule:

Children from eighteen years upwards can consent to treatment.

(2) The maturity approach:

A child's competence, even if he is under eighteen years of age, is determined as to whether he has sufficient knowledge or understanding of the consequences.

Justice Thorpe in *Re C (Adult: Refusal of Medical Treatment)* defined the legal test for competence as being 'first comprehending and retaining information, secondly, believing it and thirdly, weighing it in the balance to arrive at a choice'. In other words this is the basis of an informed consent be it for a child or an adult.

Children are differentiated according to their understanding. Sixteen is an age of great significance in the Maltese legal system because at sixteen one can get married, one can work, one can be emancipated and carry out commercial acts of trade and yet one cannot seek medical treatment by himself except at the Genito-Urinary (GU) Clinic. Moreover, through research which will be shown further on it transpires that at that age young adults are already seeking out treatment by themselves and sometimes with their parents' blessing!

It is suggested by the British Medical Association (Shaw, 2001, 151) that a child's competence should include:

- (1) The ability to understand that there is a choice and that the choices have certain consequences;
- (2) The willingness and ability to make a choice even if that choice entails that someone else makes a choice for you;
- (3) The understanding of the nature and purpose of the procedure;
- (4) The understanding of the risks and side-effects of the procedure;
- (5) The understanding of the alternative treatments available and of their risk and the understanding of choosing not having any kind of treatment;
- (6) There is freedom from any kind of pressure.

Shaw (2001, p. 152) states that children who have a healthy and supportive relationship and who are allowed to participate in the decision-making process are more likely to be competent. It is also imperative that the child has a trustworthy relationship with the doctor, and the child must be given adequate information about the procedure in an appropriate way fit for his age. For the child to be competent, such child must be free from pressure, panic, pain and any other temporary debilitating factors such as fear (Shaw, 2001, p. 152).

Understanding should include the comprehension of the nature of the illness; the nature of the recommended intervention and of any alternative treatment available; the risks or benefits and the long-term consequences of having such intervention or not; that a decision must be made and that a decision has consequences (Shaw, 2001, p. 152).

GILLICK TEST

In *Gillick v. West Norfolk and Wisbech Area Health Authority*, the age versus understanding debate was clearly tested, wherein the House of Lords recommended that the arbitrary chronological age should be replaced by a test of maturity. Likewise this has been adopted in other countries such as New Zealand and Australia. This test places an additional burden on the clinician in order to secure that the child is indeed competent, but such a test is essential to safeguard the rights of the child (UNESCO, 2007). Before providing medical treatment, the practitioner must determine whether the child below sixteen years of age has the understanding and maturity to form a balanced judgement about the proposed treatment (Ministry of Health, 1998, p. 13).

If so, the child can be treated without obtaining parental consent and, if not, parental consent must be obtained before treatment is administered (Ministry of Health, 1998, p. 13).

The Court in *Gillick* said that the practitioner should encourage the child to involve the parents but if the former does not want to, then the practitioner has to respect the child's wishes and proceed with the treatment if it is in the child's best interests and if the practitioner is satisfied that the child has the sufficient maturity and understanding to take such a decision. The latter is deduced not from a fixed chronological age but on a case by case basis. Lord Scarman adds that '...Parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.' Ekeelaar (1986) observed that his quotation was interpreted quite literally to mean that the attainment of competence by the child would terminate parental responsibility over the matter in question and would give the child an exclusive right to decide.

The 'Gillick Test' was held as consisting of three steps:

- (1) If a doctor is of the view that the procedure can be said to be in a child's best interests, and
- (2) If that doctor cannot persuade the child to tell his/her parents, and
- (3) Provided that the child is able to understand the nature and consequences of the medical procedure.

After the three steps have been taken, then the child is competent to consent without the knowledge or consent of his/her parents.

However Carabott (2008) stated that 'the child's best interests' should be rephrased into 'the patient's

best interest'. We must stop looking at the child as a child but we should look at the child as a patient when he seeks medical advice.

Article 9(i) of Malta's Commissioner for Children Act states that children should be given the 'highest standards of health'. However if a competent minor is deterred from seeking medical help because he/she does not want parental involvement, then such minor is not being given the highest standards of health. By imposing parental consent for treatment or therapy one is breaching Article 24 of the UNCRC which states that no child should be 'deprived of his or her right of access to such health care services'.

Sub-article 10(d) of the same Act states that children should be allowed to participate in the decision-making process. This sub-article is very pro-*Gillick*.

The Public Health Act (Chapter 465 of the Laws of Malta) considers health issues which are of public concern. The requirement of consent is removed and it is the Superintendent of Public Health who decides and takes decisions affecting public health. Nevertheless, consent in this Act is defined as 'approval given by an individual without any force, fraud or threat' (Article 2). It is interesting to note that this definition is not constrained to adults only but it is open to any individual who feels free to give consent without any duress of any kind.

Article 3(2) of the Mental Health Act is very interesting as it sets an age lower than the traditional age of competency. It states that if a minor is aged sixteen years and upwards and is capable to form his own opinions (usually formed if the child has sufficient understanding and intelligence – that is *Gillick* competent) such minor can be informally admitted to the mental hospital without the need of any parental consent. By setting the age limit at sixteen, this article shows that the traditional concept that competency is reached on the 18th birthday is outdated.

Consent is a form of contract undertaken by the person giving the consent in return for health treatment (Cauchi et, 2006, p. 26). Article 960 of the Civil Code defines a contract as 'an agreement or an accord between two or more persons by which an obligation is created'.

For a contract to be valid, one of the requisites is the appropriate capacity of the parties and Article 188(1) of the Civil Code states that minors who have not yet reached the age of eighteen are incapable to contract. However as per Article 969(2) such rule is diminished to the extent that a contract entered into by a child between the ages of nine and fourteen is valid in so far as it in

his favour. However, as per Article 970, for those who entered into a contract at fourteen years of age, such contract will be legally valid.

This clearly shows that in the eyes of the law minors from the age of fourteen years upwards have the faculty to contract if such contract is deemed to be valid, and for children from the age of nine upwards the law felt that they also have the faculty to contract but since they are still young it feels the added need to protect them by upholding the agreement if it is in the child's favour.

Perhaps the most important document which strengthens the argument in favour of adopting *Gillick* competency in Malta is a letter by the Medical Council to the Doctor-in-Chief at the GU Clinic. The Medical Council quoted Article 7(1)(a) (repealed by Act XII of 2003) of the Medical and Kindred Professions Ordinance which states that medical practitioners are bound to practise their profession without any delay and to prescribe the appropriate remedies.

The Medical Council rightly interpreted this provision as stating that the parental consent of the minor is 'subordinate' to the innate medical profession to help out and to prescribe remedies. Thus a medical professional need not obtain parental approval before treating the minor.

This interpretation adds strength to the argument in favour of *Gillick* competence since medical help should not be held back from minors because of lack of parental consent. This principle should also be applied where a competent minor seeks medical help on his own initiative.

In the Regulations no distinction is made between minors and adults since only the term patient is used. This can be taken to mean that in medical eyes no distinction should be made between a minor or an adult since both are patients.

Consent under the Clinical Trials Regulations is defined as informed written consent by 'any person capable of giving consent' (Article 3 of SL 458.43). Article 5(a) of the Regulations states that although parental consent is required, such consent must 'represent the minor's presumed will' and if not, it can be 'revoked at any time'. Article 5(b) and (c) are very pro-*Gillick* competency as well – a clear indication that Europe is moving towards adopting competency according to maturity and intelligence instead of the traditional age determined competency. They state that the minor should be given sufficient information according to his intelligence and if the minor 'is capable of forming an opinion and assessing this information' such opinion

will be given 'due consideration'. Therefore the criteria of competency in this sub-article are two: the ability to form an opinion and the ability to assess such information. This is similar to *Gillick* competency's sufficient understanding and intelligence because the child must have enough understanding and intelligence to be able to assess the information and form an opinion.

METHOD

As part of my research on the subject matter, in 2009 I conducted quantitative and qualitative research.

Quantitative research involved school children from Grade 2 to 6th Form. The students selected were from church schools so that the study covers as wide a spectrum of students as possible since these students come from all over Malta. The study consisted of a questionnaire with carefully selected questions and the purpose was to find out what minors think about competency and how they look at taking medical decisions for themselves. Questions were given out to each student in each classroom and were filled out without any parental assistance. The questions were a mix of 'yes' or 'no' answers and open ended questions. Parental consent was obtained for each minor involved in the study. The study was anonymised.

Qualitative research involved structured and semi-structured one-to-one interviews with legal and medical professionals. The interviews were not recorded. The transcript was sent out to the interviewees for approval. The study was not anonymised.

Research ethics clearance was obtained from the University of Malta Research Ethics Committee.

RESULTS

Despite their young age, the results for males aged 6-13 years show that male minors want to be active decision-makers in their own health. Fifty-seven per cent of 237 male students in this category believe that they should be the ones taking the decisions as shown in Q.19. However, as they know that they are young, they feel that their parents should be present when the doctor is explaining the illness and the available treatment. This is shown by 66% answering 'No' to Q.18 being 'Do you prefer that the doctor tells you and not your parents what you are suffering from?' Answers to Q.14 show that 19% wanted to go to the doctor and their parents still didn't take them – this is quite alarming.

If *Gillick* were to be implemented, these minors would be able to go to the doctor on their own. In fact a 12 year old wrote that he had gone to the doctor on his own

because of an earache. This shows that minors do care for their health and some are mature enough to actually go to the doctor even though their parents disagree. A poignant remark was made by a 10 year old who wrote 'I would like that the law would leave us and make a decision by our own'.

Sixty per cent of 112 male minors interviewed between 13 and 16 years prefer that the doctor speaks to them and not their parents about what they are suffering from, leaving them at liberty to tell their parents themselves as shown in Q.20. Thus minors in this age group value the issue of confidentiality. A 15 year old boy wrote 'If there is a sex-transmitted disease, I wouldn't want my parents to know.' This can be contrasted with the fact that 89% stated that presently the doctor addresses their parents rather than them about their health as shown in Q.23.

In Q.19, 96% would like the doctor to tell them exactly what they are suffering from. Two 15 year olds wrote that as teenagers they should be informed about their health and be allowed to take decisions. A 14 year old wrote 'Children have the right to know when it comes to their health on their own demand'. Another 14 year old wrote '*Iddiskuti mal-ġenituri imma id-deċiżjoni finali int teħodha*'. ('Discuss with parents but you must make the final decision.') Although parental involvement is welcomed, minors in this category want to be the ultimate decision-makers.

Even though presently they are legally incompetent, 19% of the minors have already gone on their own to seek medical advice without parental consent as shown in Q.13, and when asked why in Q.14, the answers varied from mere sickness, influenza and pain to fracture, sports related injury, to how their body works, while some opted to just write confidential.

As they grow older minors become less dependent and parental responsibility fades into parental guidance. In fact in Q.21, 84% of 218 males who filled out the questionnaire aged 16-18 years believe that they have the right to decide themselves for their own health. The majority remarked that maturity is the key to decision-making and not age. Twenty-five per cent of respondents aged 16-18 actually made health visits without their parents' knowledge. This is an increase of 6% on minors aged 13-16 (19%). The independent visits included a number of reasons such as mere medical advice, cough and influenza, chest pain, stomach problems, asthma, fungi in feet, severe neck pain, knee injury and muscular pains, respiratory problems, insomnia, infections, ear blockage, nutrition advice and sexual advice.

An 18 year old wrote that 'When people are over 16 they should have an option to keep their health issues private. Otherwise psychologically they will not be so ready to visit the doctor, subconsciously knowing that their information will not remain confidential'.

Almost half of the 205 female minors aged 6-13 years prefer to be able to decide by themselves in Q.19. In Q.18 70% said that they prefer if the doctor talks to them and their parents simultaneously. A 13 year old girl wrote 'Health is important for our life. It's important that our parents know what I have'. Another wrote 'I would let my parents to come with me to the doctor if needed'. In Q.17 91% prefer if the doctor tells them what they are suffering from. A 13 year old girl wrote 'Health is very important. I like that doctors tell me the truth even if it is a bad thing'. The Chairman of Paediatrics, Prof. Simon Attard Montalto during the interview said that the majority of minors know what is in their best interests and this is shown in Q.14 where 17% wanted to go to the doctor and their parents did not take them. A 12 year old wrote 'Sadly a lot of parents don't let their children know what they are suffering from and sometimes the parents don't take action, after their children say they are sick'. If *Gillick* competency were to be applied minors could go to see the doctor by themselves.

All 98 (100%) female minors aged 13-16 years who filled out the questionnaire prefer that the doctor tells them exactly what they are suffering from and 69% believe they have a right to decide by themselves as shown in Q.21. A 15 year old wrote '...sometimes because we're young certain parents do not take notice of their children and ignore what young pupils have to say'. However 64% prefer parental participation as shown in Q.20. A 14 year old wrote 'I think I'm mature to take decisions but it's always right to ask for parent's opinion'. Six per cent visited the doctor on their own because of a cold, a dental appointment, prescription for eye infection, pain in the stomach and one girl went to the doctor because of a sore throat with her parents' permission to go on her own. Therefore these parents already consider their minor daughter competent enough to go to the doctor on her own.

A majority of 80% of 181 females aged 16-18 years (Q.21) believe that they should have the right to decide on health issues with 55% (Q.20) preferring that the doctor tells them and not their parents about their health and 96% (Q.19) preferring that the doctor tells them exactly what they are suffering from. A 16 year old wrote 'One should go in to see the doctor on their own'. Another 16 year old wrote '...if a person, even if

under age, has an illness like cancer, she should be told as it is her life'. Another 16 year old wrote 'Information about general health should be more available to people my age'. Sixteen per cent stated that there were times when they wanted to go to the doctor and their parents didn't take them as indicated in Q.16, while 13% actually visited the doctor on their own as shown in Q.13, for various reasons amongst which general sickness, check-up, influenza, throat, advice and consultation, ear infection, strong headaches, stomach pain, stress migraines and physiotherapy. One of them was refused medical assistance because she was underage.

DISCUSSION

The conditions of confidentiality are twofold: firstly the practitioner must agree not to disclose the patient's secrets and secondly the patient must disclose information which he deems secret.

Jackson (2006, p. 33) observed that in England competence doesn't determine confidentiality as the latter is extended to minors independently of whether they are competent or not and disclosure to parents is carried out only if the practitioner feels it is in the child's medical interests.

In Malta the confidentiality of a minor whether he is competent or not should be respected. This conclusion has been extracted from regulation 12(a) of Schedule A and regulation 5 of Schedule B of SL 94.15 (Ethics of the Medical Profession Regulations) where it states that medical practitioners and dental practitioners shall not breach patient confidentiality without the patient's consent preferably in writing. No mention is made to the age or competency of the patient or not thus following in the vein of England's British Medical Association (BMA).

Age is an artificial method to assess competency. Competency is gained through maturity and maturity is gained gradually and not everyone attains maturity at the same time. This is why *Gillick* competency is the best method to ensure that minors are not discriminated against by denying them the right to decide because they are not yet legally competent, when in fact on the basis of their maturity they are competent.

However, although age should not be the factor to assess competency, a cut off age delineating when parental responsibility ends and minors become fully competent in the eyes of the law, should be retained, and 16 seems to be the best safe age for the following reasons:

- (1) At 16 minors are legally entitled to work; can terminate education; carry out acts of trade and even get married;

- (2) Care Orders are issued till 16, the Child Development Assessment Unit (CDAU) and the Child Guidance Unit (CGU) cater for minors till 14 and 16 respectively;
- (3) The study conducted among school children revealed very clearly that the majority of minors deem themselves to be mature enough to be able to take decisions regarding surgery, vaccinations and blood tests at age 16;
- (4) The opinions drawn up by the various medical and legal professionals.

As evidenced by the past, the age of competency is not a sacrosanct age but one which needs to be adapted to the different ages.

In the not so distant past the age of competency was 21, and then it was lowered to 18. More and easier access to education and information resulting in higher levels of knowledge calls for a decrease in the age of competence. Sixteen is the perfect age for health competency since it coincides with various other forms of competency such as work and marriage.

Maturity is the real test of competency and anyone below 16 should have the right to be able to decide regarding his health if he is deemed mature enough. The right to access to health should not be denied to a minor simply because he does not have the appropriate parental consent. If the minor is mature and seeks help regarding his health, such minor should be deemed competent and given the required medical assistance. Sufficient understanding and intelligence can be assessed by the minor's understanding of the nature of the illness, the risks and benefits of the treatment or of no-treatment, any alternative treatment, and the ability to arrive to a reasoned decision.

A committee should be set up within the Medical Council to serve as guidance to all medical practitioners when it comes to assessing competence. The committee should be formed by legal professionals and health professionals ranging from paediatricians, child psychologists, child psychiatrists and other professionals whom the Medical Council deems fit to appoint.

Parental participation differs from parental consent in that the former refers to mere moral support and/or guidance of the parents whereas parental consent is the legal requirement that parents should give on behalf of their child.

Parental participation should always be encouraged as parents can contribute to the minor's health by giving advice and moral support.

However parental participation can never be imposed. Therefore if the minor wishes not to have parental involvement, such choice should be respected.

A new legislation is being proposed to contribute to the requirement that competent minors should be allowed to be able to decide for themselves. The proposed legislation is to be modelled on English legislation namely S.8 of the FLRA 1969, and the Children (Scotland) Act 1995 and New Zealand's Guardianship Act 1968 as general guidance.

CONCLUSION

The following Legislation on Consent is proposed:

Article 1: Consent by persons over 16 to any health treatment:

The consent of a minor who has attained the age of sixteen years to any health treatment be it surgical, medical, dental, psychological or psychiatric and any ancillary treatment, which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this article given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

Article 2: Consent by persons under 16 to any health treatment:

The consent of a minor who has not attained the age of sixteen years to any health treatment be it surgical, medical, dental, psychological or psychiatric and any ancillary treatment, will be valid only if such minor has sufficient understanding and intelligence, and such consent shall be as effective as it would be if he were of full age. A minor who has by virtue of this article given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.

Sufficient understanding and intelligence means to be able to analyze the risks, benefits and consequences of the proposed treatment and of any available alternative treatment and to be able to arrive to a reasoned decision.

The following Legislation on Confidentiality is proposed:

Article 3: Confidentiality of Minors:

- (1) The confidentiality of any minor, competent or otherwise to any health treatment be it surgical, medical, dental, psychological or psychiatric and any ancillary treatment, shall be upheld as it would be if he were of full age.

(2) An exception to the abovementioned sub-article will be allowed where the minor is at risk of harming himself/herself or others be it through his direct or indirect actions.

The benefits of the proposed legislation is the general move towards accepting the competency of minors who are mature enough to be able to decide for themselves, increased access to healthcare to minors who without such legislation would not have sought such healthcare, and alleviating the Court from having to give medical authorisation where parents withhold their consent.

ACKNOWLEDGEMENTS

I would like to thank Prof. Pierre Mallia for giving me the opportunity to present my research at the seminar organised by The Bioethics Research Programme of the Faculty of Medicine and Surgery in collaboration with the Medicine and Law Programme of the Faculty of Laws, University of Malta & Office of the Commissioner for Children, entitled, 'Confidentiality and Treatment of Young Adults: Proposals for Amendments' (17 October 2012, Medical School Auditorium, Mater Dei Hospital, Malta).

Source

This paper is a summary of my Doctor of Laws thesis entitled, *Competency and Best Interests of the Child relating to Health Issues – A Maltese and International Legal Perspective* which was also published as a monograph by VDM Verlag in 2010.

Reference

- British Medical Association and the Law Society, 1995. *Assessment of Mental Capacity, Guidance for Doctors and Lawyers*. BMA, London
- Cauchi, MN, Aquilina, K, and Ellul, B, 2006. *Health, Bioethics and the Law*. MUP Malta.
- Ekeleaar, J, 1986. *The Eclipse of Parental Rights* 102 LQR 4.
- Gillick v West Norfolk Wisbech Area Health Authority*, [1986] 1 AC 112, [1985] 3 All ER 402, [1985] 3 WLR 830, [1986] 1 FLR 224, [1986] Crim LR 113, 2 BMLR 11
- Interview with Dr. Philip Carabot, Doctor-in-Chief, GU Clinic (Floriana 11th December 2008)
- Jackson, E, 2006. *Medical Law: Texts, Cases, and Materials*. OUP, Oxford.
- Ministry of Health, 1998. *Consent in Child and Youth Health: Information for Practitioners*, Ministry of Health, Wellington
- Re C (Adult: Refusal of Treatment)* [1994] 1 FLR 31, 37
- Shaw, M., 2001. *Competence and Consent to Treatment in Children and Adolescents* 7 APT 150
- The United Nations Convention on the Rights of the Child
- UNESCO, 13 April 2007. *The Working Group of IBC on Consent, 'International Bioethics Committee'* (Draft Report) (Paris) SHS/EST/CIB-13/O6/CONF.505/2 Rev.1, 12.

Dr Ann Marie MANGION

LL.B., LL.D., LL.M (Family Law) (Lond.), M.A. Mat. Can. Law (Melit.)
Family Law and Medical Law
Email: annmarie@mangionlegal.com