CONSENT TO MEDICAL TREATMENT OF YOUNG PEOPLE

Submission to Queensland Health: Review of *Health Act 1937* - New Population Health legislation for Queensland
MP 14

Queensland Law Reform Commission
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HOW TO MAKE COMMENTS AND SUBMISSIONS

You are invited to make comments and submissions on the issues and on the preliminary proposals in this Paper.

Written comments and submissions should be sent to:

The Secretary
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PO Box 312
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or by facsimile on: (07) 3247 9045

Oral submissions may be made by telephoning: (07) 3247 4544

Closing date: not applicable

It would be helpful if comments and submissions addressed specific issues or preliminary recommendations in the Paper.

CONFIDENTIALITY

Unless there is a clear indication from you that you wish your submission, or part of it, to remain confidential, submissions may be subject to release under the provisions of the *Freedom of Information Act 1992* (Qld).

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Queensland
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18 December 1995

Health Act Review (Population Health)
Legislation Reform Branch
Queensland Health
GPO BOX 48
BRISBANE QLD 4001

Dear Sir/Madam,

RE: POPULATION HEALTH LEGISLATION

Please find enclosed a submission from the Queensland Law Reform Commission on your Discussion Paper *Review of Health Act 1937: New Population Health Legislation for Queensland.*

If you have any queries on the submission or would like any further information which we may be able to provide, please do not hesitate to contact the writer.

Most sincerely yours.

Wayne Briscoe
COMMISSIONER

QUEENSLAND LAW REFORM COMMISSION

SUBMISSION TO: QUEENSLAND HEALTH:

REVIEW OF THE HEALTH ACT 1937: NEW POPULATION HEALTH LEGISLATION FOR QUEENSLAND, DISCUSSION PAPER, AUGUST 1995

1. INTRODUCTION

The Queensland Law Reform Commission has a reference from the Queensland Attorney General on *Consent to Medical Treatment of Young People* and is currently in the process of preparing its Report on the reference. The Commission has defined the term "young person", for the purposes of this project, as people under the age of 18 years. It is anticipated that that Report will be finalised in the 1995/1996 financial year. A copy of the Commission's Discussion Paper is enclosed for your information.

Queensland Health has assisted the Commission greatly during the course of the reference, for example, by way of submissions to preliminary papers produced by the Commission such as the Commission's Discussion Paper on *Consent To Medical Treatment of Young People* (WP 44 May 1995), and at a regional level by assisting the Commission with the organisation and facilitation of consultation meetings on issues raised by the Discussion Paper. A number of individual officers of Queensland Health have either provided the Commission with submissions or have assisted the Commission by way of the provision of information.

Given the Commission's interest in issues relating to consent to medical treatment of young people, the "population health" provisions of the *Health Act 1937* which are of particular interest to the Commission are the provisions relating to school children and schools in sub sections 47 (5) -(8) (pages 33 and 36 or paragraphs 4.5, 4.6 and 4.7 of your Paper). This submission is therefore restricted to those provisions.

The Commission's Discussion Paper dealt with section 47 very briefly - in the context of those statutory provisions enabling a health care provider to avoid criminal liability for treating, examining or operating on his or her patient in the absence of a valid consent. In other than those statutorily prescribed circumstances, the health care provider and those assisting him or her (including, for example, parents) may very well be liable for assault for touching with the patient in the absence of a valid consent.

In a number of submissions received by the Commission in response to the Discussion Paper, as well as at a number of the consultation meetings organised at a regional level, concern was expressed with the current provisions in section 47 (5)-(8) of the *Health Act 1937.*

2. COMMENT ON QUEENSLAND HEALTH DISCUSSION PAPER: MEDICAL AND DENTAL SERVICES TO CHILDREN (PARAS 4.5, 4.6, 4.7).

4.5 Should the Department be able to conduct health inspections of schools children unless permission is denied by parents/guardians?

As described in the Commission's Discussion Paper, the current law relating to consent to medical treatment of young people is in a confusing state. Nevertheless it is relatively certain that when young people are intelligent and mature enough to understand the nature and consequences of the treatment being proposed for them, then they are able to provide a valid consent to the treatment and the health care provider need not obtain the consent of the parents or guardian before proceeding with the treatment.

In such circumstances, although the health care provider may still be liable in civil law if he or she treats the young person in a negligent manner, it is unlikely that he or she would be liable for assault. This test of competency of young people to be able to consent to treatment is often referred to as the *Gillick* test after a United Kingdom case which has been recognised as the leading authority on this matter.[1]

Although, as outlined in the Commission's Discussion Paper, there are a number of problems with the *Gillick* test, it at least recognises that at a particular stage of their development most young people are able to make as good a decision in relation to their health care as adults. This in turn respects the young person's bodily integrity and, where appropriate, his or her relative independence.

Obviously, the older the young person is, the more likely it is that he or she would be classified as competent to consent to his or her own treatment under the *Gillick* test. However, it is possible that even a very young child could consent to relatively minor procedures so long as he or she was intelligent and mature enough to understand the nature and consequences of the proposed treatment - and in such cases the consent of the child's parents would not be required.

The common law has acknowledged that adult patients have an absolute right to choose whether or not to consent to treatment, to refuse it or to choose one rather than another, provided the patient suffers no relevant mental or intellectual incapacity. This emphasises an adult's right to bodily integrity. However, in relation to the refusal of treatment by young people, the law has developed with a different focus. In Chapter 8 of the Commission's Discussion

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1 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112. This case was recently acknowledged by the High Court of Australia as also stating the Law in Australia. See *Secretary, Department of Health and Community Services v JWB and SMB* (Marion's Case) (1992) 175 CLR 218 at 237.

Paper the Commission set out what it believed to be the law relating to a young person's ability to refuse treatment in Queensland.

The Australian law relating to refusal by young people is less certain than the law relating to consent. It does seem, however, that Australian Courts may be in favour of a proposition that as a young person matures, parental power to consent diminishes and thus, a young person may be able to refuse treatment, to which his or her parents were purporting to give their consent. This is not the position in England where it appears that a health care provider could proceed with the treatment simply upon the basis of parental consent and irrespective of the young person's refusal. It is sufficient if the health care provider has one good consent from either parent or from the young person, if legally competent. The Commission's Discussion Paper presents arguments in favour of and against giving young people a right of refusal. Where non treatment would pose a threat to the life or long term well-being of the young person, the debate as to whether or not a young person should be able to refuse treatment becomes, predictably, more intense.

The Commission is yet to finalise its recommendations in relation to young people's right to refuse treatment although there has been wide support in the submissions received in response to the Discussion Paper, for the recommendation that at 16 young people should be treated as if they were adults, for the purposes of consent and refusal.

At page 33 of your Discussion Paper you mention that:

> **the fact that the current Act does not directly address the question of parental consent for assessment or treatment of school children by public health authorities is a reflection of the age of the legislation**

As "school children" may include young people from 4 years of age to 17 years of age, it is also the case that the current Act fails to address the question of the young person's consent.

If the Department were able to conduct health inspections of school children unless permission were denied by parents/guardians, the question also arises, whether the Department should be able to conduct such inspections unless permission were denied by a young person with capacity.

The provisions of section 47 (5) - (8) of the *Health Act 1937* fall within Part 3 of the Act: *Prevention, Notification and Treatment of Disease or Disability* and, in particular, Division 3 of that Part: *Notifiable Diseases*, and have done since 1937. Although subsections (5) - (8) do not specifically refer to notifiable diseases, they should be read in the context of the whole section and in the contexts of the Part and Division of the Act within which they it appear. It could be strongly argued that the Minister's and Director General's powers under section 47 (5) - (8) are restricted to situations involving notifiable diseases. However, this is not the impression that a number of health care providers

working in Queensland schools have of those provisions. The Commission has heard from a number of nurses working in primary and high schools about their confusion with these provisions. The confusion arises from a number of beliefs, such as, that everything a nurse does in his or her line of duty in a school is protected by the authority given to the nurse by the Minister or Director General. Thus, even if a valid consent is not obtained from the parent or child, and a touching is involved in the examination or treatment of the child, the nurse may believe that he or she would not be liable for the touching because he or she has an immunity from liability due to the nature of his or her relationship with the Minister.

It is not clear that this is the law. Unless the Minister gives a specific order to examine school children in a particular way, the nurse acting without a valid consent may be liable for assault. If the health care provider relies on the consent of the young person, the health care provider must make a correct assessment of the young person's intelligence and maturity to be able to rely on the young person's consent solely.

There will be no liability for assault if the nurse does not literally touch the child during the assessment or treatment, although in rare circumstances, there may be liability for false imprisonment whether or not there was a touching.

The Commission has also noted confusion over the liability attaching to non touching treatment or assessment. Although for assessments or treatment not involving a touching consent is not required in order to avoid the possibility of liability for assault, it is widely regarded as desirable that no treatment proceed without a valid consent. In relation to the patient himself or herself, no matter what his or her age, being involved in the decision making process has obvious benefits. The Commission is currently considering whether certain non-touching treatments or procedures should be subject to a legal consent requirement.

If consent is not specifically sought from parents or the child then, unless there has been some action indicating an implied consent, it is unlikely that silence on the part of parents or child could constitute a valid consent to the assessment or treatment proceeding, unless a statutory deeming provision were incorporated in the new legislation.

"Parent" in the *Health Act 1937* is defined as "the father or mother or any other person having the custody of the child" (section 5). Under the common law the child's parents are able to consent to the treatment of the child (except where the Courts have determined that Court authority is first required such as with respect to proposed sterilisations of children unable to consent to their own treatment) where the proposed treatment is in the child's best interests. If the child is in the care and protection of the State as a ward, the Director General of Family Services or his or her delegate can consent to treatment. It is also possible for the Supreme Court and the Family Court to make treatment decisions in relation to a child who is not competent to make his or her own

decisions. Other adults are unable to provide a valid consent to the treatment of a child. Thus, although a person may have the day to day care and control of a child, and may in fact have a legal obligation to have the child treated, that person may not have the authority to consent to the treatment. If treatment proceeds without a valid consent then the health care provider and the adult (as an accessory) may be liable for the assault of the child. Of course, in an emergency, consent is not normally required.

The Commission is considering enlarging the concept of "parent" for the purposes of consent to treatment so that those people with a legal duty to provide treatment for a young person, who is not legally competent, are able to consent to the treatment.

The Commission has heard of many situations where children are living with someone other than the parent or legal guardian of the child and where that adult assumes the role of consenting to the child's treatment. On occasion this has caused difficulties for the child when health care providers have not been willing to treat the child upon the consent of a person other than the parent or legal guardian of the child.

Under the proposal in your paragraph 4.5 consideration should be had to an appropriate definition of those who are able to consent to "health inspections". Not every one with the custody of the child may be the appropriate person to seek consent from. Parents who have been denied the custody of their child may not be the appropriate person to seek consent from. A "legal guardian" may be an appropriate person from whom to obtain consent but any other guardian would not necessarily be an appropriate person.

4.6 What type of consent should be gained before any treatment of children is undertaken?

It was obvious during our consultations that different health regions were developing their own consent forms for parents to consider and sign. Of the drafts we saw, there were clear misunderstandings relating to the current law and the requirements needed to ensure that treatment proceeds without liability attaching to the health care provider (assuming no negligence is involved). If it is to be assumed that consent for examinations, whether or not the examinations involve a touching, is preferable to proceeding upon the basis of no consent, then a written consent is probably more appropriate than a verbal consent. At least a written consent could provide some evidence that consent was sought and obtained. The written consent form could also be the vehicle for conveying information to the consent giver about the proposed procedure or assessment.

A question that has been raised by a number of health care providers working in schools is whether a written consent form returned in one year is valid for a

follow-up assessment in subsequent years. Obviously this will depend upon how the consent form is drafted. However, it is unlikely to be considered reasonable to expect parents or others to recall having provided such a consent, if the consent being relied upon was provided a long time in advance of the procedure being performed.

4.7 What other considerations need to be taken into account in the provision of health services to schools/preschools?

The Commission has received a number of submissions concerning the provision of health care in schools, but not necessarily from the perspective of population health issues.

Obviously to avert major population health problems it is necessary for the State to have some power to examine and treat. Ideally this should be with a valid consent obtained from the patient or an appropriate substitute decision maker such as the parent of a young child. It may be, for example, that the substitute decision maker is in possession of information about the patient which would influence the decision as to the most appropriate treatment.

Young people should not be subject to treatment or assessments which are not related to containing contagious or notifiable diseases without a valid consent, under any circumstances other than an emergency. The current provisions in section 47 (5) - (8) *Health Act 1937* are not clearly restricted to notifiable diseases, although that is the interpretation that the Commission has adopted. It should be placed beyond doubt that those provisions only relate to notifiable diseases and that in each case, an examination or treatment can only proceed upon the basis of an appropriate order from the Minister.

It is also apparent that some health care providers working in the school system are unaware of the current law and are confused about their potential liability for providing assessments and treatment in certain circumstances. There appears to be little consistency in the approach adopted in relation to consent between the various regional health authorities and non-legally qualified people appear to be in charge of developing consent forms which could potentially have a major impact on the liability of people working within the school system and also on the heath care provided to young people.