

Consent to treatment in childhood

The ability of children to give a legally valid consent to medical treatment has been a vexed one ever since the matter was addressed by Parliament in the Family Law Reform Act of 1969.^{1 2} This legislation, which was far from clear in its scope stated that a child could consent to medical or surgical treatment on attaining the age of 16 years, but said nothing as to the ability of children under that age to consent. Then came the case of *Gillick v West Norfolk and Wisbech Area Health Authority*,³ a case which addressed the issue of whether doctors could prescribe contraception to a girl under the age of 16. The decision reached by the House of Lords in this case was that the provision of treatment to a child under 16 was legal, provided that the patient understood the nature of the proposed procedure. This was in line with an earlier Canadian case, which had linked the capacity of children to consent with the concept of individual ability to understand the implications of medical treatment. On the basis of the decision there came into existence a standard known as 'Gillick competence', which appeared to settle the matter, at least to an extent. Yet the Gillick test is not without its grey areas, and indeed the courts have continued to pronounce on the issue.

The basic outlines of the law of consent in this context are as follows:

(1) As far as consent is concerned, children are special for two reasons: they may not have the capacity to consent, and the wishes of parents have to be taken into account. A decision as to the medical treatment of a child under the age of 16 inevitably involves some consideration of parental wishes, even if parental views are eventually overridden.

(2) Children who are too young to understand the implications of treatment cannot give a valid consent to treatment. In the case of such children, the doctor must obtain the consent of the parent to the treatment proposed. If the parent consents, then the doctor is entitled to proceed with the treatment even if the child himself or herself objects to what is being done.

A, a 10 year old is admitted to hospital with acute abdominal pain. A diagnosis of appendicitis is made and A is informed that he must have an operation. A says that he does not want an operation and is adamant that nothing will be done to him. Once parental consent is obtained, treatment may proceed. If the parent is not available to give consent, hospital authorities are justified in such a case in proceeding on the basis of necessity, on the grounds that the operation cannot reasonably be delayed until the parent is traced or the authorisation of a court sought.

In this example, if the parent declined to give consent to the operation (for example, on grounds that a blood transfusion might be required and this offends the religious scruples of the parent, permission to perform the operation might be sought from a court). If there is no time for this to be done, and the matter is one of urgency, necessity justifies the carrying out of the procedure and the chances of a court ever holding this unjustified are effectively nil.

(3) The obtaining of parental consent to the treatment of children who are too young to give a valid consent themselves is important, and will normally be required, but there are cases where the wishes of the parent will not be the deciding factor. This may be so, for example, where a decision has to be made about the treatment to be given to a grossly handicapped or chronically sick infant. Here the fact that parents do not wish the child to be treated is not necessarily going to commit the doctor to a regimen which is

calculated to do no more than palliate suffering. It may be that a parental veto of treatment in such a case should be ignored in the child's best interests, although doctors may be advised in such a case to seek court approval.

Over the last few years the courts have clarified the position in this sort of case, giving useful guidance to doctors involved in the treatment of infants in this category. The first of this series of case was that of *Re B*,⁴ decided over a decade ago. B was a baby with Down's syndrome who required an operation for the removal of an intestinal blockage. The parents took that view that this was nature's way of dealing with the abnormality and declined to give consent to the operation. Medical evidence was put before the court that B's life expectancy was between 20 and 30 years, and the court decided to authorise the procedure on the grounds that these years were a life to which B was entitled, even if she was to live them under the shadow of mental handicap. The more recent case of *Re C*,⁵ however, involved a very different prognosis. C at the time of the hearing was a 16 week old baby suffering from congenital hydrocephalus. The medical evidence put before the court was gloomy in the extreme: C would never develop any real intellectual ability; she would be unable to lift her head or communicate, and she was not expected to live to adolescence. In these circumstances the court authorised treatment that was directed only towards the relief of suffering and agreed that treatment for the prolongation of life was not required. C was a ward of court, and there was no conflict with parental wishes, but the case is none the less important in this context in that it demonstrates the sort of case where a parental decision not to authorise life prolonging treatment would be upheld. Parents do not have the right to deny treatment to children who have some prospects of at least some quality in their lives, but they do have a right to prevent a child from being treated in a way which will only prolong considerable misery. This has recently been further supported by the decision of the Court of Appeal in *Re J*⁶ in which an unsuccessful attempt was made by the Official Solicitor to seek a ruling that the denial of life saving treatment was never justified where a child had been made a ward of court, even if the life saving treatment would only serve to prolong a severely limited life.

(4) Where children have the ability to understand the nature and implications of medical treatment, their consent renders treatment legal. The assessment of competence is a matter for the doctor and obviously there will be room for doubt in individual cases. In determining whether a child is mature enough to consent, a doctor must bear in mind what a reasonably competent doctor in his position would be expected to decide in the situation. Thus a doctor who formed the opinion that an 8 year old—even an intelligent 8 year old—was capable of understanding the full implications of a surgical operation would be running a distinct risk. By contrast, a doctor who decided that an intelligent 15 year old girl understood the implications of chemical contraception would no doubt be widely supported. But what about the ability of a 13 year old girl to understand the implications of contraception? This is more controversial, but perhaps not so marginal as to make a medical assessment of capacity in such a case unlikely to be supported.

(5) Finally, there is the difficult case where a child under the age of 16 withholds consent to a medical procedure, although he or she would be judged to have the capacity to consent to it. This issue has now been raised before the

courts in *Re R*,⁷ a case involving a 15 year old girl suffering from episodes of psychotic illness. The girl's refusal to continue with drug treatment, articulated during a period of lucidity, was overruled by the court on a variety of grounds. Lord Donaldson said in his judgment that where there was more than one person or body who could give consent, treatment would be vetoed only where *all those who could consent had refused to do so*. A parent has a right to consent to the treatment of a minor, and this right lasts as long as minority does (that is, until the age of 18 years). This would appear to suggest that a competent child (that is, a child capable of understanding the implication of what is being proposed) who declined treatment might still be treated legally if either the parent consents or the court exercises wardship authority and authorises treatment. The court in *Re R* point out, however, that the consent of the parent in such a case would not mean that the treatment *had* to be given; the minor's wishes should carry great weight in the doctor's decision making. This is rather difficult to square with current notions of adolescent competence, and indeed with the philosophy underlying the Gillick decision. For this reason it is possible that a future court, faced with such a conflict, would restrict the application of the principle suggested in *Re R* to those cases where (i) the rationality of the child is in doubt (and where there would therefore be doubt as to capacity), or where (ii) the child is considered too young to make an informed decision. There is no real difficulty in holding that a 14 or 15 year old who places his or her life in jeopardy by refusing treatment is too young to have the capacity to make a decision of that significance. This may be done on the grounds that a refusal of treatment

requires a greater degree of capacity than the giving of consent does.

(6) Scotland is different, and the basic question of ability to consent is resolved in a recent statute. Under the Age of Legal Capacity (Scotland) Act, 1991, a child under the age of 16 may give a valid consent provided that, in the opinion of a medical practitioner, he or she is capable of understanding the nature and possible consequences of the procedure or treatment. Two points might be made: the determination of competence is left entirely to the doctor, and nothing is said about the case of a competent child who withholds consent. In the latter case, if there were a serious threat to the child's health, the courts would probably override the child's refusal on the grounds suggested above, namely that consent and refusal involve different degrees of capacity.

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- 1 Meyers DW. Parental rights and consent to medical treatment of minors. In: Mason JK, ed. *Paediatric forensic medicine and pathology*. London: Chapman and Hall, 1989: 428-40.
- 2 Mason JK, McCall Smith RA. *Law and medical ethics*. 3rd Ed. London: Butterworths, 1991:231-5.
- 3 [1986] AC 112.
- 4 [1981] 1 WLR 1421.
- 5 [1989] 3 WLR 252.
- 6 [1990] 3 All ER 930.
- 7 [1991] 3 WLR 592.

Molluscum contagiosum

Molluscum contagiosum is a self limiting cutaneous viral infection, especially common in children. It produces characteristic pale papules, which usually cause little discomfort. Indeed for most patients, attempts at treatment and limitation of activities associated with spread of the infection may cause greater distress.

Molluscum contagiosum virus (MCV) belongs to the poxviridae; like other members of this family it is a DNA virus which replicates in the cytoplasm of the host cell and is especially adapted to epidermal cells. The only significant host is man and MCV cannot be grown in tissue culture or eggs. Restriction endonuclease analysis permits classification of MCV into at least two types, named 1 and 2, of which type 1 is much the commoner, but there is as yet no consistent evidence relating the virus type to the clinical appearance of the lesions or to their anatomical distribution.^{1 2}

Epidemiology

Infection follows contact with an infected person or contaminated objects. It is assumed that epidermal injury facilitates inoculation of the virus, but infection of intact skin may also be possible. In hot countries, where close contact between lightly clad children is frequent, molluscum contagiosum is commonest in young children, the incidence peaking for example in Fiji between the ages of 2 and 3 years.³ In more developed countries the infection is commoner in school age children and correlates with the use of swimming pools,^{3 4} although the precise mode of transmission in this situation is unknown. In a Japanese study involving over 7,000 children, the incidence of molluscum contagiosum was 7.5% among swimmers and 3.6% among non-swimmers.⁴

In adults transmission between sexual partners is recog-

nised, and such infections usually occur on genital, perineal, pubic, and neighbouring skin. Transmission of molluscum contagiosum to a child during sexual abuse must be possible in principle, but does not appear to have been recorded. Innocently acquired childhood molluscum contagiosum is often widespread and lesions are frequently seen on and near genital and perineal skin. Therefore sexual transmission of molluscum contagiosum to a child should be suspected only if there is other evidence of sexual abuse.

Immunity

Specific antibodies against MCV can be detected in the majority of infected patients, but their biological significance is unknown. The importance of cell-mediated immunity is inferred⁵ from occasional reports of widespread infections in patients immunosuppressed by disease or on immunosuppressive treatment and especially those with HIV infection.⁶ Atopic eczema and use of stronger topical steroids are sometimes associated with more widespread infections.

Natural history

The incubation period is estimated at between two weeks and six months, though the source of infection is seldom reliably identified. In the immunocompetent patient, individual lesions regress mostly within two months, although solitary lesions may persist for up to five years. New lesions may be due to virus acquired at the time of initial infection, but are probably more commonly due to autoinoculation. The whole infection clears usually within six to nine months, but occasionally persists for a few years. Lesions may appear after apparently successful treatment,