

# Should a doctor stop rendering medical services? Part II – Analysis of medico-legal conduct in cases of uncertainties regarding informed consent in minors. The Polish perspective

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## Abstract

**Introduction.** The doctor's decision whether to save the life of a minor who has attempted to commit suicide depends on the decision of the person who, under legal regulations, is responsible for the minor. In everyday medical practice doctors are often placed in difficult situations and often cannot make any decision. Such doubts arise when it is impossible to contact the person(s) responsible for the minor. The doctor encounters similar issues when the parents of a minor under 16 years of age express different opinions on the recommended procedures, and are against the doctor's decision and do not want their child to be hospitalized.

**Materials and methods.** The current legislation and doctrine was analyzed and an attempt was made to determine the way of conduct with regard to suicidal minors, and algorithmize the way of conduct towards such suicidal minors. The conduct was discussed on the two examples, based on real clinical cases.

**Results.** With regard to minors in a clinical state demanding urgent procedures, who have of the decision made by the guardian, and regardless of the fact there is no contact with the guardian. If the status is stable, the physician's *modus operandi* depends on various accompanying circumstances. However, he is still obliged to provide medical help.

**Discussion.** A practical algorithm is presented and all the possible legal variations discussed and clarified.

## Key words

Informed consent, informed refusal, suicide attempts, minors, youths, adolescent, statutory representatives, statutory guardians, factual guardians, custody court, urgent, withhold

## INTRODUCTION

The problem of suicidal attempts or at least acute, life-threatening poisonings, is a well-recognized problem among the subpopulations of minors [1]. The physicians dealing with such patients face the problems of alcohol, narcotics and so-called legal highs abuse [2, 3, 4]. Thus, every doctor should clearly realize how to legally proceed when encountering such patients. Regulations on expressing a conscious consent or refusal by minors differ considerably from those which apply to adults and legally incapacitated patients. The age of the minor is also a criterion for differentiating the way of expressing a consent or refusal. As for minors between the age of 16–18, the consent or refusal should be expressed both by the patient and the statutory representative, and in some particular cases, also by the factual guardian [5]. As for minors under 16 years of age, exclusively legally responsible persons make decisions on accepting the recommended medical procedures [6]; the minor has only the right to express an opinion. Although the doctor should listen to the opinion, it is not, however, binding for him, which means that the minor cannot change the decision taken by the statutory representative or the factual guardian.

Some situations become unclear when the statutory representative is the only person who can agree to the recommended medical procedures but it is not possible to get in touch with that person. Current legal regulations provide a general code of conduct in order to render required high-risk medical assistance, despite the lack of consent by the statutory representative [7].

There are also situations when a minor under 16 years of age should undergo some risky medical procedures performed for diagnostic purposes, but the parents of the minor are not unanimous in their decision, or clearly object to the child undergoing the medical procedures. According to legal regulations, the custody court decides about initiating the recommended medical procedures. In urgent cases, when the minor's life and/or health is threatened, the doctor is obliged to make a decision [8,9]. A very specific but rare situation arises when the guardian does not agree to medical procedures necessary for saving the life or health of minor who has made a suicide attempt. Polish law does not provide regulations which directly apply to the above situation.

The authors of the presented paper have attempted to solve the doubts arising from the problems of informed consent for delivering medical procedures to minors, and create a uniform opinion which would be the grounds for the conduct towards minors who have attempted to take their lives, where the minors' statutory representatives are not available or when they express objections to accepting medical services.

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**Objective.** In the context of the issue of rendering medical services to minors who have attempted to commit suicide, the following questions were posed:

- What should the doctor do in the situation in which a medical procedure has to be provided for the suicidal minor and the legal guardian is not available; therefore, it is not possible to obtain such a consent from the guardian? Moreover, is the objection of a factual, not legal guardian binding for the doctor?
- Is the objection to hospitalization and accepting necessary medical activities binding for the doctor if it is expressed by both the parents of the minor?
- Is the objection to hospitalization and accepting necessary medical activities binding for the doctor if the parents' decisions are different?

## MATERIALS AND METHODS

Particular case studies are the most reliable research material. Below, the authors have presented two case studies. They are accompanied by current opinions of the judiciary, doctrine and legal regulations.

The research method included analysis of the particular case studies in the context of the current legal regulations, and the application of algorithmization, in order to create a proper way of conduct towards minor suicidal patients. Some terms have been defined to clarify the discussed legal issues;

*Factual guardian:* 'the person who is not statutorily obliged but provides permanent care for the person who needs such care because of his age, health state or mental state' [10].

*Standard medical examination:* any medical examination with no interference into the patient's body and which does not entail any negative consequences or complications for the patient's life or health. Standard medical examination includes physical examination and anamnesis, taking 'standard' biological material (e.g. blood, urine, buccal swab) for laboratory tests.

*Urgent medical services:* medical services which are required to be administered without delay; not initiating them might or even will result in the patient's death, serious detriment to health, or other risky health consequences. Under Article 15 of The Act of Medical Activity, 'the person/institution dealing with rendering medical services is forbidden to refuse to provide medical help to a person whose life and/or health is threatened' [11].

**Case 1.** A female patient, aged 17, admitted to the Toxicology Unit in the Department of Occupational Diseases and Toxicology of the Institute of Occupational Medicine in Łódź after a suicidal intoxication with baclofen. The drug, which is an inhibitory neurotransmitter in the central nervous system might cause serious disorders in the respiratory, cardiovascular, as well as central and peripheral nervous systems [12]. The patient found by her grandmother was deeply obtunded and breathed regularly. The anamnesis indicated that the patient might have taken about 40 tablets of baclofen 4–5 hours previously. It was determined that the girl's parents were currently living abroad. On admission, the patient was in a serious condition, unconscious, respiration and circulation sufficient, HR – 48/min, BP – 100/60 mmHg. Urine test confirmed the presence of baclofen. Because the patient's life and health were threatened, the doctors on duty decided to

intubate the girl in order to perform gastric lavage. Due to the absence of girl's parents who were her only legal guardians, the intubation – which is a medical procedure involving the patient with an elevated risk – was performed without consent. Since the patient suffered from acute respiratory failure, the doctors decided to include respiratotherapy on the second day of hospitalization, which was continued for the period of 47 hours. During the hospital stay, the patient's state of health improved. Because of the suicide attempt the patient was examined by a psychiatrist. She was diagnosed with 'post-suicide state and personality disorders' and sent to an outpatient clinic to continue the treatment.

**Case 2.** A female patient, aged 15, was admitted to the Toxicology Unit of the Department of Occupational Diseases and Toxicology of the Institute of Occupational Medicine in Łódź, Poland, due to suicidal intoxication with acetaminophen. Taking acetaminophen at a dose greater than 150 mg/kg/24 h (>10 g) induces a direct hepatotoxic effect and leads to acute liver failure [13]. The anamnesis proved that about 5 hours before admission to hospital, patient had taken an unknown amount of paracetamol (tablets 0.5 g each). On admission, the patient was conscious and remained in a good clinical state; she was respiratory and circulatory sufficient, HR – 76/min and regular, BP – 120/80 mmHg. The skin was pale, liver not enlarged; there were no symptoms of haemorrhagic diathesis. Laboratory tests showed a regular level of aminotransferases (ALAT – 13U/L, ASPAT – 19 U/L). The paracetamol level in the blood serum was 150µg/ml.

On admission, both parents were present, but only the mother agreed to the recommended procedures. The father was definitely against performing any medical procedures. Despite the father's objections, vomiting was provoked and the child was administered activated carbon. From the very beginning, the doctors applied N-acetylcysteine (NAC), which is a detoxifying drug administered to patients intoxicated with paracetamol [14]. The applied procedure prevented acute liver failure from developing.

Due to the suicide attempt, the patient was examined by a psychiatrist and diagnosed with 'post-suicide state, suicidal tendencies, personality disorders', and instantly sent for psychiatric therapy. The duty doctor notified the parents of the necessity of admitting the child to a psychiatric hospital in order for a further diagnosis to be made and introduce the right therapy. The parents objected and demanded the child be immediately discharged from hospital. Considering the patient's mental state and the outcome of the psychiatric consultation, the doctor decided to notify a custody court. The girl was transported to a psychiatric hospital against the parents' will.

## RESULTS

In the first case study, the doctor had no possibility of contacting anyone who had the right to give consent. With regard to patients between the ages of 16–18 who are not legally incapacitated, both the patient and statutory representative are required to give the consent (dual consent) [5]. When it is not possible to contact the statutory representative of the minor patient, the custody court of local jurisdiction can grant such a consent [7]. It should be stressed that the principle applies only to the cases when the period of time



needed to obtain such consent will not lead to negative implications for the patient's life and/or health. However, in cases where the delay in initiating the recommended medical services might, or even will have negative consequences for the patient's life and/or health, or the recommended medical procedures will be implemented later than at the time when the prognosis was the most promising possible, the doctor has the right to make a decision without the prior consent of the custody court [9]. Thus, the duty doctor's conduct in this case was absolutely justified.

Regardless of the above-discussed problem of providing medical services of increased risk without the consent of an authorized entity (parents or custody court), the specific legal status of the grandmother who accompanied the minor patient should be explained. A factual guardian who cares permanently for the patient is competent to consent to action against a minor [5]. However, the catalogue of such activities has been essentially reduced in comparison with the catalogue comprising action in which the legal representative is competent. Article 32 of The Act on the Medical Doctor Profession and the Dentist Profession provides that a factual guardian can consent to take action against the patient only when the planned procedure is related with normal, not increased risk to the patient. It should also be noted that Polish law does not contain a list of medical activity related with increased risk to a patient. The nature of every activity is determined individually by the physician, taking into account both current medical knowledge, as well as the current status of the patient.

In light of the above argument, the grandmother who accompanied the patient had the right to consent to the commencement of hospitalization, as well as conducting the necessary studies and undertaking those activities that did not involve the minor with an elevated risk. Therefore, the doctor had every right to perform intubation without the consent of the grandmother – the factual guardian – and the custody court, because of the lack of time.

Age is not the only patient-related condition which exempts the physician from the obligation to obtain the patient's or statutory or factual guardian's informed consent prior to the undertaking the medical procedure against the patient. Under Article 33 of The Act on the Medical Doctor Profession and the Dentist Profession, the legal reason that releases the physician from the duty of obtaining the consent comprises the state of the patient (lack of consciousness) [8]. However, it is especially important in adult and patients who are not incapacitated, it should be borne in mind that the physician can perform the necessary instant medical procedures to an unconscious patient, even though their close families or relatives object to these procedures. When possible, the physician is obliged to discuss his medical decision with another physician, preferably a specialist in the same field. One should remember that every such a situation need to be reported thoroughly to the custody court, or to the patient's statutory representative *ex post*, and, what is obvious, thoroughly documented in the patient's medical history [8, 15]. The word 'or' means the doctor can choose which of the two he is going to notify. It should be stressed that this special permission refers only to such a condition of the patient that demands immediate and urgent medical treatment. If a delay is permissible without prejudice to the health and/or life of the patient, the physician is obliged to obtain suitable permission from the custody court.

To sum up, it must be stressed again that in the first case the doctor should discuss the problem with another specialist, then immediately implement necessary medical procedures, justify the fact of initiating such procedures without the consent of the patient's statutory representative and custody court. Finally, after implementing all the necessary medical procedures, he should notify either the child's statutory representatives or the custody court (according to his own choice) about the medical procedures applied.

In the second case, most striking is the fact that the statutory representatives of the minor patient took different decisions on the recommended medical management. They then made a unanimous decision: they both definitely objected to their child's stay in a psychiatric hospital.

While determining whether the doctor's conduct was legal, the authors try to answer two questions: Is the consent expressed by one parent only binding for the doctor when the other parent expresses his/her refusal? Does the doctor have to accept the refusal and discharge the minor suicidal patient from hospital if the parents demand it?

It seems that the answer to the first question can be found in Article 34, Paragraph 6 of The Act on the Medical Doctor Profession and the Dentist Profession. The paragraph states that:

if the statutory representative of the minor patient does not agree for the doctor to perform necessary medical procedures which are necessary to save the patient from death or prevent any serious detriment to health, the doctor has a right to implement such procedures after obtaining a consent from the custodian court [9].

On the other hand, one should recall Article 34, Paragraph 7 which permits the physician to proceed without the custody court's consent when required. However, it must be emphasized that the quoted regulations do not apply to situations in which both parents are present, and each of them makes a different decision. The solution can be found in The Family and Guardianship Code which states that:

if both the parents exercise parental authority, each of them is obliged and entitled to do it. Issues important for the child require the parents' unanimous decision. If they fail to work out a compromise, the decision is taken by the custodian court [16].

The article provides that each parent has a right to represent the child independently, and the right includes making independent decisions on behalf of the child. A joint decision is required only in issues important for the child. Professional literature states that such issues are: the child's place of residence, giving the first name, the choice of school, citizenship, and decisions about medical treatment [17]. In the opinion of the authors, the decision with regard to the child's treatment does not have to be made by both the parents; a joint decision should be required only before implementing risky medical procedures, and if the doctor abandoned them the consequences might be serious – both for the patient's life and health [18]. It should be assumed that the doctor can initiate life-saving activities after a suicide attempt if both parents agree to such activities. If the parents' decisions are different, the question can be solved only by the custody court.



The appropriate approach in a given situation (being simultaneously the answer to the first question) depends on the clinical condition of the patient. If the patient's condition is good enough that one can wait until the decision of the custody court about how deal with the patient, the physician is obliged to suspend operations and wait for the decision of the court. If the clinical state is worse and the patient cannot wait, the doctor, having discussed the problem with another specialist, implements all the necessary medical procedures without obtaining consent, and notifies the appropriate custody court. Adopting such an algorithm of conduct allows the doctor to initiate the required medical management, despite the objection made by either parent.

When looking for the answer to the second question, the content of the Article 29, Paragraph 1 of The Act of Medical Activity' should first be recalled, which states that a minor patient is allowed to be discharged from hospital only after his statutory representative demands it [19]. However, the important exception to the quoted regulation is included in Paragraph 2 which provides that:

the doctor has a right to refuse to discharge the [minor] patient from hospital if he still requires to be treated despite the demand of his statutory representative. The doctor can withhold the discharge until he has obtained a consent from the custodian court of local jurisdiction (...) [20].

If the doctor decides that hospitalization is necessary, it is his duty to notify the custody court of the refusal, and give an explanation for such decision [21]. The Act does not directly state in what form such decision should be expressed to the custody court, but professional literature states that the institution should be notified in writing. The letter should contain information on the reasons for the doctor's refusal [22].

Summing up the analysis of legal conduct presented in the second case, the authors would like to stress that the doctors should implement all the necessary medical procedures, although the patient's statutory representatives have expressed different opinions on the recommended medical management. Moreover, the doctors should continue the treatment, then include psychiatric therapy despite the lack of the parents' consent, and finally notify the custody court of the refusal to discharge the patient from hospital on demand of the statutory representative, and the reasons why he has taken such decision.

## DISCUSSION

The right to give parallel informed consent in the process of treatment applies to patients who have completed 16 years of age. It should be noted that the age has been increased by the Centrum Onkologii Ziemi Lubelskiej in relation to age, which under Polish law can give minors limited legal capacity, and thus, the right to make certain decisions under the law. According to the Civil Code [23], a limited legal capacity is granted to minors after completing 13 years of age. However, those who are under 16 years of age do not have the right to make binding decisions, their lives and health is protected in a special way. This is due to the fact that persons under 16 years of age who cannot validly decide for themselves, are dependent on the decisions of their legal representatives in the

plane of providing health care services [24]. These decisions are not always optimal to the minors. Thus, the rule is that once the decisions made by the representatives are objectively adverse to the minor, it is possible to 'suspend' the right to decide, and obtain consent from the alternative subject in the form of the legal guardian of the life and health of the minor (custody court). This rule is a solution that has a similar legal construction to the institution of the state of necessity, as defined in Article 26 of Penal Code, according to which one should rescue the welfare of obviously a greater value [25]. A similar conclusion has been given by Dukiet-Nagorska T. [26]. In the context of health care, the welfare of obviously a greater value is the life and health of a minor child; thus it's protection should prevail over welfare in the form of the autonomy of decision-making, which is vested in the legal representatives of a minor. The problem of choice between the welfares to be protected, in the context of health care, was discussed by Zoll A. who concluded, that such choices are quite common. Zoll pointed out, that so-called 'state of need' can be the solution to such uncertainties [27]. The problem of statutory representative's lack of consent for necessary treatment – often 'tragic and avoidable' – was discussed by Wilkins L P. in 1992, who 'abandoned the consent doctrine and suggested new rules for medical treatment of minors' [28]. His conclusions had similar effects as the rules outlined by the authors of the presented paper.

The same applies to the situation when not the legal representative but a minor alone objects to the required treatment or assessments. Under Polish law, the situation is clear with regard to minors younger than 16 years of age. Due to the necessity of parallel respecting the decisions of the minors aged 16–18, as well as their representatives, a physician faces the dilemma of how to proceed when a minor refuses. The Polish perspective clarifies the dilemmas: the algorithm is the same in the case of minors as well as their representatives, and corresponds to the situations discussed above.

The dilemma mentioned above also applies in the other countries as well as their legal systems. Devereux J. A., et al. stated in 1993, that the rule in the UK was to recognize the minor as competent to consent when he/she consented, and to doubt his/her mental competency and maturity when they disagreed [29]. The necessity of finding the optimal (quick) solution, together with simultaneously maintaining the balance between the protection of obviously the greater welfare and the violation of the rights of the individual to self-determination, was highlighted by Elton A. in 1995 [30]. The results of the presented study are similar to general conclusions proposed by the quoted authors.

Knowledge of medical law among doctors in Poland is unsatisfactory [31, 32]. Poland's current legal status orders the following algorithm of proceeding.

- A. In urgent cases, when a physician has to initiate a medical procedure immediately, he has a right to perform it and then notify the patient's legal guardian or the custody court of the implemented medical procedure. If necessary, he has the right to violate both the rights to self-determination of a minor and/or the disagreement of statutory representatives. In such cases, he is obliged to notify the custody court afterwards.
- B. When the condition of a minor patient is stable enough, the physician is obliged to obtain the informed consent before the procedure is started. The possible cases are as follows:



- a. if no statutory nor factual guardians are available, the physician performs the necessary procedures unless the patient (16–18 y. o.) objects. The position is then decided by the custody court;
- b. if no statutory guardians are available, but the factual guardian is in contact, the physician can perform standard medical *examinations* (those which do not interfere into the patient's body or entail any negative consequences) only after consent has been obtained from the patient's factual guardian. The same refers to simple treatment procedures related with normal, not increased risk to the patient. If the risk is increased, the physician is obliged to obtain consent from the custody court. A similar way of conduct was given earlier by Filar M. [33].
- c. If only one statutory guardian (e.g. parent) is in contact and:
  - i. the patient is younger than 15 years of age, consent is given by the statutory guardian, or in the case of refusal to grant consent, by the custody court.
  - ii. the patient is aged between 16–18 years, parallel consent is needed, i.e. consent should be expressed both by the patient and the statutory representative [5]. If the patient refuses to express consent or/and the statutory guardian refuses, consent is granted (or not) by the custody court. If the patient is unconscious or unable to understand the procedure information [31], the informed consent of the statutory representative is sufficient.
- d. If more than one statutory guardian is available, it is a general rule that crucial decisions concerning the child are undertaken by both parents (statutory representatives) [34]. However, if the views of the statutory guardians (e.g. parents) are different, then decides the position of the custody court. The age of the patient plays a minor role due to the necessity of obtaining the consent from the custody court. If the view of minor patient (16–18 y. o.) differs from the view of any or all statutory guardians, the position of the custody court is conclusive.

The authors realize that sometimes the legal regulations are morally controversial, and as Pawlikowski J. et al. reveal, 'can provoke conflicts between patients and physicians' [35]. Violation of one's privilege to self-determination or determining the life of legally dependent persons can be seen as step back in the process of shifting the physician-patient relation from paternalistic towards partnership approach [36]. Legal solutions are still needed because the ethical attitudes of physicians do not necessarily correlate with the respect for autonomy [37].

Consent for procedures involving minors raises many issues. Some authors admit that 'minors are unable to express any conscious consent' [38]. Under such conclusions, the more it seems reasonable to create highly algorithmized procedures for obtaining informed consent in the process of treatment of minors.

It seems clear that general regulations about expressing refusal and agreement to recommended medical services apply to all cases if they are standard services, planned beforehand and not urgent. In immediate cases which require prompt decisions, different regulations should be applicable after Article 34, Paragraph 7 of 'The Act on the Medical Doctor Profession and the Dentist Profession'.

Having considered the above, the authors conclude that:

1. when it is not possible to contact the statutory representative of the minor patient, and the doctor has to initiate a medical procedure immediately, he has the right to perform it and then notify the patient's legal guardian or the custody court of the medical procedure implemented;
2. different decisions of the child's parents on the recommended medical services do not result in abandoning them by the doctor;
3. the doctor does not have to agree with the parents' objection to their child's being hospitalized and demand for discharge from hospital.

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