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LEGAL ISSUES IN ADOLESCENTS' RIGHTS UNDER MEDICAL TREATMENT AS A CONSTITUENT OF RIGHT TO HEALTH

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Abstract

The paper addresses the question of the rights and autonomy of the adolescent when receiving medical treatment. This result in seeing adolescents as active right holders, notwithstanding their age or level of development. The exercise of this right is not absolute, where adolescent's life is in issue. Courts in most cases have held that they cannot decide contrary to medical authorities' decisions concerning treatment of the adolescent as this will be a breach of the child's right to life. The paper intends to contribute in facilitating the implementation of adolescents' right within the myriad instances of daily decision making by the medical personnel which touch and concern the health of the adolescents. This paper has provided a comprehensive and detailed account of the law and practice of adolescents' rights as it relates the patient, parents, and medical personnel showing that none of them has absolute power when it comes to medical treatment. It is concluded that the adolescent rights do not prevent interventions that will protect the adolescent from adverse health consequences.

Key words. *Adolescent, best interest of the child, rights, consent.*

Introduction

The rights violations adolescents encounter include a lack of autonomy and access to confidential health care services. Despite the critical health issues at stake for adolescents, discussing the treatments for these young persons typically sparks controversy. A further challenge for advocates of the rights of adolescents is confronting and refuting the assertion of culture and beliefs as a justification and a defense for adolescents' rights violations. When adolescence intersects with other factors, such as poverty, race, and gender, it compounds the challenges they face in exercising their basic human rights.The principle of universality, indivisibility and interdependence of all human rights is reaffirmed repeatedly in human rights. As regards right to health of the child or adolescents, three other rights of the child are recognised in the Convention on the Right of the Child (CRC), namely; the duty to promote best interest of the child as a primary consideration in all actions affecting children (article 3 CRC), the right to life, survival and development (article 6 CRC) and the right to be heard (article 12 CRC). The best interest of the child means that all children or adolescent must be approached in the first place as a child and only in the second place as a sick child, or refugee or migrant as the case maybe. In essence, in realising adolescents' right to health, their best interest must be taken into account. Several issues on right to life for adolescents' right to health are particularly controversial. It is an important concept when there is decision to make on the medical treatment for a sick adolescent, also on the continuation of medical treatment and the start of palliative care in the case of children and adolescents with chronic or terminal diseases. It has been argued by some that decisions should be left to the individual adolescent and the parents where it is a terminal illness issue and the

medical practitioners should be family-sensitive. This is not what happens most of the time, as a result there are lots of cases where parents have gone to court over the treatment of their children under this condition. There was the celebrated UK case – (*The Charlie Gard Case* of *2017.) Great Ormond Street Hospital v.Yates* [2017] EWHC 1909 (Fam) 24 July 2017. It is a case of a little child (not an adolescent, but it is relevant), which involves a high profile dispute between the parents of a terminally ill child and doctors at the Great Ormond Street Hospital London over the child's course of treatment. The UK court ruled against experimental medical treatment which the parents of the child want for their terminally ill child. The most important thing is to ensure that such terminally ill child or adolescent is provided with relief from pain and other distressing symptoms. Parents with parental responsibility have the power to give consent to their child to undergo medical treatment if their child lacks the capacity to consent. However a court has the power to override parental consent in the exercise of its independent and objective judgement in the adolescent's best interest. The adolescent's right to participate and be heard is laid down in article 12 of the CRC. The adolescents must not be pressured or manipulated in expressing their opinions over their medical treatments. There must be confidentiality when speaking to the health officials. The note of warning is that it should be borne in mind that the views of the adolescent must be given due weight according to the age and maturity of the adolescent. Because adolescents do not fit within the traditional categories of child or adult, they require particular legal consideration. The CRC (article5) acknowledges that minors have "evolving capacities" to make decisions affecting their lives and recognizes that some minors are more mature than others depending on individual circumstances (article 12).It is the duties of parents to provide appropriate direction and guidance in children's exercise of their rights.It is clearly reiterated that, in all matters, the best interests of the adolescents take precedence and they should be enabled to exercise their rights.

Definitions: 'child' and 'adolescent'.
According to the definitions of 'child' and 'adolescent' under international instruments, there is overlap in the age range of an adolescent and a child so there is the need to give the definitions of a 'child' 'childhood' and 'adolescent'. The meaning of 'child' and 'childhood' vary greatly between different societies or even within one society. In the African traditional settings definition of a child is dictated by situational factors, thus cessation of childhood takes different forms in various communities.

'Child' -The Convention on the Rights of the Child (CRC,1989) defines a child as any human being under eighteen unless under laws applicable to the child, majority is attained earlier. (Art 1 CRC). The CRC definition must have been enthused by the awareness of the fact that various communities view duration of childhood differently. The African Charter on Rights and Welfare of the Child (ACRWC, 1990) however defines a child as any human being below eighteen years, (Article 2 ACRWC). Under the two international instruments, age is the sole dominant factor for being a child.
'Adolescents'- World Health Organisation (WHO, 1986)defines an adolescent as any person between the ages 10 and 19. Sacks (2003) further pointed out that adolescence begins with the onset of physiologically normal puberty and ends when adult behaviours are accepted, while adolescence is a recognizable phrase of life, its end is not always

easily demarcated and that this poses problems for practitioners when adolescent patients require care facilities with restrictive age limits. It usually occurs during the period from puberty to legal adulthood. In this paper 'adolescent' and 'child' will be used interchangeably where the adolescent being referred to is below the age of 18. This is reinforced by the fact that the CRC Committee in its General Comment No 4explains extensively adolescents' health and development in the context of the Convention on the rights of the child which establishes the inter-relationship between 'child' and 'adolescent'.

Legal Framework on the rights of the adolescent

International law recognises adolescence as a developmental stage when young people's capacities are evolving. The human rights legal framework contains a number of provisions protecting right to health with regards to the rights of the adolescents which are set out in the various international human rights instruments, regional instruments and the municipal laws. The global community recognises health as a human right due to its indispensability to the preservation and enhancement of the development, survival life and inherent dignity of the adolescent. Article 25 of the Universal Declaration of Human Rights (UDHR 1948) clearly provides that everyone is entitled to a standard of living adequate for the well-being of himself and of his family including medical care. Apart from the UDHR, the right to health is covered comprehensively in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), (Article 24), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in Article 12. Regional human rights treaties also include provisions on the right to health. For example, the African Charter on Human and Peoples' Rights (ACHPR or Banjul Charter1981). The CRC Committee (CRC General Comment 4) interpreted Article 16 of the CRC, which protects adolescent privacy, as follows: 'In order to promote the health and development of adolescents, States parties are also encouraged to respect strictly their right to privacy and confidentiality, including with respect to advice and counselling on health matters…' (CRC General Comment 4 para.7) Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment. (CRC General Comment 4 para. 7).

Best interest of the Adolescent

The principle of the 'best interests' of the adolescent as a primary consideration' in all actions concerning the adolescent. The best interest principle provides that the best interest of the child or adolescent shall be a primary consideration in *all* measures concerning the adolescent. It is central in ensuring all individual adolescent's rights. The concept of the 'child's' best interest was enshrined in the 1959 Declaration of the Rights of the Child (para.2), the CEDAW (articles 5(b) and 16), and the CRCArt 3 CRC),as well as in many national and international laws. The concept of the child's best interest is aimed at ensuring both the full and effective enjoyment of all the rights recognized in the CRC and the holistic development of the child from anywhere in the world. Freeman (1992) emphasized that the recognition of the importance of traditions and cultural values of each people for the protection and harmonious development of the child does not mean that implementation of the rights granted by the CRC should be relinquished if such traditions are inconsistent with the substance of those rights. Different cultures also use different concepts of what the best interest of the child are. Care must be taken so that harmful traditional and religious practices such as early marriage and female genital mutilation (FGM) and blood transfusion in the case

of Jehovah Witnesses are not applied and passed on as being in the best interest of the child. Adults say that, "children, because of their limited level of development, knowledge and experience, cannot judge what is in their interests or what will be the consequences of their thoughts and behaviour". De Langen (1992) explained that the fact that children are not yet grown up, had been used and is being used as an excuse by adults (including parents) to follow their interpretation of the child's interests. At times adults make decisions that have far-reaching consequences for children which no one can anticipate and which might not be in the child's best interest. An adult's judgment of a child's best interests cannot override the obligation to respect all the child's rights under the CRC (CRC General Comment 14).

The most difficult cases in taking the best interest of the adolescent into account have been identified in medical decisions. In determining the best interest of the adolescent in medical decisions, there might be short-term and long-term considerations on the best interest of the adolescent which may be conflicting. Fortin (2009)stressed that there are several jurisprudential arguments for maintaining that adolescent's rights do not prevent interventions to stop adolescent making short- term choices, which thereby will protect their potential for long time autonomy. Adolescents are no longer imagined as mere recipients of services or beneficiaries of adult protections. Rather they are right holders, as well as participants in matters affecting them, and therefore should be respected in their individuality. The cautionary advise is that adolescent rights do not prevent interventions that will protect the adolescent.

Right to privacy and confidentiality of the adolescent in health care

The information adolescent patients share with their health care provider is often sensitive and at times embarrassing. The adolescent expects that it will be kept private. Various international human rights treaty have asserted that adolescents must have access to confidential health care. For example, International Covenant on Civil and Political Rights (ICCPR) in Article 17 provides that; 'No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence...'CRC in Article 16 states that a child must not be subjected to arbitrary or unlawful interference with his or her privacy or correspondence and the child has the right to protection of the law against such interference. CRC Committee in interpreting Article 16 CRC states that health care providers have an obligation to keep confidential medical information concerning adolescents such information may only be disclosed with the consent of the adolescent. In addition, adolescents must be provided with understandable information (Article 17 CRC) about proposed treatments, side effects and outcome in a manner consistent with their evolving capacities. Doctors are also expected to respect the responsibilities, rights and duties of parents, legal guardians or members of the extended family to give direction and guidance to the child in her or his exercise of its rights. In this way the lack of knowledge or experience of the child is compensated by the guiding of its parents or caretakers.

Autonomy Rights and Medical Treatment

People with parental responsibilities are entitled to give consent for medical treatment on behalf of their children. The moral authority behind the parental responsibility depends in large on the supposition that parents will act in the best interest of their children. If it appears however that the parents are acting contrary to the child's interest their decisions will be challenged or refused. For example where a child needs blood transfusion to prevent death, refusal by a parent based on their religious belief will not be binding on the doctor and will be refused. There are limits to what parents are entitled to decide when it pertains to medical

treatment for their child. There are many jurisprudences to support this. For example, in the Nigerian case *Esanubor v. Faweya,* (2009) FWLR (Pt 478) 380 CA where the court upheld the decision of the lower court that it was right to issue an order that the child be given blood transfusion in order to save the life of the child, despite the refusal of consent by the mother on the account of the religious belief of the mother. Court held further that *''...the mother's desire to sacrifice her son's life is an illegal and despicable act which must be condemned in the strongest terms...''* The court relied on a previous decision; *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo* (2001) 7 NWLR (Pt 711) 206. In sum, if a decision to override the decision of a patient not to submit to medical treatment on medical terms is to be taken on grounds of recognised interest of others such as parents of dependent minor children, it has to be decided by the court.

As children grow and mature, so also their abilities to make decisions on their behalf increases. Parental authority dwindles as the child grows older and become more independent. Parental rights yields to the right of the adolescent to make his or her own decision when he reaches a sufficient understanding and intelligence to be capable of making up his mind on the matter requiring decision. Adolescent's autonomy entails that the adolescent can act completely independently of others. However the adolescent is not granted the full responsibility to take medical decisions completely autonomously. Adolescent's involvement in medical decisions has been found to increase the understanding of their diseases and medical treatment which has been found to have assisted in the sick juvenile's adherence to the treatment. The CRC Committee recommends that- Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society, (CRC General Comment No 4 para. 29).

Children's autonomy rights have been considered by the courts mainly in the context of consent to medical treatment. The decided case, *Gillick v. West Norfolk and Wisbech Health Authority* [1986] AC 112 was an important case for two reasons. First it gave greater recognition to the right of children to make decisions for themselves without parental interference. Second, it emphasised that it is better to talk about parental authorities rather than parental rights. *Gillick* was hailed as a landmark decision in the development of children's rights, because it brought about recognition that children particularly those of sufficient age and understanding should have greater say in decisions concerning them. An adolescent who is considered matured and intelligent enough to make an informed decision is regarded as '*Gillick* competent'. However children or adolescent does not necessarily have the final say. An adolescent has no absolute power of veto over medical treatment. The court can overrule the adolescent's wishes. Thus the outcome of a case depends not just on whether a child is *Gillick* competent, but on the nature and seriousness of the decision to be taken. *Gillick* was about consent not refusal, but there are also cases where juvenile have refused to consent to medical treatment. In these cases the courts have overridden the wishes of the juvenile and authorised the treatment even though the juvenile concerned was mature enough to make an informed decision. In the case, *Re W* (A Minor) (Medical Treatment; Court's Jurisdiction) [1993] Fam 64, where W who was 16 years old suffered from anorexia nervosa, despite her deteriorating condition, she refused treatment. The local authority applied to court and the court authorised the treatment. Similarly in the decided case *Re P (Medical Treatment; Best Interest)* [2004] FLR1117 where a Jehovah's witness (aged 17) with a medical condition of tendency to bleed objected, as did the parents, to the doctors using medical treatment involving blood or blood products. The hospital sought leave of the

court to administer blood treatment should his situation become immediately life threatening. Court authorized that treatment be imposed.

Disputes between parents and doctors about medical treatment of adolescents

Although a failure to obtain parental consent could result in a medical practitioner being liable for assault under civil and criminal law. However, conflicts may arise when parents and doctors disagree over the need to perform a potentially life- saving treatment on a child. Parental rights in medical matters are not absolute as they can be overridden by the court. Where there are dispute between the medical professionals and parents, the court will be asked to intervene. If doctors treat (or fail to treat) an adolescent in defiance of parental wishes, this may be a breach of the parents' and child's rights to family life under international human rights laws. As provided in article 18 CRC, parents have the primary responsibility over their children and only in exceptional circumstances should this be replaced by the State. It is also important that both children and their parents are given opportunities to express their views in medical decision-making and their views are seriously considered. If doctors treat or fail to treat a child in defiance of parental wishes, this may be a breach of the parents' and child's rights to family life. Where parents are in dispute with medical practitioners, the following principles are applied by the court: The best interest of the child applies. The court has to conduct a balancing exercise and weigh up the advantages and disadvantages of giving or withholding medical treatment in order to decide what is in the child's best interest. While the courts accord great respect to parental wishes, parental wishes never prevail over the child's best interest. The consent of the court may be needed in respect of certain type of medical treatment of a child where the child parents cannot agree about the treatment. The court will also take into account the pain and suffering and quality of life which the adolescent will experience if life is prolonged and the pain and suffering involved in a proposed treatment. Though there is strong presumption in favour of prolonging life, but there is no obligation on medical practitioners to give treatment which will be futile.

Conclusion

The author, documented detailed account of the law and practice of adolescents' rights as it relates to the patient, parents, and medical personnel showing each of them has no absolute power when it comes to medical treatment. Therefore, the adolescent rights, do not prevent interventions that will protect the adolescent from any harm that may result to adverse health consequences.

Recommendations

Based on the discussion thus far, the following recommendations are hereby made :

1. Adolescent's rights should be included in the education of all medical professionals working with children. To the largest extent possible, adolescents must be informed from the very beginning and in age-appropriate way about their health status, options for treatment and prognosis, applying creative and child-specific modes of communication. When adolescents are involved in their own health care it will enhance their capacities to take ownership of their own health.
2. Adolescent-friendly care should be nonjudgmental. Many adolescents are concerned about stigma or shame associated with their health issues ,this stigma not only makes it difficult for adolescents to find nonjudgmental medical advice and guidance but it also makes them less willing to seek counseling and care.

3. Health providers should be specially trained to work directly with adolescents and provide information about how to protect adolescents' health without judging their choices. Likewise, medical professionals can play a valuable role in enabling adolescents to be involved in medical decisions on their individual treatment.
4. Proper communication to both parents and children is essential in ensuring participation of children that is compliant with the best interest of the child.
5.. Having given insight into the triad relationship between doctors, adolescents and their parents, it is recommended that there should be coalitions between the parties. Under Article 24 CRC, parents, other care takers (including medical professionals),have the primary responsibility to ensure the right to health of the adolescent, also the government must ensure the necessary health infrastructure that will enable this to be effected is in place. T
6. There should be greater enforcement of existing international legal protection. Access to health and health services are not just basic needs of children and adolescents but their fundamental human rights.

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