

THINK OF THE CHILDREN: LIABILITY FOR NON-DISCLOSURE OF INFORMATION POST-*MONTGOMERY*

Emma Cave, Craig Purshouse

This is a pre-copyedited, author-produced PDF of an article accepted for publication in the Medical Law Review following peer review in May 2019. The definitive publisher-authenticated version is available online at: <https://academic.oup.com/medlaw>

ABSTRACT

In 2015 the Supreme Court in *Montgomery v Lanarkshire Health Board* handed down a landmark decision on informed consent to medical treatment, heralding a legal shift to a more patient-centred approach. *Montgomery*, and the extensive commentary that has followed, focuses on ‘adult persons of sound mind’. We consider the potential claims that may flow from a failure to adequately inform children. We argue that the relevance of the best interests test blurs the boundaries between negligence and battery. Limitations on children’s rights to make treatment decisions for themselves impact on their potential to claim in negligence for non-disclosure and, conversely, enhance the potential relevance of the tort of battery. In paediatric cases, *Montgomery* raises expectations that the law is currently ill-equipped to satisfy. Tort law provides a legal incentive to disclose relevant information to children but limits the availability of a remedy.

KEYWORDS

Battery, children, disclosure, informed consent, *Montgomery*, negligence, non-disclosure

I. INTRODUCTION

This article considers the potential tort claims that may follow from a healthcare practitioner's (HCP's) non-disclosure of information when treating a child patient. Focusing on children¹ who are capable of contributing to or making treatment decisions, we address situations where the patient would have refused medical treatment had relevant information been disclosed.

We begin with a brief reminder of relevant general principles of law. If an HCP fails to disclose information to a patient then they may commit the tort of battery or the tort of negligence. The former is committed where the medical procedure involves intentional and direct bodily contact with the patient.² The consent of the patient is a defence to a battery claim but in order for the consent to be valid, the patient must be informed in broad terms about the nature of the procedure.³ The tort of negligence is committed if an HCP breaches their duty of care to the claimant and that breach causes actionable damage. The HCP's duty to take reasonable care not to injure their patient will be breached if they fail to warn the patient of material risks in or reasonable alternatives to the treatment.⁴ The breach will have caused injury if the patient would not have consented to the treatment had they been warned and the risk in the treatment eventuates. Both torts therefore require the HCP to provide information to the patient though, as we shall discuss below, the level of information differs between the two. The difference is considerable in

* All web links last accessed 21st May 2019.

¹ 'Children' is shorthand for 'children and young people'. We will differentiate between children aged under 16 and aged 16-17 at various points in the article.

² *Collins v Wilcock* [1984] 3 All ER 374 (Div Ct), 377 (Goff L.J.).

³ *Chatterton v Gerson* [1981] 1 All ER 257 (QB). We will refer to consent as a defence to battery but there is debate about whether this is the case or whether lack of consent is part of the cause of action. If the latter, it would be for the claimant to establish that they did not consent to the defendant's intentional and direct touching. There is some authority for this proposition (*Freeman v Home Office (No. 2)* [1984] QB 524 (CA), 539 (McCowan J.)). However, Sir Anthony Clarke M.R. maintained that it was 'open to debate whether McCowan J.'s conclusion on burden of proof [in *Freeman*] is correct' in *Ashley v Chief Constable of Sussex Police* [2006] EWCA Civ 1085, [31]. Furthermore, the editors of *Clerk & Lindsell on Torts* note that this appears inconsistent with the weight of authority that states consent is a defence (see the cases listed at [3-104]) and the burden of establishing a defence rests with the defendant. They state: 'A claimant attacked in the street with a knife should not have to plead and prove that he did not consent to the attack (easy though that may be). By the same token, a competent patient cut by the surgeon's scalpel should not have to prove the absence of consent—it is a matter for the surgeon to justify by reference to the patient's consent' (MA Jones (Ed) *Clerk & Lindsell on Torts* (Sweet & Maxwell, 22nd edn, 2018), [15-93]). See also FA Trindade, 'Intentional Torts: Some Thoughts on Assault and Battery' (1982) 2 OJLS 211, 229. Whichever view is preferred, it does not affect our core argument.

⁴ The power to choose treatment is subject to the medical view that the treatment is clinically indicated: *R (Burke) v General Medical Council* [2005] EWCA Civ 1003, [50] (Lord Phillips M.R.).

adult cases, but we will argue that the requirement to consider the child's best interests could blur the boundary between negligence and battery.

With regard to negligence, the Supreme Court decision of *Montgomery v Lanarkshire Health Board*⁵ adopted a more patient-centred approach to negligent non-disclosure of information for 'adult person(s) of sound mind',⁶ but how far does and should tort law uphold the principle of 'informed consent' in the case of children? Despite there being a wealth of academic literature on the law of information non-disclosure as it applies to adults, until now the extent to which this law applies to child patients has not been explored in any depth.

The lack of legal clarity is problematic as it may result in the autonomy of child patients being violated. Autonomy is equated with a person's 'freedom to decide what shall and shall not be done with their body'⁷ and, though the weight given to autonomy has sometimes been contested,⁸ respecting it is widely considered to be an important ethical principle. There are different definitions to the term autonomy in the literature. The case law tends to support a liberal conception that seeks to give effect not only to an individual's current desires but also their long-term choices and values.⁹ It is true that these theories of autonomy can result in different outcomes when determining whether an interference with an individual is morally justified. Whichever of these definitions of autonomy is preferred,¹⁰ though, failing to inform a patient of the risks involved in medical treatment could constitute an interference with autonomy and so it is not necessary for us to take a firm stance on this issue for the purposes of this article.

⁵ [2015] UKSC 11.

⁶ *Ibid.*, [86] (Lords Kerr and Reed).

⁷ *Ibid.*, [108] (Lady Hale).

⁸ See M Brazier, 'Do No Harm – Do Patients Have Responsibilities Too?' (2006) 65 CLJ 397, 400-403.

⁹ See J Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15 Health Care Analysis 235, C Purshouse, 'How Should Autonomy be Defined in Medical Negligence Cases?' (2015) 10 Clinical Ethics 107 and G Turton, 'Informed Consent to Medical Treatment Post-*Montgomery*: Causation and Coincidence' (2018) 27 Med L Rev 108.

¹⁰ The second-named author has previously argued that the 'current desire' view of autonomy better represents the case law (Purshouse, *ibid.*) but, as a result of Turton's critique of his position, he now recants this view. See G Turton, *ibid.*, 113-114.

It could also be argued that negligence focuses on carelessly caused injury and so is arguably ill-suited to protecting autonomy.¹¹ But following the decision in *Chatterton v Gerson*¹² to limit the scope of the tort of battery, negligence has become the dominant mechanism for protecting autonomy in medical treatment decisions. In 1999 Jones stated:

The underlying ethical principle of informed consent is that one should respect the patient's autonomy: the capacity to think, decide and act on one's own thoughts and decisions freely and independently.¹³

This was confirmed in *Montgomery*¹⁴ and *Chester v Afshar*¹⁵ before it, when the courts recognised the relevance of autonomy when developing the doctrine of informed consent. The issues considered in this article will therefore enable us to assess whether tort law is adequately respecting autonomy in paediatric cases.

Furthermore, our argument has important implications for access to justice. A Freedom of Information request submitted by the authors to NHS Resolution indicates that, since *Montgomery*, paediatric claims related to non-disclosure of information have increased, whilst the number of successful claims has fallen.¹⁶ This suggests that raised expectations of information disclosure following *Montgomery* extend beyond 'adults of sound mind' and that access to justice in

¹¹ *Duce v Worcestershire Acute Hospitals NHS Trust* [2018] EWCA 1307, [88] (Leggatt L.J.). For arguments that the claims in battery are more appropriate than negligence in cases of information non-disclosure see TK Feng, 'Failure of Medical Advice: Trespass or Negligence?' (1987) 7 LS 149 and, more recently, A Beever, *A Theory of Tort Liability* (Hart: Oxford, 2016), ch 15. By way of contrast, C Beuermann has recently argued that the torts of trespass to the person have been overtaken by negligence and are now obsolete ('Are the Torts of Trespass to the Person Obsolete? Part 2: Continued Evolution' (2018) 26 Tort L Rev 6, 9-10 and 13-17).

¹² (n 3).

¹³ MA Jones, 'Informed Consent and Other Fairy Stories' (1999) 7 Med L Rev 103, 123.

¹⁴ (n 5) [68] and [80] (Lords Kerr and Reed) and [108] (Lady Hale).

¹⁵ [2004] UKHL 41, [24] (Lord Steyn) and [54] and [56] (Lord Hope).

¹⁶ FOI_3279, 29 March 2018. Annual number of claims where patient 17 and under where informed consent / failure to warn was the main cause of action: Between 2010/11 and 2014/15 the highest number of annual claims was 14 and the average 11.6. In 2015/16, the year of *Montgomery*, there were 18 and in 2016/17, 27. Claims closed or settled as a periodical payment order for the same age group: Between 2010/11 and 2014/15, the highest was 9 and the average 7.8. In 2015/16 there were under 5 and in 2016/17 there were 6. When expressed as a percentage of claims settled or closed, the average between 2010/11-2014/15 is 67.2%. In 2016/17 this dropped to 22.2%.

paediatric cases is limited. Indeed, we will present evidence of legal uncertainty as to the mechanisms for protecting information non-disclosure that supports this claim. Clarification here is therefore both timely and important.

We focus on children's interests in receiving information and the tort claims they might bring. Taking the existing law as a starting point, the first part of the article outlines the law so far as it determines when children and proxies can consent to medical treatment. We then set out a number of barriers to a successful claim in negligence for non-disclosure where the treatment involves a child. In particular, we demonstrate that the principle that child patients must be treated in their best interests, combined with the fact that proxies can still consent on their behalf, has potential to thwart claims by children for negligent non-disclosure of information. We then consider the tort of battery. Whereas for adult patients, battery offers only limited protection in cases of non-disclosure of information, we argue that the tort has paradoxical significance in paediatric cases. We conclude that whilst tort law provides a legal incentive to disclose relevant information to children, there are limitations in the availability of a remedy.

The term 'informed consent' is potentially misleading given that it implies an element of validity which in fact is a matter for battery.¹⁷ We will therefore differentiate 'consent' from 'informed consent' to distinguish the laws of battery and negligence, and refer to '(informed) consent' when we seek to capture both torts.

II. LEGAL CAPACITY OF CHILDREN

Before discussing the tort remedies for children who have received insufficient information about medical treatment, it is necessary to outline the law on the legal capacity of children. This will determine whether they can consent to treatment and, by extension, is relevant to claims for negligent non-disclosure of information and battery.

¹⁷ *Rogers v Whittaker* (1992) 175 CLR 479 (HCA), 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh J.J.) and see *Montgomery* (n 5) [108] (Lady Hale).

It is well established that children under the age of 18 can provide a valid consent in certain circumstances. The law recognises some children to be of sufficiently ‘sound mind’ to provide an effective consent, in which case there is good reason to demand that information about the treatment is disclosed to them. In the landmark case of *Gillick v West Norfolk and Wisbech AHA*,¹⁸ the House of Lords held that children under the age of 16 (under 16s) can consent to medical treatment, provided they have sufficient ‘understanding and intelligence’¹⁹ to make the decision.²⁰ Such children possess ‘*Gillick* competence’, otherwise termed ‘*Gillick* capacity’ to make the decision.²¹

According to section 8(1) of the Family Law Reform Act 1969, young people aged 16-17 can provide consent to surgical, medical or dental treatment which is ‘as effective as it would be if he were of full age’. Most of the provisions of the Mental Capacity Act 2005 (MCA) and accompanying Code,²² which govern decision-making for adults who lack capacity, also apply to 16-17-year-olds.²³ The Act presumes capacity²⁴ and sets out a two-stage functional test for incapacity:²⁵ Is there an impairment of or disturbance in the functioning of a person’s mind or brain? If so, is the impairment sufficient that the person lacks capacity to make the relevant decision?

Where a child lacks *Gillick* capacity, it was established in *Re R*²⁶ that proxy consent should be obtained, in which case the HCP must decide what to disclose to the child and proxies respectively.²⁷ Provided material information is disclosed to the proxy, the incapacitated child’s

¹⁸ [1986] 1 AC 112 (HL).

¹⁹ *Ibid.*, 170 (Lord Fraser).

²⁰ Despite later challenges, it remains good law. See *R (Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin), [115] (Silber J.).

²¹ The terms are used interchangeably by Sir James Munby in *Re D (A Child)* [2017] EWCA Civ 1695, [83]. We will employ the term ‘*Gillick* capacity’.

²² *MCA 2005 Code of Practice* (TSO: 2007).

²³ MCA 2005, s 2(5).

²⁴ *Ibid.*, s 1(2).

²⁵ *Ibid.*, ss 2-3.

²⁶ *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11 (CA).

²⁷ *Ibid.*, 22 (Lord Donaldson M.R.). For 16-17-year-olds, the MCA 2005 s 5 makes an exception to the requirement to obtain consent in certain circumstances, but persons with parental responsibility would usually be consulted in compliance with s 4.

negligence claim for non-disclosure is likely to fail. Where a 16-17-year-old lacks capacity, the MCA sets out a framework for decision-making in the person's best interests, requiring (where practicable) consultation with relevant people, including the patient.²⁸ Where there is a reasonable belief of incapacity, the HCP who examines or treats the patient in their best interests is protected under section 5.

While this article will at times refer specifically to *Gillick* capacity and MCA capacity, so as to distinguish the different legal sources of the child's ability to consent to treatment, we will employ the generic term 'capacity' to denote a child's satisfaction of either test.

A. *The Status of Children*

Should the fact that a patient is a child prevent them from bringing a claim in negligence or battery for non-disclosure? Initially, this does not seem a convincing reason for limiting these rights of action. It is clear that empowering children to understand their condition and treatment improves their health and wellbeing.²⁹ Furthermore, assuming that one of the purposes of the law of (informed) consent is to protect autonomy,³⁰ it should apply to children with capacity as, morally speaking, they have autonomy interests that warrant protection.³¹

However, capacity does not render a child's status equal to adults'. While children with requisite capacity can consent to treatment, they cannot necessarily refuse it. This stems from ambiguity as to the *ratio* of *Gillick*. In the majority, the two leading speeches were given by Lord Fraser and Lord Scarman, with Lord Bridge agreeing with both judgments. Lord Scarman appeared to hold that a child had a right to *determine* whether or not they could consent to medical treatment once they had capacity.³² According to this view, once a child has *Gillick* capacity, their

²⁸ MCA 2005, s 4: See below at IV.C.

²⁹ The Values-Based Child and Adolescent Mental Health System Commission, *What Really Matters in Children and Young People's Mental Health* (The Royal College of Psychiatrists: 2016), 4, accessible at <https://valuesbasedpractice.org/wp-content/uploads/2015/04/Values-based-full-report.pdf>.

³⁰ Cf. T Clark and D Nolan, 'A Critique of *Chester v Afshar*' (2014) 34 OJLS 659, 676.

³¹ See M Brazier and C Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy' (1996) 16 LS 84, 87-92.

³² *Gillick* (n 18), 186.

consent would prevent an action in battery. In contrast, Lord Fraser's judgment required that the treatment had to be in the child's best interests before the consent to treatment would be considered valid.³³ The consent of a child with *Gillick* capacity would not be *sufficient* to render treatment lawful. This is because the best interests test is not equated with the views or desires of the child. It is possible for treatment to be in a child patient's best interests even if the child does not wish the treatment to occur. For example, in *Re M (Child: Refusal of Medical Treatment)*³⁴ it was held that a 15-year-old girl's refusal to consent to a heart transplant could be overridden as the operation would be in her best interests. The child's views will be an important factor in the balancing exercise used to determine best interests, but they are not decisive.

Controversy has been generated by the interpretation of *Gillick* in two Court of Appeal decisions where Lord Donaldson M.R. gave the leading judgments: *Re R*³⁵ and *Re W*.³⁶ Lord Donaldson asserted that the *ratio* of *Gillick* is that while a child with capacity can consent to medical treatment, the court or those with parental responsibility retain a concurrent right to consent.³⁷ They may override the child's refusal to consent and provide consent on the child's behalf where so doing would be in the child's best interests. This means that, in addition to being *insufficient*, the consent of a child with *Gillick* capacity is not *necessary* for an HCP to avoid a battery action. The same principle applies to young people aged 16-17.³⁸

With adults, consideration of best interests by the courts only arises if it has been determined that the adult lacks capacity.³⁹ It has long been established that a person with capacity who has attained the age of 18 may refuse treatment, even if that decision is unwise.⁴⁰ As a result,

³³ *Ibid.*, 174.

³⁴ [1999] 2 FLR 1097.

³⁵ (n 26).

³⁶ [1993] Fam 64 (CA).

³⁷ *Ibid.*, 78 and *Re R* (n 26), 22.

³⁸ *Re W* (n 36), 78.

³⁹ MCA 2005, s 1(5).

⁴⁰ *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 (CA), 102 (Lord Donaldson); *An NHS Foundation Trust Hospital v P* [2014] EWHC 1650 (Fam), [11] (Baker J.).

some commentators have argued that it is illogical to say that a child, or any individual, can have the capacity to make a particular decision but is not capable of refusing it.⁴¹

Yet this critique only has force if the aim of the law is to protect children's *autonomy*. Lord Donaldson's interpretation of *Gillick* focuses not on its potential to enhance children's autonomy, but to protect their *welfare*. Children can consent to treatment that is in their best interests if they have sufficient understanding and intelligence, just as they can refuse treatment that is not in their best interests.

Of course, autonomy is a relevant aspect of the child's welfare: this is clear from reference to the child's view in the Children Act 1989 welfare checklist⁴² and from the common law.⁴³ The primary aim of the law, however, is not to protect the autonomy rights of children but to elicit 'what is best for the welfare of the particular child'.⁴⁴ According to *Re R* and *Re W*,⁴⁵ the child, persons with parental responsibility and the court can all provide a valid consent in order to protect an HCP fulfilling that aim. The law therefore allows the child's refusal of treatment to be overridden to protect their best interests. This can impact on information disclosure both in relation to what is relayed to the child and what is shared with proxies.

B. Parental Status vis-à-vis the Capacious Child

Parental powers are, however, limited in law and practice. In family law, the welfare of the child is the paramount consideration.⁴⁶ The definition of parental responsibility in section 3 of the Children Act 1989 balances parental powers and rights with responsibilities. Sir James Munby

⁴¹ See J Murphy, 'W(h)ither Adolescent Autonomy?' (1992) 14 JSWFL 529, J Harris, 'Consent and End of Life Decisions' (2003) 29 J Med Ethics 10, 12 and M Freeman, 'Rethinking *Gillick*' (2005) 13 Int J Child Rts 201, 211. For a limited defence of this distinction see R Heywood, 'Mature Teenagers and Medical Intervention Revisited: A Right to Consent, a Wrong to Refuse' [2008] 37 CLWR 191.

⁴² Children Act 1989, s 1(3)(a).

⁴³ *Axon* (n 20).

⁴⁴ *Gillick* (n 18), 173 (Lord Fraser).

⁴⁵ Applied in *An NHS Foundation Trust Hospital v P* (n 40), 12.

⁴⁶ Children Act 1989, s1(1). See *J v C* [1970] AC 668 (HL), 710 (Lord MacDermott) and H Reece, 'The Paramountcy Principle: Consensus or Construct' (1996) 49 CLP 267, 267.

recently made clear in *Re D* that *Re W* remains relevant⁴⁷ but also noted that, since *Gillick*, the ambit of parental responsibility is ‘to be ascertained by reference to general community standards in contemporary Britain, the standards of reasonable men and women’.⁴⁸ In 1993 this ambit extended to providing consent in the best interests of a capacitous child refusing treatment. It is questionable whether this remains the case.

Post-*Re W*, professional guidance at first asserted parental rights to veto harmful treatment and recognised a resulting need for persons with parental responsibility to be properly informed.⁴⁹ But *Re W* was decided before the Human Rights Act 1998 came into force. Article 8 of the European Court of Human Rights (ECHR) has been influential in the backlash against medical paternalism.⁵⁰ It was relevant in *Montgomery*⁵¹ and in assertions of children’s autonomy rights in *Axon*. In the latter case Silber J. opined that once a child has capacity to make decisions for herself, persons with parental responsibility lose any right under Article 8 to consent on the child’s behalf.⁵²

Today, professional guidance is more protective of the autonomy rights of children with capacity, urging a court declaration rather than reliance on parental consent where refused treatment would prevent loss of life or grave harm.⁵³ The court is required to take into consideration the wishes and feelings of the child under the welfare checklist set out in section 1(3) of the Children Act 1989. The Care Quality Commission (CQC) goes further still, advising that: ‘Parents cannot override a competent child’s refusal to accept treatment.’⁵⁴ This is a bold stance that runs contrary to *Re R* and *Re W*. It is an approach that places dwindling emphasis on parental powers once the child has capacity, and the restricted power is likely to be matched by a

⁴⁷ *Re D (A Child)* (n 21), [126].

⁴⁸ *Ibid.*, [85].

⁴⁹ See e.g. Welsh Assembly Government, *Reference Guide to Consent for Examination or Treatment* (2002), 8.3, accessible at <http://www.wales.nhs.uk/Publications/treatmentgd-e.pdf>.

⁵⁰ See J Fortin, ‘Accommodating Children’s Rights in the Post Human Rights Act Era’ (2006) 69 MLR 299, 320, *Pretty v United Kingdom* (2002) 35 EHRR 1 (2346/02) and *VC v Slovakia* (2014) 59 EHRR 29 (18968/07).

⁵¹ *Montgomery* (n 5), [80] (Lords Kerr and Reed).

⁵² *Axon* (n 20), [130].

⁵³ Department of Health, *Reference Guide to Consent for Examination or Treatment* (2009), 3.15, accessible at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf

⁵⁴ *Ibid.*

limited right to information about the child's treatment. The case law adopts an approach that encourages HCPs to share information but, does not extend to breaching the child's confidentiality without a strong best interests justification.⁵⁵

If the child lacks capacity, HCPs can rely on parental consent. In this regard, the vagueness and high threshold of the *Gillick* test can result in assessments that effectively focus on outcomes and inadequately protect autonomy.⁵⁶ On the other hand, reduced reliance on parental veto means, as we shall see, that HCPs will need to furnish the child with relevant information in order to determine whether the decision is valid and made with capacity. The law is less concerned with a doctor-centred approach protecting HCPs from liability and increasingly sympathetic to a patient-centred approach protecting patient autonomy.

However, the development of respect for children's autonomy only goes so far. In the next section we argue that limitations on their right to decide may impact on their ability to claim in negligence for non-disclosure of material information.

III. NEGLIGENCE

A. *Negligent Non-Disclosure of Information*⁵⁷

The HCP's duty of care includes giving the patient enough information so that they can make a decision whether to accept or reject treatment.⁵⁸ Prior to *Montgomery*, the case of *Sidaway v Bethlem Royal Hospital*⁵⁹ governed the standard of care expected of HCPs in information non-disclosure cases. Marked differences characterised the speeches of their Lordships but the majority were broadly supportive of utilising the *Bolam* test to determine whether an HCP had breached their

⁵⁵ See *Gillick* (n 18), 174 (Lord Fraser) and *Axon* (n 20), [103] (Silber J.).

⁵⁶ See E Cave, 'Goodbye *Gillick*? Identifying and Resolving Problems with the Concept of Child Competence' 24 (2014) LS 103.

⁵⁷ Whilst non-disclosure may also lead to actionable psychiatric harm, this is beyond the scope of this paper.

⁵⁸ *Sidaway v Bethlem Royal Hospital* [1985] AC 871 (HL), 893 (Lord Diplock).

⁵⁹ *Ibid.*

duty to advise patients.⁶⁰ An HCP would escape liability if he or she could find a responsible body of medical opinion that would have chosen not to inform the patient of a particular risk.⁶¹

In *Montgomery* it was held that the majority decision in *Sidaway* was flawed.⁶² Echoing Lord Scarman's dissenting judgment in *Sidaway*, Lady Hale asserted that informed consent is firmly part of UK law.⁶³ Henceforth, HCPs must disclose information that a reasonable patient would consider significant or, where the HCP is or ought reasonably to be aware, that the actual patient finds significant.⁶⁴ Reflecting a shift in 'societal attitudes towards the practice of medicine'⁶⁵ and developments in other common law countries,⁶⁶ the decision puts the patient and their rights centre-stage.⁶⁷ Lords Kerr and Reed said:

An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken.⁶⁸

B. Negligence Claims by Children with Capacity

For *children*, the powers of persons with parental responsibility to overrule their capacitous treatment decisions are, in practice, limited. However, the *courts* are willing to override a capacitous refusal in sufficiently serious cases, where the treatment is deemed to be in the child's best

⁶⁰ See the judgments of Lord Diplock, Lord Bridge (with whom Lord Keith agreed) and Lord Templeman.

⁶¹ See *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (QB).

⁶² *Montgomery* (n 5), [86] (Lords Kerr and Reed).

⁶³ *Ibid.*, [107].

⁶⁴ *Ibid.*, [87] (Lord Kerr and Reed).

⁶⁵ *Hii Chii Kok v Ooi Peng Jin London Lucien* [2017] SGCA 38, [120] (Menon C.J.). There is some debate about whether the judgment in *Montgomery* is actually revolutionary or merely an evolution of the patient-friendly decisions following *Sidaway*. See R Heywood and J Miola, 'The Changing Face of Pre-Operative Medical Disclosure: Placing the Patient at the Heart of the Matter' (2017) 133 LQR 296, 298.

⁶⁶ The fact that Canada (*Reibl v Hughes* [1980] 2 SCR 880 (SCC)) and Australia (*Rogers v Whitaker* (1992) 175 CLR 479 (HCA)) had adopted patient-centred approaches to risk disclosure influenced the decision in *Montgomery* (n 5), [70]-[73]. Post-*Montgomery*, a similar approach was adopted in Singapore in *Hii Chii Kok* (n 65).

⁶⁷ See T Elliot, 'A Break with the Past? Or More of the Same?' (2015) 31 PN 190 and Heywood and Miola (n 65). Cf. C Hobson, 'No (,) More *Bolam* Please: *Montgomery v Lanarkshire Health Board*' (2016) 79 MLR 488 and J Montgomery, 'Patient No Longer? What Next in Healthcare Law?' (2017) 70 CLP 73.

⁶⁸ *Montgomery* (n 5), [87].

interests.⁶⁹ Best interests is a primary consideration as a ‘universal theme of the various national and international instruments’,⁷⁰ including Article 3 of the United Nations Convention on the Rights of the Child. Whilst the principles of informed consent applicable to adults are shifting inexorably from a transferal of responsibility designed to defend HCPs from tortious liability to a means of protecting patient autonomy, *Re W* adopted a paternalistic approach whereby a valid and informed consent provides a ‘flak jacket’ to protect the HCP from liability.⁷¹ The decision-making powers conferred on children by virtue of their capacity are restricted.⁷² We will argue that the concept of best interests impacts on consenting children’s ability to claim in negligence.

Children can bring claims for negligent diagnosis and treatment.⁷³ It has long been established that HCPs owe a duty of care to their patients and that, in addition to diagnosis and treatment, this duty encompasses advising the patient.⁷⁴ Although sometimes issues may arise about the extent of the HCP’s duty to his or her patient,⁷⁵ there is, ostensibly, no reason why the HCP would not owe this duty to children with capacity whose consent is relied upon.

The test for breach in information non-disclosure cases, set out in *Montgomery*, establishes that an HCP is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.⁷⁶ As mentioned earlier, these are assessed from the position of the reasonable patient (or the actual patient where the HCP ought reasonably to be aware that the patient would find the risks or alternatives significant).

For 16-17-year-olds, *Montgomery* is likely to apply because the Family Law Reform Act 1969 treats them like adults. For under 16s, application would rely on the incremental extension from ‘adult patients of sound mind’ to children with *Gillick* capacity. There are grounds for this given

⁶⁹ *An NHS Foundation Trust Hospital v P* (n 40).

⁷⁰ *ZH (Tanzania) v Secretary of State for the Home Department* [2011] UKSC 4, [45] (Lord Kerr).

⁷¹ *Re W* (n 36), 78 (Lord Donaldson M.R.).

⁷² See Cave, ‘Goodbye *Gillick*?’ (n 56).

⁷³ See e.g. *Wilsher v Essex AHA* [1988] AC 1074 (HL); *Phelps v Hillingdon LBC* [2001] 2 AC 619 (HL).

⁷⁴ *Sidaway* (n 58), 881 (Lord Scarman).

⁷⁵ See for example *McFarlane v Tayside Health Board* [2000] 2 AC 59 (HL).

⁷⁶ *Montgomery* (n 5), [87] (Lords Reed and Kerr).

the legal recognition of the child's capacity and Lady Hale's statement in *Montgomery* that: 'The medical profession must respect her choice, unless she lacks the legal capacity to decide.'⁷⁷ However, as we have seen, capacity does not equate children with adults, and so this extension is not assured. If *Montgomery* were not to apply, HCPs would not be considered negligent if they were acting in accordance with a responsible body of medical opinion 'merely because there is a body of opinion who would take a contrary view'.⁷⁸ The focus would not be on what the reasonable or actual patient would want to know, but on what the reasonable doctor would disclose in the circumstances.

Causation provides a more extensive hurdle. Usually, in order for factual causation to be established, the claimant must show on the balance of probabilities that 'but for' the failure to warn they would have avoided the damage. First, the failure to warn must have caused actionable damage, which means that the risk inherent in the procedure must have eventuated: no claim will succeed where the procedure improves the claimant's health. Second, the patient must demonstrate that they would not have undergone the treatment if they had been properly warned and thus avoided the bad outcome. Where a patient's treatment turns out to be unsuccessful, there is an incentive for them to say that they would not have undergone the operation, otherwise the claim would fail. The court is wary of hindsight bias and will give weight to an objective assessment of whether the reasonable patient would have undergone the procedure if warned (the objective limb). If the reasonable patient would still have gone ahead then it is for the claimant to demonstrate that they would have acted differently to the reasonable patient (the subjective limb).⁷⁹ This approach has been confirmed post-*Montgomery*.⁸⁰ Finally, under the exceptional rule in *Chester v Afshar*, causation may also be established if the patient would have *delayed* having the treatment

⁷⁷ *Ibid.*, [115].

⁷⁸ *Bolam* (n 61), 587 (McNair J.).

⁷⁹ *Smith v Barking, Havering and Brentwood HA* [1994] 5 Med LR 285 (QB). See also Turton, (n 9).

⁸⁰ *Diamond v Royal Devon Exeter NHS Foundation Trust* [2017] EWHC 1485 (QB), [47] (Freedman H.H.J.). Indeed, recent cases on causation could be regarded as more conservative than the patient-centred approach to breach of duty taken in *Montgomery*. See *Duce* (n 11), *Correia v University Hospital of North Staffordshire NHS Trust* [2017] EWCA Civ 356; *MC & JC v Birmingham Women's NHS Foundation Trust* [2016] EWHC 1334 (QB); *Barrett v Sandwell & West Birmingham Hospitals NHS Trust* [2015] EWHC 2627 (QB).

and therefore avoided the risk by running it at a different time or in different circumstances.⁸¹ We will consider the *Chester* exception below.

Prima facie, it appears that an HCP should warn a child who has capacity of the risks of treatment. If a capacitous child has a right to *determine* their own medical treatment then there would be no barriers, beyond those that adults face, to them bringing a negligence claim. A failure by an HCP to warn the capacitous child of material risks in the treatment, or reasonable alternatives to it, would constitute a breach of duty and, if those risks eventuated and the child would have refused the treatment if warned, causation could be established. The child would have been able to avoid the damage by not undergoing the risky treatment.

A problem with this analysis is that even if an HCP breaches their duty to disclose information, provided the treatment is required in the child's best interests, the child will have difficulty convincing the court that they would have avoided the risks involved in the procedure. This is because, given alternative consent would have been provided even if the child had refused the treatment, it is more likely than not that they would have undergone the procedure even if they were properly warned.

Let us imagine that an HCP fails to warn a child of a ten per cent risk of paralysis inherent in a procedure and that risk eventuates. The child may be able to demonstrate that if they were warned of the risk then they would not have consented to the operation. But that alone does not mean that they would have avoided the risk. If the case for treatment is compelling on the basis that it is required in the child's best interests, it is more likely than not that the HCP would have been able to obtain alternative consent from a proxy. If so, then it appears that the risk of injury would not have been avoided and the failure to warn would have made no difference to the eventual outcome.⁸² A negligence claim would fail.

⁸¹ *Chester* (n 15). See J Stapleton, 'Occam's Razor Reveals an Orthodox Basis for *Chester v Afshar*' (2006) 122 LQR 426.

⁸² This is assuming that the proxy consent would have been obtained at the same time.

Chester v Afshar may assist children who have not been informed of the material risks of treatment: they might be able to establish causation if they can convince the court that they would have *delayed* the procedure if they had been warned. As the case is complicated, it is worth recounting the facts. In breach of duty, the defendant failed to warn the claimant of a 1-2 per cent risk of cauda equina syndrome inherent in back surgery. This risk would exist no matter how expertly the surgery was performed. The claimant underwent the surgery on 21 November 1994. Although it was carefully performed, the risk eventuated and she became paralysed. In her claim against the defendant, she did not argue that if warned of this risk she would never have undergone the surgery. Had she done so, causation would have been straightforward as she would have avoided the risk altogether. Instead, she argued that she would have sought further advice, with the result that the surgery probably would have taken place at a later date.

By a narrow majority, she was successful in the House of Lords (Lords Bingham and Hoffmann dissenting). In the majority, Lord Steyn said that her ‘right of autonomy and dignity can and ought to be vindicated by a narrow and modest departure from traditional causation principles.’⁸³ Although the case has spurred a vast academic literature about whether it can be reconciled from ordinary causation principles and, if it cannot, whether such a departure from orthodoxy is justified,⁸⁴ we do not need to take a stance on these debates.

Notwithstanding some views to the contrary,⁸⁵ the idea that *Chester* means damages can be awarded for lost autonomy has been resoundingly rejected by the Court of Appeal in England and Wales and by the highest court in Singapore.⁸⁶ A child patient must therefore have suffered personal injury as a result of the HCP’s negligent non-disclosure in order to claim. Furthermore,

⁸³ *Chester* (n 15), [24].

⁸⁴ A useful summary of the debate can be found in Turton (n 9) 118-1119 and Clark and Nolan (n 30).

⁸⁵ For a recent advocate of the position that lost autonomy should be recognised as actionable damage see T Keren-Paz, ‘Compensating Injury to Autonomy in English Negligence Law: Inconsistent Recognition’ (2018) 26 Med L Rev 585, 592-593. For a summary of this position see C Purshouse, ‘Liability for Lost Autonomy in Negligence: Undermining the Coherence of Tort Law?’ (2015) 22 Torts LJ 226, fn 45 and ‘Autonomy, Affinity and the Assessment of Damages: *ACB v Thomson Medical Pte Ltd* [2017] SGCA 20 and *Shaw v Kovak* [2017] EWCA Civ 1028’ (2018) 26 Med L Rev 675, fn 1.

⁸⁶ See *Shaw v Kovak* [2017] EWCA Civ 1028 and *ACB v Thomson Medical Pte Ltd* [2017] SGCA 20 respectively. The same conclusion was also reached in *Diamond* (n 80).

while, as Turton notes, subsequent decisions have ‘sought to confine the *Chester* principle narrowly’,⁸⁷ it allows factual and legal causation to be established if the patient would have delayed the treatment if warned. This may assist a child patient in establishing causation but it is more likely to be successful where the treatment is elective and not *mandated* in the child’s best interests. In the latter type of case, it may not be possible to delay treatment.

Even if the treatment would ultimately be considered by a court to be in the child’s best interests, *Chester* will assist the child if she can show that the process to determine best interests – namely court authorisation – would have delayed the procedure. Let us imagine during a Monday consultation an HCP failed to warn a child patient of a 10 per cent risk in surgery. The child underwent surgery on a Wednesday and the surgery carried a 10 per cent inherent risk of injury. As in *Chester*, the evidence indicates that this unfortunate outcome is liable to strike at random (so 10 patients in every 100 will be injured). If this risk eventuated then, according to *Chester*, causation would be established if the child claimant could demonstrate that they would have delayed the surgery. If it took place at a later date – say, Friday – then there would be a 90 per cent chance of avoiding injury. It would be more likely than not that the injury would not have occurred.

Chester therefore offers some hope to child claimants, but it is subject to limitations referred to above regarding criticism of and reluctance to apply the case. Furthermore, it may not be possible to establish delay as there is often a time gap between information disclosure and the procedure. Again, let us imagine an HCP fails to warn the child on Monday of a 10 per cent risk inherent in surgery that is in the child’s best interests and the surgery is scheduled to take place on Wednesday. The child would not have consented if warned and the risk eventuates. Provided the consent of the court or a proxy could be obtained before Wednesday and the surgery proceeds as planned, the failure to warn would make no difference. *Chester* offers only limited assistance and causation represents a stumbling block for children. It will only apply in situations where the child

⁸⁷ Turton (n 9), 121. See *Meiklejohn v St George’s Healthcare NHS Trust* [2014] EWCA Civ 120, *Crossman v St George’s Healthcare Trust* [2016] EWHC 2878 (QB) and *Correia* (n 80).

can demonstrate that if they had been properly informed the treatment would have been delayed, no alternative consent would have been obtained and that the risk would have been avoided.

So far, we have focussed on children with capacity who accept treatment they would have refused (in favour of either no treatment or alternative treatment) if properly informed. What of patients who suffer harm having refused all treatment in circumstances where they would have chosen treatment had they been given material information about reasonable treatment options? If *Montgomery* applies to children, it might assist here because whilst the selection of variant and alternative options is a medical consideration,⁸⁸ the communication of them to the patient is governed by *Montgomery* and therefore by the reasonable and particular patient limbs of the test for materiality.⁸⁹ Again, in the case of non-disclosure, the patient would need to show that the (alternative) treatment would have been accepted and that it would, on balance of probability, have averted the harm suffered. It is unlikely to be enough for the patient to reframe their damage as a loss of a chance of avoiding injury.⁹⁰

A third potential stumbling block exists in the form of the defence of therapeutic exception. This applies when disclosure would 'be seriously detrimental to the patient's health'.⁹¹ The Department of Health has advised that, for adult patients, 'serious detriment' means 'more than that the patient might become upset or decide to refuse treatment'.⁹² Given the legal prioritisation of child welfare, might a broader exception be supported in the case of children? If so, an HCP could argue that informing a child patient of risks would have a negative effect on the child's health where it is likely to cause the child to refuse beneficial treatment.⁹³ The Supreme

⁸⁸ *Montgomery* (n 5), [83], *Duce* (n 11), [33] (Hamblen L.J.).

⁸⁹ *Montgomery*, *ibid.*, [87] (Lords Kerr and Reed) and *Sidaway* (n 58), 904 (Lord Templeman).

⁹⁰ *Hotson v East Berkshire Area Health Authority* [1987] AC 750 (HL) and *Gregg v Scott* [2005] UKHL 2 do not completely rule out such claims but they appear unlikely and, as far as we are aware, no court has allowed a claim to succeed on this basis (see Rachael Mulheron, *Principles of Tort Law* (CUP: Cambridge, 2016) 469-475). In any event, loss of a chance claims are beyond the scope of this article as the law is equally applicable to adults and raises no issues particular to child patients.

⁹¹ *Montgomery* (n 5) [88] (Lord Kerr and Reed) and see [85] and [91].

⁹² Department of Health, *Reference Guide to Consent for Examination or Treatment* (2009), [19]-[21], accessible at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138296/dh_103653__1_.pdf.

⁹³ Reluctance on the part of HCPs to disclose information they consider harmful is demonstrated in *Re L (Medical Treatment: Gillick Competence)* [1999] 2 FCR 524, [1998] 2 FLR 810. One of the grounds for finding L to be incompetent

Court emphasised that this exception was ‘limited’ and should not be abused,⁹⁴ but that related to adult patients. We would argue that a child who would be harmed by the disclosure of material information may lack the information required to make a capacitous decision, in which case proxy consent should be sought.⁹⁵

In practice, it will be sensible for an HCP to comply with *Montgomery* and advise children who have capacity of material risks in treatment and reasonable alternatives, particularly because the HCP may be incorrect in their assessment that the treatment is in the child’s best interests. The less compelling the case for treatment, the more likely the child will be able to establish that their views were central to a best interests assessment. Consider, for example, a child who consents to a cosmetic procedure on the basis of inadequate information and can demonstrate that they would have refused consent had they known the risks, such that a court would not have considered the procedure to be in the child’s best interests. The child would have been able to avoid the risk in the treatment (as it is likely that a proxy would not have consented to it) and so might succeed in a negligence action.

Negligence therefore offers an incentive to disclose information to children with capacity, but in the event of non-disclosure, the chances of a remedy are slim. Hurdles exist in relation to breach, causation and the HCP’s ability to rely on the therapeutic exception.

C. Negligence Claims by Children who Lack Capacity

Additional limitations apply if the child lacks capacity. Children in this position maintain an interest in participating in the decision, and a failure to involve them might result in harmful treatment that would otherwise have been refused in their best interests. Nevertheless, given that a proxy will provide consent (or, in the case of 16-17-year-olds, treatment will be provided in accordance with

was that she had not been informed of the likely horrific nature of her death should her refusal of blood products have been upheld.

⁹⁴ *Montgomery* (n 5), [91] (Lords Kerr and Reed).

⁹⁵ See below at IV.A.

section 5 of the MCA) it is unlikely that a duty of care to disclose information to the child exists. Even if it did, *Montgomery's* relevance is dubious given its explicit restriction to those with capacity. If *Montgomery* does not apply to patients lacking capacity, then the *Bolam* test would continue to govern the standard of care.

A proxy (with parental responsibility) has a right to consent to treatment in an under 16-year-old's best interests and needs relevant information to make an informed and valid decision. However, a claim by the proxy is unlikely to focus on *their* loss of autonomy because the function of providing consent is not to protect the autonomy interests of the adult, but to prioritise the child's welfare.⁹⁶ The proxy may have a claim in negligent information disclosure on the child's behalf if a failure to inform the proxy led to a decision to treat that would have come within the scope of the proxy's parental responsibility to refuse.

IV. BATTERY

Having outlined the potential difficulties children face in claiming in negligence, we now turn to battery. Our aim is not to provide a single definitive position but to outline a variety of possible arguments that might be raised as to battery's relevance. These arguments demonstrate the paradoxical relevance of battery to children and provide an additional incentive to disclose to children information needed to make a decision.

In *Collins v Wilcock*, Goff L.J. defined battery as: 'the actual infliction of unlawful force on another person'.⁹⁷ As a trespass tort, the touching must be intentional and direct.⁹⁸ This tort is actionable per se, meaning that, unlike with negligence, there is no need for the claimant to suffer any loss or damage. Consent provides 'those concerned in the treatment with a defence to... a civil

⁹⁶ Children Act 1989, s 1(1). See also *Gillick* (n 18), 173 (Lord Fraser).

⁹⁷ *Collins* (n 2), 377 (Goff L.J.). See also *Wilson v Pringle* [1987] QB 237 (CA), 252-253 (Croom-Johnson L.J.).

⁹⁸ See *Wilson* (n 97), 249 (Croom-Johnson L.J.) and *Reynolds v Clarke* (1725) 1 Stra 634, 636 (Fortescue C.J.) respectively. Recklessness will suffice for the mental element of the tort according to *Bici v Ministry of Defence* [2004] EWHC 786 (QB), [67] (Elias J.).

claim for damages for trespass to the person'.⁹⁹ In relation to unconsented to bodily invasions, the case law is clear that a claim in battery will lie in the case of an adult with mental capacity,¹⁰⁰ and by extension to a young person of 16 or 17. For children under 16 too, treatment without any consent constitutes a battery, except in cases of emergency.¹⁰¹ Consent may come from the child or a proxy, such as a parent or the court.

Historically, the prevalent view in the literature was that 'it would be very much against the interests of justice if actions which are really based on a failure by the doctor to perform his duty adequately to inform were pleaded in trespass'.¹⁰² Brazier argued that after *Sidaway* '[l]iability in trespass for failure to disclose risks appeared to have been stamped on'.¹⁰³ She said that bringing an action against a doctor in battery appears to place them on a par with the police officer who beats a suspect.¹⁰⁴

There is, however, evidence that the courts could, and should, consider utilising the tort in paediatric cases. The evidence in question is of a more permissive stance regarding the protection of patient autonomy *via* the tort of battery. Since Brazier's important article, *F v West Berkshire HA*¹⁰⁵ confirmed that hostility was not a requirement for battery. There has also been a retreat from medical paternalism¹⁰⁶ and a reduction in deference to healthcare professionals.¹⁰⁷ Tacit reliance on battery is at the heart of the landmark decision in *Aintree University Hospitals NHS Trust v James*.¹⁰⁸ There, the Supreme Court emphasised the unlawfulness of continued medical treatment that was not justified in the best interests of a patient who lacked capacity. The Court

⁹⁹ *Re W* (n 36), 76 (Lord Donaldson M.R.). Cf. the discussion fn 3 as to whether consent is a defence or absence of consent is part of the cause of action.

¹⁰⁰ *Chatterton* (n 3) subject to MCA 2005, s 5.

¹⁰¹ *Re R* (n 26), 22 (Lord Donaldson M.R.); Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, SI 2014/2936, reg 11(1). Once the minor is 16 or over, the need for consent is subject to the MCA 2005: Reg 11(3).

¹⁰² *Chatterton* (n 3), 443 (Bristow J.). Cf. Feng (n 11), 164 and Beever, (n 11) ch 15.

¹⁰³ M Brazier, 'Patient Autonomy and Consent to Treatment: The Role of the Law?' (1987) 7 LS 169, 179.

¹⁰⁴ *Ibid.*

¹⁰⁵ [1990] 2 AC 1 (HL).

¹⁰⁶ *Montgomery* (n 5), [81] (Lords Kerr and Reed).

¹⁰⁷ See S Devaney and S Holm, 'The Transmutation of Deference in Medicine: An Ethico-Legal Perspective' (2018) 26 Med L Rev 202.

¹⁰⁸ *Aintree University Hospitals NHS Trust v James* [2013] UKSC 67.

recognised that ‘the fundamental question is whether it is lawful to give the treatment, not whether it is lawful to withhold it.’¹⁰⁹ Consider also *Ms B v An NHS Hospital Trust*,¹¹⁰ where Butler-Sloss P. upheld Ms B’s refusal of treatment even though it would result in her death. She had capacity to make the decision so continued treatment, absent valid consent, would constitute a battery.¹¹¹

An argument that the courts should permit battery claims in paediatric cases flows from the relevance of best interests and evidence of barriers to children claiming in negligence. For adult patients, in order for a valid consent to exist it has to be given by someone with capacity, be voluntary and the individual concerned has to know what they are consenting to, which requires them to be given at least *some* information about the treatment. All that is required is that they are informed in broad terms about the nature of the treatment.¹¹²

Paradoxically, the tort that offers minimal protection to adult informational autonomy may have extended significance to under 16s for three reasons: firstly, the application of a different test for capacity; secondly, the requirement to demonstrate capacity; and, thirdly, the relevance of the best interests test regardless of capacity. As we have seen, the best interests test is also relevant to young people of 16-17 which suggests that the law of battery may also have special relevance to this age group.

A. Non-Disclosure and the Test for Capacity

Let us take the most tentative reason first. For children found to have *Gillick* capacity (unlike adults), the tort of battery might be committed where the child is given substandard information because a higher threshold for what constitutes a valid consent may apply. Lord Scarman said it was ‘not enough’ that the child should ‘understand the nature of the advice which is being given’.¹¹³

¹⁰⁹ *Ibid.*, 20. This was recently confirmed in *An NHS Trust v Y* [2018] UKSC 46, [92] (Lady Black).

¹¹⁰ *Ms B v An NHS Hospital Trust* [2002] EWHC 429 (Fam).

¹¹¹ *Ibid.*, [97].

¹¹² *Chatterton* (n 3).

¹¹³ *Gillick* (n 18), 189.

In order for children to have capacity to consent they need to have ‘sufficient maturity and understanding of what is involved.’¹¹⁴ Lord Scarman said that minors should ‘understand fully what is proposed’.¹¹⁵ This indicates that in order for a child to have capacity they need to have a greater understanding of the consequences of the decision than an adult in a comparable situation, which in turn would impact on the requirements to disclose information.¹¹⁶ If the child’s consent is to be relied upon, disclosure must enable this high level of understanding or risk liability in battery.

What must the child understand? We have seen that *Montgomery* moves away from the paternalistic model of the HCP proposing a treatment and the patient deciding whether or not to accept it. Instead, where reasonable variant and alternative treatments exist, the HCP should identify them and their risks and the patient should be furnished with information and dialogue sufficient to choose between them. It is unclear whether the reasonableness of alternative treatments is determined by *Bolam* or *Montgomery*,¹¹⁷ but the former seems likely.¹¹⁸ If *Montgomery* applies to children, then the standard of disclosure in negligence might have relevance to what is required of the child with *Gillick* capacity: coherence might require that the test setting out what must be disclosed (for the purposes of negligence) and the test requiring what must be fully understood (in battery) converge. At the risk of repetition, this is not relevant in adult cases because adults are not required to have full understanding to make a valid consent.

If this interpretation were adopted, fewer children would be found to have *Gillick* capacity, but non-disclosure of risks or reasonable alternatives could potentially lead to a claim in battery if the child’s consent (as opposed to a proxy’s or the doctrine of necessity) was relied upon. It would need to be established that a failure to provide information resulted in denial of the choice of reasonable alternatives (potentially including not having the treatment), so that the child cannot

¹¹⁴ *Ibid.*

¹¹⁵ *Ibid.*

¹¹⁶ On which see S Gilmore and J Herring, ‘“No” is the Hardest Word: Consent and Children’s Autonomy’ [2011] 23 CFLQ 3 cf. E Cave and J Wallbank, ‘Minors’ Capacity to Refuse Treatment: A Reply to Gilmore and Herring’ (2012) 20 Med L Rev 423.

¹¹⁷ Heywood and Miola (n 65).

¹¹⁸ *Duce* (n 11).

be said to have fully understood the decision. Without this level of understanding their decision cannot be regarded as capacitous, thus rendering their consent invalid. In the absence of harm, damages would be minimal, but battery serves a vindicatory function with respect to the interest in physical integrity, or protection from unwanted physical contact.

However, there is evidence of a softening in the judicial approach to *Gillick* capacity. *Gillick* was recently applied for the first time in the context of a minor's consent to adoption in *Re S*.¹¹⁹ Counsel argued that full understanding of the implications of adoption and the legal processes was required. Cobb J. disagreed, preferring instead to focus on *sufficiency* of understanding, importing the (adult) MCA approach to *Gillick* capacity.¹²⁰ A test based on 'sufficient' rather than 'full' understanding would enable more children to provide consent. Like adults, capacity would be decision-specific taking into consideration the factual context.¹²¹ Like adults, children would be reliant upon negligence if they wanted to argue that disclosure was sufficient to allow valid consent but insufficient to allow informed consent.

It therefore seems that if the *Gillick* approach is followed, a consenting child may have a claim in battery if the information was not sufficient to allow full understanding, but if the reasoning in *Re S* is applied in medical treatment cases, the information required to ensure 'sufficient' understanding would align child and adult cases in this respect.

B. Non-Disclosure and the Requirement to Demonstrate Capacity

A related argument focuses on the requirement to demonstrate capacity. *Re S* suggests an MCA-aligned approach in relation to the *test* for *Gillick* capacity but does not alter the fact that for children under the age of 16, capacity is not assumed:¹²² the section 1(2) presumption of capacity in the Mental Capacity Act 2005 does not apply. Thus, a child who is incapable of understanding

¹¹⁹ *Re S (Child as Parent: Adoption: Consent)* [2017] EWHC 2729 (Fam).

¹²⁰ *Ibid.*, [60].

¹²¹ *City of York Council v C* [2013] EWCA Civ 478, [35].

¹²² *Gillick* (n 18), 169 (Lord Fraser) and 186 (Lord Scarman).

need not be informed, but a child who is so capable and whose consent is relied upon in defence to battery, must be shown to actually understand the relevant information, which in turn requires information disclosure. Because under-16s must be *shown* to have capacity, it seems an informational component attaches to its assessment.

Ambiguity surrounds the potential liability in trespass of an HCP who misjudges (in)capacity. The pre-MCA case law on adults offers some assistance. In *Re T*, Straughton L.J. said:

Some will say that, when there is doubt whether an apparent refusal of consent is valid in circumstances of urgent necessity, the decision of a doctor acting in good faith ought to be conclusive. ... However, I cannot find authority that the decision of a doctor as to the existence or refusal of consent is sufficient protection, if the law subsequently decides otherwise. So the medical profession, in the future as in the past, must bear the responsibility unless it is possible to obtain a decision from the courts.¹²³

Outside the application of the MCA, mistaken belief as to the validity of consent or refusal will not necessarily justify treatment. A test case might develop a defence based on *reasonable* belief, as per the MCA.¹²⁴ There are good reasons for so doing, ‘otherwise, physicians would be encouraged to err on the side of non-treatment if a doubt about the patient’s competence arises’.¹²⁵ If so, then in order to rely on a child’s consent, information disclosure must be sufficient to allow reasonable assessment of capacity (rather than the basic level of information required for validity in the case of adults assumed to have capacity). Failure to inform at this level may give rise to a claim in battery.

¹²³ *Re T* [1992] EWCA Civ 18, [60]-[61]. And see *Re F* (n 105), 78 (Lord Goff).

¹²⁴ See *Re MB (Caesarean Section)* [1997] 2 FLR 426 (CA), 438 (Butler-Sloss L.J.): ‘The only situation in which it is lawful for the doctors to intervene is if it is *believed* that the adult patient lacks the capacity to decide’ (emphasis added).

¹²⁵ S Michalowski, ‘Trial and Error at the End of Life – No Harm Done?’ (2007) 27(1) OJLS 257, 259.

C. Non-Disclosure and Best Interests

If information disclosure is required to assess an under 16's capacity, then even if the treatment is in their best interests, disclosure that is insufficient to assess capacity might result in battery unless the defence of necessity applies, or proxy consent is sought.

An alternative argument is that even if basic information is sufficient for children to provide a valid consent, the tort of battery may still have resonance if the correct interpretation of *Gillick* and subsequent cases of *Re R* and *Re W* is that a child must be treated in their best interests. Battery might be committed if the consent of the child is relied upon in a situation where consultation is insufficient to generate a reasonable belief that the treatment is in their best interests and the treatment is shown not to be in their best interests.

This argument develops in three stages. First, because best interests are not a purely medical consideration, consultation is required to make a determination that takes into account the particular interests of the child. Second, the HCP must have a reasonable belief that a course of action is in the patient's best interests and the belief will not be reasonable if the HCP failed to adequately consult a child who is capable of contributing to the decision to a level that would determine their best interests. Third, if the child can show that adequate consultation would have led to a different appraisal of their best interests and therefore a different treatment decision and the decision taken was contrary to their interests, they might claim in battery.

An HCP cannot determine the child's best interests on clinical grounds alone.¹²⁶ The Supreme Court has recognised that an important part of the best interests determination is to consult the child to ascertain their views.¹²⁷ This emanates from Article 12 of the United Nations Convention on the Rights of the Child¹²⁸ and is featured in the Children Act 1989 welfare checklist.¹²⁹ HCPs who fail to engage with the child can err in their assessment of best interests

¹²⁶ *Re T (A Minor) (Wardship Medical Treatment)* [1997] 1 WLR 242 (CA), 250-251 (Butler-Sloss L.J.), *Aintree* (n 108), [39] (Lady Hale).

¹²⁷ *ZH* (n 70), [34]-[35] (Lady Hale).

¹²⁸ *Ibid*, [34].

¹²⁹ Children Act 1989, s1(3).

even if their motives are honourable and a relevant consent is obtained. In the 1976 case of *Re D*,¹³⁰ Dr Gordon, a consultant paediatrician, supported by a consultant gynaecologist made a clinical judgement that an 11-year-old girl with Sotos Syndrome should be sterilised for non-therapeutic purposes with her mother's consent. A consultant psychiatrist challenged the decision and the court held the operation was neither medically indicated nor necessary, that it would be an infringement of her rights and was contrary to her best interests.¹³¹ The court lamented Dr Gordon's refusal to consult relevant others.¹³² The evidence suggested that Dr Gordon had already performed two similar operations in Sheffield.¹³³ Had those cases come before a court post-operatively, there would have been strong grounds for a claim in trespass given the finding of the court in *Re D* that it was, in fact, contrary to D's interests.¹³⁴

As for reasonable belief in best interests, we must start with the position relating to 16-17-year-olds. If they are reasonably supposed to lack capacity, the MCA provides a defence for an HCP who, taking account of the factors listed in section 4 of the Act, '*reasonably believes* that what he does or decides is in the best interests of the person concerned.'¹³⁵ This means that the *outcome* of the treatment does not *actually* have to be in the best interests of the patient lacking capacity provided that the HCP *reasonably believes* it to be. Under the MCA, for an HCP's 'reasonable belief' that treatment was in the incapacitous patient's best interests to be a valid defence, certain procedural requirements set out in section 4 must be satisfied. These include, where practicable, consultation with the patient and relevant others.¹³⁶ Failure to do so can result in battery¹³⁷ and

¹³⁰ (*A Minor*) (*Wardship*) (*Sterilisation*) [1976] Fam 185 (Fam). Cited in *Re F* (n 105), 20, 41, 69 and 79.

¹³¹ *Re D*, *ibid.*, 193 (Heilbron J.).

¹³² *Ibid.*

¹³³ *Ibid.*, 194.

¹³⁴ *Re F* (n 105) (CA), 20 (Lord Donaldson M.R.).

¹³⁵ MCA 2005, s 4(9) (emphasis added).

¹³⁶ MCA 2005, s 4(4) and 4(9).

¹³⁷ *ZH v Commissioner of Police for the Metropolis* [2013] EWCA Civ 69, [88] (Lord Dyson M.R.). In *Eseghona v King's College Hospital NHS FT* [2019] EWHC 77 (QB) the hospital failed to make a best interests assessment of an adult patient and avoided consultation with the family in breach of the MCA. Deprivation of liberty safeguards were not followed. Aggravated damages were awarded for false imprisonment.

breach of Article 8 ECHR.¹³⁸ 16-17-year-olds who lack capacity cannot consent, but best interests is no defence to battery if the best interests decision was not reasonable because they or others were not properly consulted.

For consenting 16-17-year-olds with capacity who have been given basic information sufficient to make a valid consent, one might assume that, like adults, they have no claim in battery. But if it is accepted that *Re W* requires the decision to be in their best interests, and there is a failure to adequately consult them to determine those best interests, and a court finds that the decision was not in their best interests, they could argue that their consent was invalid.

Re W applies the best interests test regardless of capacity. It does so in the specific context of refusal of life-sustaining treatment and may extend no further, but welfare is the paramount consideration under the Children Act 1989 and cases such as *Re W* indicate that the age of 16 is not a 'bright-line'.¹³⁹ Moreover, attempts to limit *Re W* focus on allowing young people with capacity to define their own best interests. In non-disclosure cases we are concerned with children who have been denied that opportunity due to inadequate consultation.

If the HCP has a reasonable belief that treatment was in the young person's interests there will be no battery where the child consents, even if consultation was minimal and whether or not it was in fact in their interests. But if the HCP's view that the decision is in their best interests is unreasonable because consultation was minimal and a court finds that the decision was not in fact in the young person's best interests, then the child could argue that the limited consultation was insufficient to protect their best interests and rendered their consent invalid.

The position for under 16-year-olds is less clear. In *Re F*, Lord Bridge asserted that where treatment is curative, doctors should be 'immune from liability in trespass' where they have 'acted with due skill and care'.¹⁴⁰ Lord Donaldson recognised that the duty to consult will vary according

¹³⁸ *R (on the application of Tracey) v Cambridge University Hospitals NHS Foundation Trust* [2014] EWCA Civ 822; *Winspear v City Hospitals Sunderland NHS Foundation Trust* [2015] EWHC 3250 (QB).

¹³⁹ *Re D* (n 21), [126] (Sir James Munby P.)

¹⁴⁰ *Re F* (n 105), 52.

to the complexity of the treatment. Where the course is unclear ‘for example, a variety of different treatments are available each involving different potential risks and benefits’, greater consultation may be required ‘in order for the doctor to satisfy himself, and it may be subsequently a court, that he is performing his duty under the law and so is immune from suit’.¹⁴¹

Because the principles that influenced the framing of the MCA are also relevant to under-16s, a court is likely to require reasonable belief rather than proof that the outcome was in the child’s best interests. Again, it will be difficult for an HCP who has not sufficiently informed a consenting child to demonstrate that their belief of the child’s best interests was reasonably held. As such, subject to evidence that disclosure would cause harm, the HCP will need to inform such children in order to obtain their views and establish a reasonable belief of what is in their best interests.

The duty to consult does not tell us what and how much information must be communicated. We have seen that the test of materiality governs negligence and that battery requires basic information and, where children are concerned, this potentially extends to adequate information to enable a capacity assessment and a best interests decision incorporating the child’s perspective. Damages may flow if it can be shown that the consent was not valid on the basis that the treatment was not in the interests of the child. A failure to consult may result in battery and a declaration of violation of Article 8 if procedure is breached. If so, damages may be awarded if the breach impacts on treatment.

The duty to consult differs according to the procedural requirements with respect to each age group. Under the MCA there must be enough information to facilitate capacity and it is significant that in *Re S*, Cobb J. opined that the same duty applies to children.¹⁴² But a duty to facilitate capacity does not necessarily require disclosure of material risks, benefits and alternative choices, such as is required in relation to ‘adults of sound mind’ under *Montgomery*.

¹⁴¹ *Ibid.* (CA), 18.

¹⁴² *Re S* (n 119), [60].

V. CONCLUSION

Montgomery was a landmark decision that has since been extended to apply to other aspects of patient choice.¹⁴³ Though children have the power to consent to treatment in some cases, their powers of choice are limited and their welfare is the paramount consideration. Breach of duty is but one part of the negligence inquiry. A failure to warn does not give rise to a free-standing claim in damages. While some jurists have made normative arguments about why such claims should be permitted,¹⁴⁴ the Court of Appeal in *Shaw v Kovac*¹⁴⁵ rejected this argument. It seems likely that the Supreme Court would agree: it refused permission to appeal in that case.¹⁴⁶ In adult cases, claimants have struggled to show that a failure to disclose reasonable alternatives would have changed the outcome.¹⁴⁷ It is for these reasons that many commentators have disputed the ability of the tort system to adequately protect patient autonomy.¹⁴⁸ We suggest that these criticisms have additional force when it comes to children.

There is scope to challenge the paternalistic interpretation of *Gillick*. As we have seen, one interpretation of Lord Scarman's judgment in *Gillick* is that the child with capacity can make a determinative treatment decision. Sir James Munby in *Re D* recognised as a 'fundamental principle' set out in *Gillick* that 'the exercise of parental responsibility comes to an end not on the attaining of some fixed age but on attaining 'Gillick capacity''.¹⁴⁹ Mostyn J. has stated that it was implicit in *Gillick* that 'provided the child, under the age of 16, has sufficient understanding and intelligence, she can then be lawfully prescribed with contraception even if the result of that would lead her to take steps which are wholly contrary to her best interests.'¹⁵⁰ Might vindication in *Montgomery* of

¹⁴³ E.g. *Jones v Royal Devon and Exeter NHS Foundation Trust*, Unreported, 22nd September 2015, on choice of surgeon.

¹⁴⁴ See Keren-Paz, (n 85). For the contrary view, see Purshouse (n 85).

¹⁴⁵ (n 82).

¹⁴⁶ <https://www.supremecourt.uk/docs/permission-to-appeal-2017-12-2018-01.pdf>

¹⁴⁷ *Diamond* (n 80).

¹⁴⁸ See E Jackson, "'Informed consent" to medical treatment and the impotence of tort' in S McLean (ed.), *First Do No Harm: Law, Ethics and Healthcare* (Routledge: Aldershot 2006).

¹⁴⁹ *Re D* (n 21), [125] (Sir James Munby P.).

¹⁵⁰ *An NHS Trust v A, B, C and a Local Authority* [2014] EWHC 1445 (Fam), [10] (Mostyn J.).

Lord Scarman's pro-patient position taken in *Sidaway* one day be emulated in relation to this aspect of his Lordship's position in *Gillick*?

For now, an alternative view dominates, based on Lord Fraser's judgment which appears to require that the treatment must be in the child's best interests, and that there are cases where this can be determined by others, even where the child has capacity. The dominance of best interests in decisions about treatment of children limits the relevance of negligence. However, on the basis of procedural requirements to facilitate participation in order to determine capacity and best interests, it enhances the relevance of the tort of battery, which for adults offers only limited protection of their right to information. Like adults, children might claim in battery if no authorisation has been obtained for their treatment. Our focus has been on substandard information disclosure. We have considered three ways in which battery might be relevant in light of the test for *Gillick* capacity and the role of best interests. Because battery is actionable *per se*, this offers a powerful incentive to involve children in decisions made about them.

However, it only goes so far. In practice, the courts have shown reluctance to protect patients from battery.¹⁵¹ Furthermore, where the HCP is satisfied that the decision is in the child's best interests – for example where no reasonable alternatives exist, the child's claim is undermined. More effective remedies may lie in the development of human rights claims associated with the duty to consult and the right to autonomy. Sir James Munby P. has lamented:

our slowness in accepting the ... profound implications of the undoubted fact that a child has, quite distinct from and sometimes in conflict with his or her parents, the important procedural rights guaranteed by Article 8 of the European Convention.¹⁵²

¹⁵¹ Michalowski (n 142), 265 citing *Ms B* (n 110).

¹⁵² The 2017 Parmoor Lecture to the Howard League for Penal Reform Given by Sir James Munby President of the Family Division, *Children Across the Justice Systems*, at <https://www.judiciary.uk/wp-content/uploads/2017/10/speech-pfd-children-across-the-justice-systems.pdf>, citing *CF v Secretary of State for the Home Department* [2004] EWHC 111 (Fam), [158]-[173].

In *Montgomery*, the law finally caught up with professional guidance on adult consent.¹⁵³ Since 2007, the General Medical Council (GMC) has also set out guidance on information disclosure in relation to children. It establishes that the child's best interests is the guiding principle in all decisions,¹⁵⁴ and emphasises the importance, where appropriate, of good communication between doctor and child.¹⁵⁵ Breach can result in disciplinary action. The GMC also sets out what information should routinely be provided:

You should provide information that is easy to understand and appropriate to their age and maturity about:

- a their conditions
- b the purpose of investigations and treatments you propose and what that involves, including pain, anaesthetics and stays in hospital
- c the chances of success and the risks of different treatment options, including not having treatment
- d who will be mainly responsible for and involved in their care
- e their right to change their minds or to ask for a second opinion.¹⁵⁶

The GMC advises that this information should only be kept from children if either that is their wish, or if it would cause them serious harm.¹⁵⁷ In this respect, the professional requirements to disclose information to children closely mirror the duties in relation to adults as set out in *Montgomery*. HCPs are rightly advised to abide by this guidance lest they treat in a manner that conflicts with the child's interests, which extend beyond clinical factors and cannot be accurately

¹⁵³ *Ibid.*, [77]-[78], referring to GMC, *Good Medical Practice* (2013) accessible at https://www.gmc-uk.org/guidance/good_medical_practice.asp; GMC, *Consent: Patients and Doctors Making Decisions Together* (2008), accessible at https://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp.

¹⁵⁴ GMC, *Guidance 0-18 Years: Guidance for All Doctors* (2007), para 8. Accessible at https://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp.

¹⁵⁵ *Ibid.*, [14].

¹⁵⁶ *Ibid.*, [17].

¹⁵⁷ *Ibid.*, [20].

ascertained without consultation. From the position of the child, however, the situations in which non-disclosure would give rise to a remedy in tort are limited.

Montgomery reconciled the law on negligent non-disclosure of information in the case of adults with social and legal developments. Is information non-disclosure in the case of children another area where the law is behind the curve? We would argue that insofar as the law limits the rights of children with capacity to make medical treatment decisions contrary to their best interests, the tort of negligence is patently ill-suited to the protection of their autonomy.