

LEGAL PRESCRIPTION FOR DOCTORS

Atty. Rodel V. Capule, M.D., FPCP*

PARENTAL NOTIFICATION AND THE MINOR PATIENT

In law, incompetence may be identified in two broad ways. Some persons as a class are considered incompetent as a matter of law (*de jure or per se incompetence*). For example, the law considers children incompetent for many types of decisions, partly because of presumptions about their immature cognitive abilities and capacities for judgment. In addition, there are situations in which persons about whom there is a question of their decision-making capacity have already been declared legally incompetent by a court to make similar decisions. In virtually all other cases, however, the question of individuals' competence requires an inquiry into their actual capacities, incompetence being determined on the basis of a demonstrated lack of the requisite functional abilities for the specific individual in question (*de facto incompetence*).¹

The traditional common law view of minors and consent to treatment was that a minor could not consent to medical or surgical treatment.² A physician was obliged to obtain the *consent of the child's* parent or of someone someone standing in loco parentis to the minor.³ The only acceptable exception was an emergency, when it was either impractical to obtain parental consent,⁴ or any delay would unduly endanger the patient's life.⁵

An offshoot of this problem is *whether or not to notify the parents of a minor patient before treatment or whether or not to disclose the medical information of the minor patient to his or her parents*. In other words, is parental notification needed before instituting treatment to a minor? Does the duty to keep the confidentiality of medical information from the minor patient's parents also apply?

In the Philippines, the age of majority is eighteen (18) years old⁶ and anybody less than eighteen (18) is a child⁷ or a minor. In civil law, a minor is incapable of giving a valid consent. Since a physician-patient relationship is contractual in nature, consent of a minor cannot bind the parties involved. The logical conclusion was that the authority to consent to medical treatment on a minor's behalf must be vested in someone else. The power has devolved to the natural guardians of a minor – his or her parents.⁸ A "mature" minor or an emancipated child is not recognized in our jurisdiction.

Arguably, when minors are to be treated as if they were adults for purposes of consent, there should be no

disclosure to parents or guardians. Confidentiality of care is a basic component of the physician-patient relationship; in the absence of statutory disclosure requirements, it should not be abridge. The policy argument favouring parental notification is based on a concern that minors receive appropriate follow-up care. This continuity of care could be provided by their parents, but a prerequisite is informing them of the nature of the treatment provided. However, in some treatment situations – such as care for sexually transmitted diseases or the side effects of birth control pills – familial ties may be strained or broken following disclosure. In the absence of laws authorizing parental disclosure or notification, it is not advisable to provide them with information without permission from the minor patient.⁹

Physicians are put in a difficult situation when parents telephone to find out if their child has received medical care and for what purpose. The better policy in these circumstances is to let the minors decide whether they want to discuss their medical care with their parents. The best legal protection available to health care providers – absent statutory directives, court orders, or written authorization by the minor – is to refuse disclosure to a child's parent.¹⁰

REFERENCES

1. Assessing Competence to Consent to Treatment; page 10; Oxford University Press, 1998.
2. Consent to Treatment, Rozovsky; page 5:1 (citing in re Hudson, 13 Wash.2d 673, 126 P.2d 765, 1942); Aspen Publishers, Third Edition, 2006.
3. Id.
4. Consent to Treatment, Rozovsky; page 5:2 (citing Tabor v. Scobee, 254 S.W.2d 474, Ky., 1952); Aspen Publishers, Third Edition, 2006.
5. Consent to Treatment, Rozovsky; page 5:2 (citing Jackovach v. Yocum, 212 Iowa 914, 237 N.W. 444, 1931); Aspen Publishers, Third Edition, 2006.
6. Republic Act No. 6809, An Act Lowering the Age of Majority from Twenty-One to Eighteen Years, 1989.
7. Republic Act 7610, Special Protection of Children against Abuse, Exploitation and Discrimination Act, 1992.
8. Consent to Treatment, Rozovsky; page 5:2; Aspen Publishers, Third Edition, 2006.
9. Consent to Treatment, Rozovsky; page 5:14; Aspen Publishers, Third Edition, 2006.
10. Consent to Treatment, Rozovsky; page 5:15; Aspen Publishers, Third Edition, 2006.

*Dr. R.V. Capule is an attorney specializing in medical malpractice, physical injuries and food torts. He is a law professor in Legal Medicine at Arellano University School of Law and a consultant in Legal Medicine at Manila Adventist Medical Center, Makati Medical Center.