ISSN 2601-8683 (Print)
ISSN 2601-8675 (Online)
European Journal of
Formal Sciences and Engineering
January - June 2023
Volume 6, Issue 1

Consent to Treatment and Anamnesis as Problem of Communication with Minor Patients in Healthcare Decision-Making

Karina Palkova

Riga Stradins University, Latvia

Svetlana Semaka

University of Latvia, Latvia

Abstract

Lately lawyers and medical professionals pay more attention too the process of minor patient healthcare. The research shall address the issues of legal relationship between minor patients and medical professionals, consent to treatment of minor patients and communication problems including the scope of information which the doctor can provide to the minor patient's relatives to protect themselves and patients. Legislation prescribes that the information provided by the medical professional to the minor patient must be not only easy-to-understand, but also be consistent with the patient's age maturity. However, in Latvia, for example, there are no guidelines that specify how medical professionals can determine the patient's maturity. In the course of provision of medical services to the minor persons legal disputes involving communiucation failures between the minor patients, their relatives, legal representatives and the doctors arise increasingly frequently. The research will look into issue of communication problems in healthcare. The aim of the research is to provide insight into challenges of legal relations betweem minor patients and medical professionals and communication problems in healthcare.

Keywords: consent to treatment, minor patient, healthcare professionals' rights, human rights, communication in healthcare

Introduction

The research covers such important issues of the relations between minor patients and medical professionals as relevance of communication in the process of medical treatment, areas of concern related to rights and obligations of the parties and their solution.

The choice of the topic of the research was prompted by practical issues encountered by medical professionals both in Latvia and in the other countries of the European Union. Working with the minor patients it is necessary to take into account a number of aspects, such as restrictions pertaining to treatment of this group of people and peculiarities of communication.

The aim of the research is to provide insight into regulation of legal relations between minor patients and medical professionals in order to study communication problems of the parties' interaction as part of the process of medical treatment and most common instances pertaining to the minor patients' rights and obligations.

The research reviews in general terms the cases when a minor patient has the right to accept or to refuse medical treatment, what may influence his choice. Particular importance is attached to the concept of minors and its relevance to the process of medical treatment. At the same time the research paper reviews the provisions of the Latvian legislation and European legislative framework on this issue.

Treatment of the minor patients also depends on the behaviour pattern of the medical professional and the ability to explain the situation to the patient. The way and the manner in which the medical professional communicates with the patient determine the progress and the results of medical treatment. Due to the fact that minor patients are a special group of patients it is important to be aware of the potential risks and significance of the incomplete communication process. Therefore in order to address the issue of the importance of communication communication process has been analysed taking anamnesis of minor patients.

The research operates mainly with analytical and comparative methods. It provies the opportunity to accomplish the objective targeted by the research more accurately. Alongside with that theoretical research method is employed in the paper.

The concept of minor patients and miscellaneous age theresholds in the enjoyment of the rights.

In actual practice medical professionals increasingly frequently must consult the rights of the minor patients. How to respect the rights of the minor patients, be deferential to the minors' opinions, views and beliefs.

Medical professionals are not always sure up to what point the minor patients are allowed to make decisions on their own, in which cases the consent of some other person to the treatment of the minor person is required and starting with what age the minor is authorized to make decisions with regard to the process of his treatment by himself. The scope of obligations of the healthcare professionals in accordance with the specifics of the activities are included in the regulatory enactments regulating the procedure of healthcare services provision (Slokenberga, Gusarova, Lieljuksis, Mucins, Stanislavska, Saberte, Slisere, Taurina, 2015). However, the answers to these questions can be also found by reviewing the regulatory enactments

of the Republic of Latvia unrelated to medicine. In particular regard must be also paid to international regulatory enactments.

Article 219[14] of the Civil law of Latvia prescribes that minority of persons continues until they attain the age of eighteen. In exceptional circumstances the person may be declared as being of age of majority at the age of 16 already.

Until the achievement of the age of 14 minors have only the right to be heard and to participate in making of the relevant decision related to treatment according to their age and maturity, however, they cannot give consent to their treatment. Treatment of such persons is permitted only upon receipt of the consent of their lawful representative.

However, upon the achievement of the age of 14 minors have the right to give consent to their treatment themselves and only in case of the refused treatment by the minor, if the doctor believes that the treatment is in the best interests of the patient, the doctor is authorized to request consent of the minor's parents or other lawful representatives. It follows from the above-mentioned that irrespective of the achievement of the age of 14 the person's rights to refuse treatment are limited. It must be noted that in Great Britain the approach is different.

In 1983 the criteria for establishing whether a child is capable of giving consent to treatment were defined - 'Gillick test'. This test shows whether children under 16 are able to fully understand what the proposed treatment involves including its purpose, risks, likelihood of success, etc.[15].

Sexual and Reproductive Health Law[16] of the Republic of Latvia with regard to termination of the patient's pregnancy presribes other age restrictions than the Law On the Rights of Patients[17] of the Republic of Latvia. Age restriction determined in Article 27 of the Sexual and Reproductive Health Law[18] of Latvia is 16 years. Until the achievement of the age of 16 the patient has the right to be heard to by the doctor and the doctor must pay due consideration to the patient's beliefs taking into account the patient's age and the degree of maturity. Consequently, if the patient herself expresses a wish to terminate pregnancy, the decision about termination of pregnancy is actually adopted at least by one of the parents or by the guardian giving a written consent. Part four of Article 27 of the Sexual and Reproductive Health Law of Latvia [19] provides the answer to the question what are the options of the patient who cannot convince her parents or guardian to allow termination of pregnancy; namely – the patient is authorized to ask the Orphans Court to deliver the judgement. Probably the

[14] Article 219 of the Civil Law, date 14.10.1998., as amended
[15] Gillick respondent and West Norfolk and Wisbeck area Health authority first applellants and department of Health and Social security second appelants, http://www.bailii.org/uk/cases/UKHL/1985/7.html
[16] Sexual and Reproductive Health Law, date 31.01.2002., as amended
[17] The Latvian Law On the Rights of Patients No 205, dated 17.12.2009, as amended
[18] Article 27 of the Latvian Sexual and Reproductive Health Law dated 31.01.2002., as amended
[19] Article 27 of the Latvian Sexual and Reproductive Health Law dated 31.01.2002., as amended

legislator believes that the decision of the parents or the guardian sometimes may be based on prejudice and the Orphans Court can render a more comprehensive assessment whether preservation of preganancy is in the best interests of the patient. This naturally brings up the question as to how long it will take the Orphans Court to consider the issue. It may happen that the judgement of the Orphans Court is delivered at the time when from the standpoint of the patient's health pregnancy termination is no longer permitted.

Whereas if the patient herself has not expressed a wish to terminate pregnancy, then the consent of one of the parents or the consent of the guardian is not sufficient. The approval of the council of physicians that the patient has medical indications for the pregnancy termination is needed, or a certificate issued by the police, prosecutor's office or the other law enforcement institution in case of the patient's pregnancy resulting from rape.

Therefore it follows from part four of Article 27 of the Sexual and Reproductive Health Law of Latvia [20] that also in the event when the parents or the guardian have given their consent to termination of pregnancy and there exists additional relevant condition (i.e. the approval of the council of physicians that the patient has medical indications for the termination of pregnancy, or a certificate issued by a law enforcement institution in case of pregnancy resulting from rape), the patient is entitled to address the Orphans Court and ask for the injunction to perform termination of pregnancy. The law does not specify what the doctor must do in case when the patient submits to the doctor an application addressed to the Orphans Court containing a request not to allow termination of pregnancy with the stamp of the Orphans Court testifying to the receipt of the application. On a formal level in the event of presence of the above-mentioned criteria prescribed by the law the doctor must perform termination of pregnancy. On the one hand, this would be logically reasonable, because in separate cases the doctor cannot wait until the Orphans Court renders a judgement, however, on the other hand, terminated pregnancy cannot be reversed and the Orphans Court even if it finds the parents' or the guardian's decision incorrect shall not be in the position to restore the previous condition.

Therefore the national regulatory enactments secure the patient's right to be the master of his health and life. However, these rights are limited as well (Šulce – Rēvele, Līkanse 2013).

International legislative framework

The tendency shows that cooperation between minor patients and healthcare professionals becomes more associated with human rights.

The research based on the human rights issue helps to gain a greater understanding of the scope of the patients' and healthcare professionals' rights and obligations. More

[20] Article 27 of the Latvian Sexual and Reproductive Health Law dated 31.01.2002., as amended

importantly is to understand to what extent the parties can exercise certain rights. (Exster, 2002).

One of the international master documents that must be reviewed is the Convention for the Protection of Human Rights and Dignity of the Europe's Convention for the Application of Biology and Medicine [21]. Second part of Article 6 of the Convention prescribes that if according to the legislative instruments the minor cannot give consent to performance of actions related to his health, then these actions can only be performed upon receipt of the permission of the minor's representative or the permission of the authorities, persons or instutitions determined by the law. Whereas Article 6 also prescribes that in adoption of the decision key attention must be paid to the minor's opinion with due regard of his age and degree of maturity.

Similar regulation is contained in the Convention on the Rights of the Child, where in part one of Article 12 it is mentioned that the member states must ensure that every child who is capable of forming his opinion has the right to express it freely with regard to all issues pertaining to him, furthermore due attention must be paid to the opinon of the child according to the child's age and degree of maturity.

If follows form the foregoing that the rights of the minor patient to provide his opinion in the course of the treatment process expand with the increment of the minor's age and the degree of his maturity. This means that the rights of the lawful representative to adopt decisions on behalf of the minor become relatively abridged.

Peculiarities of communication during the process of medical treatment

Cooperation of the patient with the medical professional begins with the visit. It should be noted that taking of the children's anamnesis is a more complicated process and involves a number of specific aspects. Intake of the children's anamnestic data includes interviewing of their parents or the persons who take care of the child. One of the major problems a medical professional may face when interviewing a child, i.e. a minor, is how the parents and the child himself look upon their health problems and are capable of reporting them. Quite often a situation may be observed when a mother or any other lawful representative describes the child's health problems and the medical professional listens only to the lawful representative. Whereas the patient is a minor and it is him who is experiencing somatic problems and can decsribe them more accurately than the lawful representative. Minors obey their parents and usually trust them, which may result in a situation when a child after having listened to his mother's or the other person's story may develop false memories about his health condition. This happens due to complicated interaction of miscellaneous memories, beliefs and anticipations in the patient's mind. Owing to the memory the patient can remember and answer the doctor's questions when they are asked. Studies show that a lot of people believe that our memory functions very much like a tape-recorder,

video-camera or a DVD, namely, human memory in the same way as these devices stores and plays back the events exactly in the way we experienced them (Alvarez, & Brown, 2002; Lenca, & Mills, 2009; Loftus, & Loftus, 1980, as mentioned by Lilienfeld, Lynn, Ruscio, & Beyerstein, 2010). Unfortunately human memories do not exist in a vacuum, they are more likely to interfere with one another in most complicated ways (Green, 1992).

Human memories are by no means the exact replicas of the past events (Clifasefi, Garry, & Loftus, 2007). Human memory is a much more complicated process than it may initially seem. However, it is the patient's memories of his illness that is the first and the most important way to take the anamnesis. Simply stated, memory is the ability of the human brain to encode, save, maintain and later retrieve the information and past experience (Andrade, 2008). Episodic memory is stored in the brain in such a way as to enable the person to remember an event of his life that he experienced a few minutes ago or even a few years ago, also remembering a number of aspects related to the event, for instance, such as perceived details, thoughts, conclusions and emotions (Gonsalves, & Paller, 2002). Neural circuitries that activate the retrieval of these memories, however, do not secure exact recording of any event. Just the opposite, episodic memory retrieval is a reconstructive process where the person starts to use the retained information which is often limited and incomplete. In the reconstructive process at the moment of the event retrieval the memory is deformed (Barlett, 1932; Schacter, 1995; Schacter, Norman, Koutstaal, 1998, as mentioned by Gonsalves, & Paller, 2002). Fundamentally memory consists of the person's background knowledge (Mitchell, & Johnson, 2009), current mental state (Jacoby, Wahlheim, Rhodes, Daniels, & Rogers, 2010) and current emotional state (Brainerd, Reyna, & Aydin, 2010). This is exactly why memory is not the ideal record-keeping of the ouside world. Episodic memory involves a reconstructive process that makes it more prone to errors and distortions and false memories are the "by-product" of the constructive memory system (Gallo, 2010).

Studies prove that memory is not reproductive – it does not reflect the bygone information accurately, but reconstructs it. It means that what the patient remembers today is blurred precise memories intermixed with the patient's beliefs, needs, emotions and anticipations. These ancticipations rest upon the patient's knowledge of himself, the event he is trying to remember and similar situations from the patients's experience (Clifasefi, Garry, & Loftus, 2007).

In one of their experiments Loftus and Pickrell (Loftus, & Pickrell, 1995) manipulated with the fact that an elderly relative was telling the participants of the experiments the four events, the three of which were real and one unreal, however, the events were described in a way as if the experiment participants took part in them. Later during the interviews the participants revealed that actual events are retieved by the memory as real in 68% of the cases, while unreal events are reproduced as true in 25% of the cases. If this effect can be observed with the adults, then it can be affirmed

with fair certainty that the effect similar to the effect on the adults can be observed with the underage children. The experiment similar in concept to the experiment of Loftus and Pickrell (Loftus, & Pickrell, 1995) was repeated by Hyman, Husband and Billings (Hyman, Husband, & Billings, 1995). In that experiment noone of the research participants recognized false memories as real during the first interview, but when the same participants were interviewed for the third time, already 25.5% of them described the event as real memories. Various researchers in the experiments with the false memories of the event that had never taken place manipulated with miscellaneous factors and discovered that a man can be convinced to be involved in the events that he had never experienced, for instance, medical procedures (Porter, Yuille, & Lehman,1999). From neurocognitive point of view there is a similarity between the way how the imagined and perceived events are encoded (Johnson, Hashtroudi, & Lindsay, 1993), which actually means that if the person imagines or overinterpretes the experienced event, both pieces of information are encoded in the brain in a similar fashion. Exactly the same may happen to the minor patient. For instance, if the mother has a track record of her child's usual illnessses, she may subconsciously adjust her story to her anticipations. Human memories can be affected and therefore can be modified with any information that the person receives already after the experienced event (the so called postactive interference), or with the information that was available to the person before the same event (the so called proactive interference) memories of which were formed (Green,1992). In practice quite often it can be observed that the patients when visiting a doctor have anticipations about their potential diagnosis and therefore the patient adjusts his symptoms to the invented diagnosis. This may be called proactive interference and it affects the intake of anamnesis. In the same manner it may happen that the doctor first tells the patient his anticipations and the patient after having received this information may imagine the details without being aware of it himself. This may be called postactive interference, which also affects the anamnesis. All this is especially dangerous if working with the minor patients, therefore medical professionals must be particularly observant and cautious when taking anamnesis, due attention must be paid to questioning the child.

Usually the intake of anamnesis starts with questioning. Taking anamnesis of the minor patients the medical professional for the most part puts these questions to the child's lawful representative in the presence of the child. In practice quite often it can be observed that doctors ask very precise questions, for instance, such as "Can you say that the child's left side hurt more?" Research shows that asking very specific questions may affect the patient's memory which respectively affects the patient's answers and may distort the anamnesis. In the experiment of Loftus and Palmer (Loftus, & Palmer, 1974) the participants of the experiment were offered to watch the film featuring several car accidents, then they were split into three random groups and each group received a different set of questions. Research results showed that the wording of the questions affects the response. This misleading effect demostrates that

when suggestive and more detailed information is received after formation of the real memories it may replace or transform the old information (Okado, & Stark, 2005; Loftus, & Hoffman, 1989; as mentioned by Straube, 2012). It means that while taking the anamnesis a medical professional must aim at asking more general questions, for instance, such as "Which of the child's sides hurt more and what can it be evidenced by?".

Conclusions

As reflected by the research, there exist several problems in the relations of medical professionals and minor patients. On the one hand, the law protects minor patients, yet at the same time it abridges the rights of medical professionals. Healthcare professionals are unable to provide high-quality care unless their rights are respected. Medical professionals must work under decent conditions, yet maintaining professional independence. (Hervey, McHale 2015).

Responsibility of the healthcare professionals for the health of the patient is enormous. However, the doctor's responsibility for the observance of the patient's rights and obligations is equally important. Performing his daily functions the doctor does not merely have to act as a specialist, but he must also be familiar with the legislative changes and their trends.

Reviewing the issue of the minor patients' rights and obligations in the process of medical treatment in Latvia and the issue of peculiarities of communication with the healthcare professionals allows for the conclusion that::

1.the patient who has reached the age of 14 has the right to refuse medical treatment and to adopt any effective resolution provided further that the doctor anticipates hazard effects of the patient's actions;

2.the patient who has reached the age of 14 on the one hand, is mature enough and is authorized to take a decision about his treatment himself, on the other hand, assessment of the degree of maturity of the patient is an extremely complicated process that is not regulated by the Latvian legislation;

3.working with the minor patients lays enormous responsibility on the medical professional. On the one hand, the doctor must be concerned with the health and survival of the patient, on the other hand, he must respect the human rights of the minor patient.

4. increased attention must be paid to the minor patients themselves, questioning must begin with the minor patient and not with the child's lawful representative.

5. in the course of communication with the minor patient and the patients's lawful representative it is necessary to refrain from announcement of the presumable diagnosis, if there is no absolute certainty about it, also when taking the anamnesis of

the minor patients it is necessary to refrain from specific questions aiming at asking general questions without specific indications.

It should be noted that if the relations between patients and medical professionals were viewed in the context of human rights, exclusive right to life would be taken as a governing principle (Abraham, Lewis, 2000).

In view of the above-mentioned it must be concluded that the Latvian statutory enactments regulating the rights of the minors in the process of medical treatment are incomplete. Proficient and professional communication of the healthcare practitioners with the minor patients are not sufficiently secured either at the legislative level or from a practical standpoint.

References:

[1] Abraham, J., Lewis, G. (2000). Regulating medicines in Europe: Competition, Expertise and Public health. Routlenge

[2] Exster A. (3th ed.). (2002). Antwep-Oxford-New York: Intersentia. P.148

[3] Slokenberga,S., A.Gusarova, A.Lieljuksis,R. Mucins, Stanislavska O, Saberte L., Slisere D., Taurina L. (2015). Medical law. Latvia: Tiesu namu agentura

[4] Šulce – Rēvele L., Līkanse D. (2013), Development of Latvian Patients' rights. Journal Jurista vārds, No. 41 (792) (online) Available at: http://www.juristavards.lv/doc/260694-pacientu-tiesibu-attistiba-latvija/ (January 12, 2016)

[5] Tamara K.Hervey, Jean V.McHale, European Union Health Law, Cambridge University press, 2015, 160 p

[6] Lilienfeld, S. O., Lynn, S. J., Ruscio, J. & Beyerstein, B. L. (2010). 50 Great Myths of Popular Psychology. Blackwell Publishing. United Kingdom.

[7] Clifasefi, S. L., Garry M., & Loftus, E. F. (2007). Setting the record (or video camera) straight on memory: The video camera model of memory and other memory myths. In S. Della Sala (Ed.), Tall tales about the mind and brain: Separating fact from fiction. 60–65

[8] Gonsalves, B. & Paller, A. K. (2002). Mistaken Memories: Remembering Events That Never Happened. The Neuroscientist, Vol.8,No.5, 391-395

[9] Mitchell, K. J. & Johnson, M. K. (2009). Source monitoring 15 years later: what have we learned from fMRI about the neural mechanisms of source memory? Psychological Bulletin, Vol. 135(4), 638–677.

[10] Jacoby, L. L., Wahlheim, C. N., Rhodes, M. G., Daniels, K. A., & Rogers, C. S. (2010). Learning to diminish the effects of proactive interference: reducing false memory for young and older adults. Mem Cognit, Vol 38(6), 820–829.

[11] Brainerd, C. J., Reyna, V. F., & Aydin, C. (2010). Remembering in contradictory minds: disjunction fallacies in episodic memory. Journal of Experimental Psychology: Learning, Memory, and Cognition, Vol.36(3), 711–735.

[12] Gallo, D. A. (2010). False memories and fantastic beliefs: 15 years of the DRM illusion. Mem Cognit, Vol. 38(7), 833–848.

[13] Loftus, E. F., & Pickrell, J. E. (1995) The formation of false memories. Psychiatric Annals, 25, 720-725.

[14] Hyman, I. E., Jr., Husband, T. H., & Billings, F. J. (1995). False memories of childhood experiences. Applied Cognitive Psychology, 9, 181-197

[15] Porter, S., Yuille, J. C. & Lehman, D. R. (1999). The nature of real, implanted, and fabricated memories for emotional childhood events: implications for the recovered memory debate. Law and Human Behavior, No.23(5), 517-37.

[16] Johnson, M. K, Hashtroudi, S., & Lindsay, D.S. (1993). Source Monitoring. Psychol Bull 114(1):3–28.

[17] Straube, B. (2012). An overview of the neuro-cognitive processes involved in the encoding, consolidation, and retrieval of true and false memories. Behavioral and Brain Functions, No.8:35.

[18] Gillick respondent and West Norfolk and Wisbeck area Health authority first applellants and department of Health and Social security second appelants, http://www.bailii.org/uk/cases/UKHL/1985/7.html

[19] Wheeler R.(2006) Gillick or Fraser? A plea for consistency over competence in children: Gillick and Fraser are not interchangeable. British Medical Journal, (8 April): 807