CLASSROOM DEBATE: "FULL DISCLOSURE SHOULD BE MADE MANDATORY IN PARENTAL PERMISSION IN PAEDIATRIC PRACTICE"

***Soe-Soe-Aye; Deeben C; Thaneshwaran M; Reenaa J; Thinagar R; Heerrtana S; Logaroobini G; Suvena Naidu; Ashwwin K; Hareshnaath S; Tanusha K; Nivetha N; Riyaalani P; Divashini Devar P; Shcantiya S; Sharminhi A.**
*Professor, Head of Paediatrics, Faculty of Medicine, Asia Metropolitan University, Johor, MALAYSIA
profsoe14@gmail.com

ABSTRACT

A classroom Debate on "Full disclosure should be made mandatory in parental permission in paediatric practice" had been conducted as a Teaching learning activity at a University in Malaysia. The activity had been organized by the 14 students of the rotation 2, Year 3 students (09/2019), during the Paediatrics posting of 8 weeks' duration in addition to other teaching learning activities. The aim of this activity is to foster learning with a unique learning strategy; to enable students to develop constructive arguments to support opposing views of the given topic. The students had been briefed on day 1 of the posting and the topic given by the Course Coordinator. The rules and regulations had been presented at start of the Debate session held in 4th week of posting, by the Chairperson. The speakers were allocated a total of 35 minutes per group strictly managed by the two timers. The 3 speakers each from the proposition and the opposition groups spoke, in alternate turns, to put across the message for or against the motion. A panel of 5 adjudicators scored the performances according to marking scheme template. The other students did the photography and video documentation. The Best speaker and the Best group were awarded prizes. all prizes being sponsored by principal author.

Keywords: Classroom debate; Full disclosure; Informed consent; Open disclosure; Parental permission; Paediatric practice.

INTRODUCTION

The doctrine of informed consent reminds us to respect persons by fully and accurately providing information relevant to exercising their decision-making rights. Experts on informed consent include at least the following elements in their discussions of the concept:
i.. Provision of information: (Full disclosure), patients should have explanations, in understandable language, of the nature of the ailment or condition; the nature of proposed diagnostic steps and/or treatment(s) and the probability of their success; the existence and nature of the risks involved; and the existence, potential benefits, and risks of recommended alternative treatments (including the choice of no treatment).
ii. Assessment of the patient's understanding of the above information.
iii. Assessment, if only tacit, of the capacity of the patient or surrogate to make the necessary decision(s).
iv. Assurance, insofar as is possible, that the patient has the freedom to choose among the medical alternatives without coercion or manipulation.

Decision-making involving the health care of young patients should flow from responsibility shared by physicians and parents. Practitioners should seek the informed permission of parents (Parental permission), before medical interventions (except in emergencies when parents

cannot be contacted). The informed permission of parents includes all of the elements of standard informed consent, as outlined previously. Usually, parental permission articulates what most agree represents the ``best interests of the child." Nonetheless, the need for child abuse and neglect laws and procedures makes it clear that parents sometimes breach their obligations toward their children. Providers of care and services to children have to carefully justify the invasion of privacy and psychologic disruption that come with taking legal steps to override parental prerogatives. A re-analysis of informed consent leads to the identification of important limitations and problems in its application to paediatric practice. Two additional concepts are needed: **parental permission** and **patient assent.** The American Academy of Paediatrics believes that in most cases, physicians have an ethical (and legal) obligation to obtain **parental permission** to undertake recommended medical interventions. In many circumstances, physicians should also solicit a **patient assent** when developmentally appropriate.

Full disclosure should not be confused with OPEN DISCLOSURE. Open disclosure begins with the identification of any patient safety incident, and concludes when the patient and/or their support person indicate that they are satisfied, that no further discussions are needed. In 1987, the Veteran Affairs Hospital in Lexington, USA introduced “Open Disclosure” in response to rising legal bills due to legal actions following adverse events. It is a truthful discussion between health care providers and consumers; patients and their support members, about an adverse event. Under open disclosure, the doctor provides relevant information about the event with apologies, explanations and offer to compensate them for their losses. Open disclosure has been increasingly adopted by doctors, hospitals and other stakeholders in healthcare in both the UK and US, as it has been shown to reduce malpractice lawsuits

LITERATURE REVIEW

All the students and the faculty did the literature review relating to topic. Please refer to the List of the References

OBJECTIVE

The objective of this paper is to showcase the presentations made on the Debate topic by the 3 speakers each for Proposition and Opposition group and highlight the Introduction, Remarks and Conclusions made upon the Debate session by the faculty.

METHODOLOGY

All the 14 Year 3 students MBBS Program (09/2019) posted to the Paediatrics posting in rotation 2 for 8 weeks, participated in the conduct of the classroom Debate session introduced as one of the Teaching Learning activities at this University, Malaysia. The aim of this activity is to foster learning with a unique learning strategy; to enable students to develop constructive arguments to support opposing views of the given topic; to encourage critical thinking; to raise students’ awareness that most issues are not straightforward and that students should learn to form opinions about their position that they can explain or defend with factual evidence. The students elected their own Chairperson and Timer for the session and 3 speakers each for PROPOSITION and OPPOSITION Team of the topic given by Course coordinator on day 1 of the posting. Each one of them did a Literature review as evidenced by the list of References given. The rules and regulations for conduct of the Debate session and the marking scheme for grading of their performances are given in the students’ guidebook.

FINDINGS (PRESENTATIONS)

The speakers spoke in turns, one from each group alternating with speaker from other group. However, the 3 presentations from each group are collated and given as below.

A. PROPOSITION TEAM

1ST SPEAKER: MR THANESHWARAN MANI

Good morning. Before I put forward my case today, I would like to define today's motion 'This house believes that full disclosure is mandatory in getting parental permission in pediatrics practice. We, the affirmative team, define the topic as to obtain parental permission, complete transparency is required. We, the affirmative team, believe that this statement is true, and we fully support this motion.

Today, I, Thaneshwaran Mani as the first speaker, will be talking about what does full disclosure means in medicine. Our second speaker, Reenaa Jeyaseelan, will be talking about why full disclosure is important for the physician and hospital and finally our third speaker, Thinagar Rajan will be talking on why it is important for the parents and children to have full disclosure

So, what is full disclosure? When things do not turn out as planned during a patient encounter, regardless of whose fault, most physicians and other health care providers want to show compassion and disclose what has happened. Significant anecdotal experience demonstrates that full disclosure combined with apology in these situations results in reduced lawsuits, pay-outs and costs while improving patient satisfaction and quality. Yet it is estimated that only one in four errors is disclosed to the affected patients. Escalating lawsuits and jury verdicts, the high cost and limited access to professional liability insurance, and fear of shame and damage to professional reputations have left providers in denial and struggle in how to respond. These fears are intensified by a sense that insurers, attorneys, and other advisers are pressuring them to remain silent to avoid premature admissions of liability in subsequent adversarial proceedings. (Actually, this is OPEN DISCLOSURE. Inserted by Faculty)

According to the American Society for Healthcare Risk Management, 35 states have laws making a professional's statements of apology, sorrow or regret following an adverse outcome non-admissible. The theory behind these "I'm sorry" or "apology" statutes is that "if patients were treated with openness and sympathy—and offered prompt compensation—when doctors make mistakes instead of showing the detachment doctors frequently feel required to project to protect themselves from malpractice suits, they would be less likely to sue and, if there were less patients suing, there would be a corresponding decline in malpractice insurance costs."
In Malaysia, the Malaysian medical council adopted a consent guideline in which the medical practitioner should assist the patient to understand the material provided and, if required, explain to the patient any information that he or she finds unclear or does not understand. The medical practitioner must afford the patient the opportunity to read the material and raise any specific issues of concern either at the time the information is given to the patient or subsequently. The medical practitioner must ensure that any pre-prepared material given to the patient is current, accurate and relevant. If such pre-prepared information material does not disclose all "material risks" either in general terms or otherwise, the medical practitioner must provide supplementary information on such "material risks" as are not disclosed, verbally. The likelier the risk, the more specific the details should be.

Let me tell you about a case where not fully disclosing medical side effect brought a huge loss for a doctor. Maree Whitaker, who had for many years been almost completely blind in her

right eye, consulted Dr Christopher Rogers, an ophthalmic surgeon, who advised her that an operation on the eye would not only improve its appearance but would probably restore significant sight to it. Whitaker agreed to the surgery. After the operation there was no improvement to the right eye and Whitaker developed inflammation in the left eye that led to loss of sight in that eye. She sued Rogers in the Supreme Court of NSW for damages for negligence. Campbell J found Rogers liable in that he failed to warn Whitaker that, because of the surgery, she might develop a condition known as "sympathetic ophthalmia" in her left eye. He awarded damages of $808,564.38. An appeal by Rogers to the Court of Appeal was dismissed. Rogers argued that the issue should be resolved on by application of the Bolam Principle as applied in the UK (Bolam v Friern Hospital Management Committee (1957) 1 WLR 582), described by Lord Scarman in Sidaway v Governors of Bethlem Royal Hospital (1985) AC 871 as: "The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment." At the end, the verdict was; "The law should recognise that a doctor has a duty to warn a patient of the material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should be reasonable aware that the particular patient " With this true case, I would like to stand firm with today's motion. (" Need for Full disclosure should be made mandatory is illustrated in this case inserted by Faculty.)

2ND SPEAKER: MS REENA JAYASEELAN

Good afternoon. We typically see a patient in the office, prior to a procedure and signing a document that explains how even the simplest procedures has risk of infection and ultimately death. Informed consent is an essential part of clinical practice to all medical consultations, investigations, diagnosis, treatment and procedures. Before the introduction of informed consent, doctors were trained to believe that they were the best person to make medical decision for their patients. Over the years, there was an increase in number of medical negligence proceedings between patients and doctors. The rise in human rights movement, improvement in the education system and rapid evolution in the information technology has led to the demand for adequate information disclosure before obtaining informed consent.

Every patient has the right of self-determination. Full disclosure gives the patient and the patient`s parent a meaningful choice rather than a meaningless one. Patient needs to be informed prior to medical treatment. Doctors need to provide their patients with sufficient information so that the patients could assent to or withhold consent from a proffered medical treatment. The law has given patient independence, autonomy and self-determination – in paediatrics patient`s parent has a right to determine whether or not for their child to undergo any medical procedure. To do this, patient`s parents need to be provided with sufficient information. According to PROVISION 3 ,MMC GUIDELINES 2013, the medical practitioner must inform the patient, in a manner that the patient can understand, about the condition, investigation options, treatment options, benefits, all material risks, possible adverse effects or complications and the likely result if treatment is not undertaken, to enable the patient to make his own decision. A medical practitioner should explain a procedure, treatment, and risks of a particular treatment to the patient and patient`s parent before obtaining a consent. Therefore, obtaining an informed consent from a patient or patient`s parent is important and should be obtained by providing sufficient information regarding the treatment plan, so that the patient`s

parents are given the right of self-determination whether to proceed with the treatment plan or not.

It is a doctor`s duty to explain the risks associated with the proffered medical treatment. Doctors needs to disclose to the patient all 'material risks' inherent in a proposed treatment. According to Provision 3 MMC Guidelines 2016, A medical practitioner is obliged to disclose information to the patient and to warn the patient of material risks before taking consent. Failure to obtain a patient's consent or disclose material risks may be interpreted as a failure of the standard of care resulting in a disciplinary inquiry by the Medical Council or may even be construed as a breach of duty of care and legal action instituted. Explaining the risks to the patient`s parents, creates a better relationship between patient, patient`s parents and the medical practitioners. This also enable the patient`s parent to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment. I would like to emphasize this statement because it is stated in the Bolam principle in the Federal Court (2007). The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment. This enables the patient to decide whether to proceed with the proposed treatment considering the risks involved or decline the treatment. But in paediatrics, I believe it's the parent`s responsibility to make that decision. There was a case in the federal court in 2017, Dr Hari Krishnan against Megat Noor Ishak Bin Megat Ibrahim who is Dr Hari`s patient. Patient had a giant retinal tear and was advised to undergo retinal detachment operation. After operation, patient complained of continuous pain and strong pressure in his operated eye. Dr Hari performed a scan and mentioned that his improvement in vision is temporary and will subsequently worsen. Therefore, patient needs a second operation. After the second operation, Patient experienced supra-choroidal haemorrhage and loss of vision. This was brought to the federal court, The patient claimed that he was not warned about any risks or that he might go blind, and Dr Hari claimed that the patient signed the consent form prior to the operation. upon investigation, the federal court found out that the consent form only consist of the general precautions and the risks were not stated clearly. It was concluded that, Dr Hari failed to advice and warn the patient on the risks in the second operation. Although a consent form was signed, there were no full disclosure between the doctor and the patient. Now it is clear that, a consent form with a signature alone is not sufficient. Doctors need to explain the risk factors in detail to the patient to avoid multiple issues such a medical error. Therefore, I believe that full disclosure is important in explaining the risks to the suggested treatment plan to a parent in order to avoid such issues.

It is important to disclose information by the person's responsible for implementing medical intervention. Several guidelines recommend doctors to provide information on the person who will provide the medical care. Providing information by the doctors who are going to perform the proposed medical intervention helps patients to achieve the desired commitment whether to proceed with the intervention and from whom the medical intervention is going to be received. Intervention that carries higher risk or more invasive will require a more explicit detail on the person performing the procedure. Informing the qualification and performance rates of the individual doctor in informed consent may help to improve patient's autonomy in making a decision and enhance medical care quality. Further information on a doctor's experience in conducting a certain procedure is essential in comparing risk statistics with other doctors conducting same procedure and the availability of other doctors and health care institution that able to execute the procedure better. Additionally, this type of disclosure may encourage frankness and accountability which subsequently can contribute to the development of doctor-patient trust relationship. Full disclosure leads to a drop in medical error.

Paediatricians' worries on disclosure due to factors such as about one's reputation, fear of litigation and lack of support from health care organizations. These can prevent paediatricians from disclosing errors. Medical Error is a human error in healthcare, rather than the underlying disease, that causes harm to a patient. The presence of a hospital disclosure policy for informing patients and families about systems failure or human errors resulted in lower mortality. Disclosure policy is crucial in identifying and investigating apparent medical errors. Full Disclosure provides opportunities for the healthcare professionals and institutions to improve patient safety from the experiences of their patients. Full Disclosure of harmful medical errors help with the human resources aspect of the HealthCare Institutions, improved provider-patient relationships and creates an opportunity for forgiveness and reconciliation.

For informed consent to be valid, adequate information need to be provided to the patient before a decision can be made. It is better to deliver the information in a few sessions especially when there is a lot of complex information. Some patients may also require a time to conduct own study to help in digesting and understanding provided information to decide. The important point to note is that obtaining informed consent is not a one -off situation but a continuous process. All consultation sessions that include disclosing vital information need to be properly documented and not necessarily just on the one-page sheet of the form where the patient put their signature on. Thank you.

3RD SPEAKER: MR THINAGAR RAJAN

Good afternoon. I am glad that our opponent brought up the issue of parents are not ready to accept the truth regarding their kid's health risks, because parents are clumsy and emotionally weak when it comes to their beloved child who is at risk. Meanwhile, is it not the duty and responsibility of a paediatrician or medical officer to explain everything to the parents and make sure they understand everything regarding child's health issue. Because that's what the doctors and house officers are trained for and even it's a part of curriculum syllabus in medical degree program. Furthermore, full disclosure is not a one-step procedure but it's a process. Full disclosure is very important for the parents to take a wise decision. So, let me start with a case example that includes Lechemanavasagar A/L Karrupiah versus Dr Thomas Yau Pak Chenk & Anor (2008). The plaintiff accidentally swallowed a fish bone, the plaintiff went to see the first defendant, an Ear, Nose and Throat (ENT) specialist. The first defendant (The ENT specialist) recommended for an operation which was performed on the same day the plaintiff came to see him. After the operation, the plaintiff suffered oesophageal perforation on the upper part of his oesophagus and his lung became infected due to the perforation and almost collapsed. An emergency chest operation was performed by the first defendant to control the infection and to prevent total lung collapse. The claim was made that the first defendant did not warn that the operation to remove the fish bone would be a highly risky one as the plaintiff was informed that the operation was a simple one and that he would be able to return home a few hours after the operation. He agreed to undergo the surgery to remove the fish bone and did not even inform his family about it as he was under the impression that it was a simple surgery. So, this clearly shows that a patient has all the rights and necessary to know what is coming on their way. This case involves an adult, what if it involves a paediatric patient? Do you think he/she could survive this medical risks? Member of the hall, there is a law which states The Law Reform (Marriage Divorce) Act 1976 makes it clear that each parent has full responsibility for each of his/her children who is under 18 years of age. Parental responsibility is not affected by changes to relationships (i.e. if the parents separate) each parent has the responsibility for his/her child's welfare. Therefore, making medical decision is not just the responsibility of the parents but their rights. Honourable judges, like I have mentioned before full disclosure is a process and it consists of 9 steps. Starting from Diagnosis, prognosis, and its uncertainties,

nature of proposed medical intervention, expected benefit of proposed medical intervention, potential risk of proposed medical intervention, alternative to proposed medical intervention, progress of proposed medical intervention, opportunity for a second medical opinion and seek further details, costs of proposed and alternative medical intervention and person responsible for implementing medical intervention. Idea of paramount importance, potential risk of proposed medical intervention is very important to be disclosed. Its crystal clear that the parents have all the rights and needs to know about their children's medical health. Therefore, they have to deal with all the side effects of a medical procedure before taking a decision and give the physician the consent. Risks of the proposed medical intervention are the most widely discussed issue in the common law world. There were numerous legal actions taken worldwide alleging failure of doctors to disclose material risks before medical intervention. Meanwhile, it is a second chance for them to reconsider what they had to do with their child's current medical condition. This is where they are led to other options such as finding for alternative to proposed medical intervention. Because for every medical problem, there could be more than one method of investigation or medical intervention. Apart from the proposed intervention, other available and accessible alternative intervention and comparative risk between alternative treatment is a mandatory disclosure. The common law has decided that failure to discuss this alternative issue is regarded as a violation of the doctor's duty of disclosure and a parent's rights to know it. The explanation on nature, benefits and risks for each of the alternatives are similar to the information disclosure required for proposed medical intervention. The additional information is to include why this alternative is not recommended and the possible outcomes of not opting for the proposed intervention. So, with all these factors in their mind, the parents could finally come with an excellent option. Meanwhile, some parents do take another step forward, by trying to get an opportunity for second medical opinion and seek further details. These measures may benefit by gaining a great deal of patient's trust and confidence in which to demonstrate that the doctor has taken an appropriate and reasonable step in helping to resolve a patient's medical issue. Adding to that, apart from decision making and knowing the risk factors and progression of the medical intervention. The patient and parents have to be informed about the costs of proposed and alternative medical intervention. Even though accessibility to health intervention is a basic human right, doctors and patients must accept the fact that health intervention incurs resources such as time, material, manpower and facility that will demand financial expenditure. Accordingly, a few medical interventions were also being chosen for its economic benefits and cheaper cost. Because not every parent has a good financial background or prepared with insurance nor medical cards to bear the costs for the medical. So, the parents are entitled to be aware of the exact or the estimated amount that they will have to get ready. If the parents/ guardian is not going to be able to afford the cost, the doctor may advise the need for obtaining funding and offer a more affordable solution within the doctor's capability or refer to another centre that can offer the medical intervention at the cost that the parents can manage. So therefore, Full disclosure is necessary in every process even after the medical procedures have been completed. So that if there are any medical errors were done, parents and patient should be notified as well as a part of full disclosure. Adding on, parent's perspectives on paediatric disclosure is where parents generally want to be informed of medical condition and errors in their child's care, regardless of severity or level of harm. In one study, desire for disclosure did not differ according to parental ethnicity/race, sex, age or insurance status. In another study, 'Asian' parents were shown to be more likely than 'North American' parents to wish for disclosure at lower levels of harm. On the other hand, children's perspectives on disclosure and information are about receiving information appears to be important to children because failure to obtain full and open disclosure about their medical care may cause them anxiety and feelings of uncertainty, and some children report feeling

excluded from communication in medical settings. In hospital settings, some children may prefer to have a private conversation with their physician, without parents present.

As a final word, let me summarize my point of view, some patients may also require a time to conduct own study to help in digesting and understanding provided information to decide. The important point to note is that obtaining informed consent is not a one-off situation but a continuous process. Up to 98,000 patients die annually in hospital's due to medical risks and carelessness of physicians. Do you still think full disclosure is not important? Because one way or another you and I will have to make a medical decision for someone we love, which could be for our parents or for our child. What do you think? Thanks a lot, that's all from me.

B. OPPOSITION TEAM

1ST SPEAKER: MS HEERRTANA SUGUMARAN

Good afternoon. I am from the opposition group, and I strongly believe that full disclosure should not be mandatory for parental permission in paediatric practice.

Moving on to my argument, clinicians' primary obligation is to their patients, and ethical discourse has focused on this obligation. But in paediatrics, the principle that the "child and family are the unit of care" raises the issue of the paediatrician's obligations to parents and other family members as well. These obligations sometimes raise the potential for conflict between a child's interests or preferences and a family member's interests or preferences. Unfortunately, full disclosure can be a reason for these conflicts to happen sometimes. It is undeniable that full disclosure is a valuable way for a paediatrician to respect the autonomy of his patient and the patient's family. However, to a certain degree, it may negatively impact parental decision-making regarding their children's treatment. We argue that full disclosure is not the most appropriate method of fulfilling all of a clinician's ethical obligations in every clinical setting, especially in cases of paediatrics, where informed consent is almost always given by parents. A good example of this scenario is the refusal of treatment by parents due to full disclosure of risks by physicians. In many countries, it is mandatory for physicians to fully disclose every information regarding treatment or procedure done on the patient. This includes disclosing even the most minute risk that probably has just 0.01% chances of happening from the procedure or treatment. However, the Delhi Medical Council proposes that there is no need for a physician to disclose any remote or theoretical risks to the patient or their surrogate as it might confuse them, and eventually lead to refusal of treatment. The director of the health law institute in the US, Dr Thaddeus Mason Pope, wrote in an article about cancer that the concern about adverse effects is one of the primary reasons parents refuse treatment for children with cancer. The reality of this scenario is illustrated by what happened to a 6-year-old boy named Oshin in Perth, Australia. He was diagnosed with an aggressive form of brain cancer and his parents had refused to consent to his potentially life-saving chemotherapy simply because they were worried about the risk of chemotherapy. Oshin's physician took legal action against the parents after all the efforts he took to convince his parents because he strongly believed Oshin can be cured. After the court's decision in March that Oshin had to receive chemotherapy, a judge in September ruled he could be given palliative care. In December 2016, the boy passed away. According to Oshin's physician, there was a 40 percent chance of survival at five years if he started chemotherapy immediately, and about a 65 percent chance if he had chemotherapy and radiotherapy. He also said that statistics from experts indicated a good prospect of a long-term cure. At the beginning of Oshin's treatment, his MRI showed a "continuing positive response" to the treatment. Imagine if Oshin's parents hadn't been aware of the 30% risk that could not even cause such detrimental effect to the child, there would have been a 65%-70% of chance for his survival and he would be alive today! A similar incident happened for a 3-

year-old boy named Noah, whose parents refused his chemotherapy treatment even though he had a 90% of chance to survive due to the same reason Oshin's parents had refused his treatment. Instead, Noah's parents chose to heal their son with natural remedies because they believed it has a lesser risk compared to chemotherapy. Thankfully, Noah's parents lost custody of their son, and a judge ruled that Noah must continue treatment despite his parents' wish. Both this incident clearly shows that due to the full disclosure of risks to the parents, sometimes children's lives are put at stake in "the name of worry". Do you think it's acceptable for such a young boy like, Oshin to die at a young age without having the chance to live life to fullest, when his death can be prevented with immediate treatment? Besides, why do you think physicians in emergency situations are not expected to get parents' consent or to provide full disclosure? According to the American Academy of Paediatrics, applying the standard rule of full disclosure before any treatment would seriously undermine the health, safety, and life of any patient who requires emergency treatment, which means saving the patient's life at that moment is more important than preserving their autonomy and I believe, that is the ultimate purpose of a doctor. Only if full disclosure is not made compulsory, a physician will be able to make the best choice of treatment for his patients who require immediate treatment without having to go through a time-consuming and complicated process. I believe the doctor's time and energy are better spent on treating and saving the patient's life. Therefore, I firmly stand by our motion that "full disclosure should not be mandatory for parental permission in paediatrics practice". Thank you.

2ND SPEAKER: MS KUNASANGGARI CHANDRASEKARAN

First and foremost, I would like to express my sincere appreciation and to convey my gratitude to Prof Dr. Soe Soe Aye for giving me this amazing opportunity to speak today.

A very good afternoon. I am Sharminhi Arasu, the second speaker on behalf of Ms Kunasanggari of the opposition team. We believe that full disclosure should not be mandatory for parental permission in Paediatrics. However, I appreciate the sincere efforts of the second speaker of the affirmative team, but there seems to be a couple of misunderstandings that I would like to clear up.

I would like to begin to strengthen our argument with a question that sets aside your logical facts and tugs at the strings of the human heart. If it was your child laying critically in the hospital, how many of you would be able to be in your right mind and make clear judgements? As educated or civilized and modern as we are, most of us would be clouded by emotions when we are in such a devastating situation, what more if they are of a less educated background. Hence, it is unwise to fully disclose all the information to parents especially when there is an emergency, and the main priority is on the patient's life rather than the parents' emotions.

Decision making in medicine is the ability to utilize professional judgment to make clinical decisions that best meet the needs of a patient. As a medical practitioner, it is essential to recognize what is the necessary information to be informed and to ensure that it does not deter the needs of their patients and provide treatment for the patient without delay so a life can be saved. In his farewell address the president of the Association of American Medical Colleges, Jordan Cohen, MD, made this statement: "The doctor's professionalism is defined not only by what he or she must know and do, but most importantly by a profound sense of what the doctor must be." We as future doctors whose mission is to serve the public must pause and realize the enormous importance of having proper judgement and be able to assess the emotional stability and logical thinking skills of the guardian in the situation and ensure best treatment is given to the patient.

According to the Hippocratic Oath, medical doctors usually after graduation take an oath to safeguard their patients from harmful and waggish activities, and such oath has been in practice since the time of Hippocrates. Hippocratic Oath guides the premier objective of the medical profession and covers obligations concerning the patient. As a conclusion, doctors should have a good judgement of the situation and ensure disclosed information does not cause emotional turbulence to the guardian in times of emergency that may affect their rational thinking that may negatively affect the patient.

In most cases, parental agreement is essential for paediatric patient examination and medical treatment. However, there are times when children arrive with life-threatening medical issues and a parent or legal guardian is unable to offer consent. According to the American Academy of Paediatrics' policy statement "Consent for Emergency Medical Services for Children and Adolescents," a medical screening examination and appropriate medical stabilization of a paediatric patient with an urgent or emergent condition should never be withheld or delayed due to consent issues. Despite the fact that clinicians, courts, and parents may disagree on what constitutes an emergency, this standard should apply when immediate and serious harm is imminent.

Then, according to a study conducted by Gemechu Jofiro and Kemal Jemal in 2018 on the prevalence and associated factors of paediatric emergency mortality, child mortality rates remain high around the world, with approximately 3.1 million neonates, 2.3 million infants, and 2.3 million childhood deaths occurring each year. Every year, 10 to 20% of very ill children in undeveloped countries are admitted to hospitals. Various factors, such as delays in seeking assessment and treatment, diarrhoea, and low nutritional status, enhance the extent and severity of child mortality. Early childhood mortality is frequently caused by avoidable and reversible disorders in paediatric departments, necessitating immediate treatment and resuscitation to avoid poor outcomes. In all this instances, the time period plays an important factor in effecting the effectiveness of the treatment. Most deaths do not occur, because of reversible and preventable diseases which, with proper time can be easily cured.

The clouded and worried mindset of parents in the time of emergency can make asking for consent an impossible task to complete. In the critical situation, explaining a condition or complication to the child's parents may do more harm than good because a complicated case may take hours to explain clearly to the parents and make them understand. A doctor's time and energy better spend on treating the patient. Through my arguments we can conclude that full disclosure to parents should not be made mandatory in saving a child's life. Therefore, I firmly stand on my statement that full disclosure should not be made mandatory for parental permission in Paediatrics practice.

3RD SPEAKER: MS SUVENA

A very good afternoon. As the third speaker of the opposition, I strongly object the proposition that full disclosure should be mandatory for parental permission in paediatric practice. I would like to elaborate on points here and my argument would be based on therapy and procedures in a paediatric case.

My first point will be the role of healthcare workers. Healthcare workers have been trained to save lives and tend to patients that have been brought to them. Healthcare workers are highly trained and skilled people and have exceptional knowledge in their field. In this instance, I would like to refer to the healthcare workers as doctors and nurses. Doctors and nurses go through many years of studies and training before they are allowed to handle patients. When a

patient is left to be treated by a healthcare worker, a certain amount of trust should be put in the healthcare worker.

Just like how parents send their children to school and allow teachers to educate and tutor their children, like how they send them to ballet classes to learn ballet, like how they send they children for art classes to learn drawing. They put their trust and faith in those skilled and experienced in that field to tend to their child. I understand those are not life-threatening situations, but trust is given and no full disclosure is given in those situations. The nitty gritty details of what goes on in the process is not given. A basic outline is given and that's all.

When it comes to treating a child, usually there is a team of skilled doctors and nurses who would be involved in the process. We should give them the due amount of freedom to use their knowledge and skill to treat paediatric patients. When a patient is brought into the hospital, especially the emergency department, some form of unsaid consent is already given to treat the child. For example: in the case of drowning, and a child is rushed into the emergency department. It is almost certain; the parents want everything to be done to save the child's life. We can explain about the complications arising from the procedure, for example: Complications of a branula insertion which include infection, phlebitis and thrombophlebitis, emboli, pain, haematoma or haemorrhage, complications of drawing blood: bleeding, bruising, rash, skin irritation from tape or adhesive from an applied bandage, Complications of CPR: rib fracture, lung injuries such as pneumothorax and lung contusion, abdominal organ injuries such as hepatic, splenic and gastric injuries, and chest and/or abdominal pain requiring analgesics. This process will take up precious time that would be needed to initiate treatment and save the child's life. Waiting for permission after giving a full disclosure regarding the therapy and procedures is not at all feasible.

McDermott et al (2015), states that Paediatric emergency department (ED) visits constitute roughly 20 percent of all ED visits in 2015 alone. To give full disclosure of every procedure and every medication that needs to be administered would consume a lot of time. Moreover, in such a situation, parents would not be in the right frame of mind to make a rational decision. If in the event a full disclosure is given, and the parents chooses not to give permission for treatment due to emotional reasons clouding their judgement, it would cost them the life of their child.

My second point is, in a medico-legal case, parental permission is not at all needed to commence therapy or perform any procedures on a child. A full disclosure cannot be given to parents as information pertaining to the case can only be revealed in a court of law. Full disclosure to the parents might affect the integrity of the case. Examples of medico legal cases in this instance would be child abuse: physical abuse and also sexual abuse

In Malaysia, majority of those who abuse children sexually are fathers, stepfathers or another relative. In most cases (67.8 percent of reported cases), the perpetrators were natural fathers, stepfathers or siblings. It is the main reason for unreported cases, states a report of the Suspected Child Abuse and Neglect (SCAN). Detection occurs when the child complains of pain, and a medical examination is carried out (Women's International Network News, 1990)
In another paragraph, it is stated that: based on the reported figures, neglect is the most common form of child abuse in Malaysia. Out of the 2,780 child abuse cases, 772 offenders were mothers of the victims, while 494 cases were attributed to fathers of the victims.

The Child Act 2001 of Malaysia, requires medical doctors, family members, and childcare providers to report a child who is physically or emotionally injured as a result of being ill-treated, neglected, abandoned or exposed, or who is sexually abused, to the social welfare officers or police (Lembaga Penyelidikan Undang-Undang, 2005).

Coming back to my point, in the event of a medico legal case, full disclosure to parents and requiring their permission to proceed with the procedures and therapy would be a hindrance to the process. In order to protect themselves or the perpetrator, after full disclosure is given, they have the right to refuse treatment or any sort of medical examination. This would be a huge hindrance in judicial process. Human rights of the child would be denied, and the perpetrator would be free. I strongly oppose the motion of today's debate due to the points that have been put forward by my team members and myself. Full disclosure for parental permission in a paediatric case is necessary, but it is not mandatory as making it mandatory can pose to be a huge downside in treating paediatric patients. Thank you.

REMARKS BY FACULTY

The six speakers had spoken with vigor and passion upon the topic given for this debate. The BEST group was won by the Opposition Group and the BEST speaker was won by Ms Suvena from the Opposition Group. Congratulations, for their abilities in putting across their messages strongly and to make their impact. However, Full disclosure is mandatory, when it comes to taking consent from parents or guardian especially in paediatric practice, because the children are not in capacity in making the decisions for the procedures or treatment done for them. Therefore, knowing every detail of the procedures and treatment with their side effects are very essential and that's the obligation of the medical team or the healthcare workers to disclose to the parents before getting the consent. But is it mandatory during an emergency case? Well, that is where beneficence comes in and you can treat the patient without giving full disclosure because it is involving life and death. In real life setting, full disclosure is mandatory in cases where there is no emergency and if there is emergency, it is not mandatory for the full disclosure but the need of disclosing the acute side effects of the procedure and treatment is still required. For example, blood transfusion side effects in case of motor vehicle accident.etc.,

CONCLUSION

CONSENT if given to a procedure, treatment or participation in research in an informed way, implies that one is competent to act, had received a full disclosure of benefits and risks, comprehends the disclosures, acts voluntarily and gives agreement to the intervention. Secondly, informed consent is needed both for ethical and legal reasons. Lastly, limitations in Paediatric practice introduces two additional concepts of parental permission and Assent/Dissent for children. In cases involving emancipated or mature minors with adequate decision-making capacity, or when otherwise permitted by law, physicians should seek informed consent directly from paediatric patients.

The right to security of a person means that it is legally and ethically mandatory that the doctor obtain the consent from the patient (or if patient is unable to do so), the patient's lawful substitute for any investigation, treatment choices or participation in research.

"If ethics are sufficient, law is unnecessary; If ethics are insufficient, law is unenforceable"

-Emile Durkheim.

ACKNOWLEDGEMENTS

We would like to thank the Dean Faculty of Medicine, Asia Metropolitan University, the Adjudicators AP Dr Myat Thida Win, AP Dr Mya Sanda Khaing, AP Dr Yin Moe Han, Mr Cyril Deeben invited by the Principal Author Prof Dr Soe Soe Aye, Professor Head of Department of Paediatrics, the Year 3 Students who had participated in the Classroom Debate without whose efforts this publication would not have been materialized

REFERENCES

1. April Wilson, MD, MPH, and Brenda Rea, MD, DrPH, PT, RD. (2018). Informed Consent: Is It Accompanied by Full Disclosure?
2. Child Act 2001 of Malaysia (Act 611, Part V, Chapter 2, Section 27-29).
3. Clinical Excellence Commission. NSW. Open Disclosure. CEC. Locked Bag 2030 St Leonards NSW 1590.
4. Hope T, Savulescu J & Hendrick J. (2008). Concept of Informed Consent; Medical Ethics and Law. The core curriculum.2nd Edition 2008. Churchill.Livingstone. Elsevier.
5. https://ejournal.um.edu.my/index.php/MJSA/article/download/3032/1181/8505
6. https://hcup-us.ahrq.gov/reports/statbriefs/sb242-Pediatric-ED-Visits-2015.jsp
7. https://www.abc.net.au/news/2016-08-25/oshin-kiszko-cancer-battle-returns-to-court/7785198
8. Kamarudin MNH bin, (2014). Breaking the cycle of child abuse in Malaysia: linking mandatory reporting, service delivery monitoring and review capacity mechanisms. Malaysian Journal of Social Administration, University of Malaya.
9. Kaushik, J. S., Narang, M., & Agarwal, N. (2010). Informed consent in paediatric practice. Indian Paediatrics, 47(12), 1039–1046. https://doi.org/10.1007/s13312-010-0173-4
10. Koller, D., Rummens, A., le Pouesard, M., Espin, S., Friedman, J., Coffey, M., & Kenneally, N. (2016). Patient disclosure of medical errors in paediatrics: A systematic literature review. Paediatrics & Child Health, 21(4), e32–e38. https://doi.org/10.1093/pch/21.4.e32
11. Laschon, E. (2016, August 25). Oshin Kiszko parents' fight to stop cancer treatment for son continues. ABC News.
12. Lydia Aiseah Ariffin. (2020). Information Disclosure in Informed Consent. Malaysian Journal of Public Health Medicine, 20(3). https://doi.org/10.37268/mjphm/vol.20/no.3
13. McDermott KW (IBM Watson Health), Stocks C (AHRQ), Freeman WJ (AHRQ). Overview of Pediatric Emergency Department Visits, 2015. HCUP Statistical Brief #242. August 2018. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb242-Pediatric-ED-Visits-2015.pdf.
14. Malaysian Medical Council Guideline:2013.CONSENT FOR TREATMENT OF PATIENTS BY REGISTERED MEDICAL PRACTITIONERS
15. Packer, R. J. (2008). Childhood Brain Tumours: Accomplishments and Ongoing Challenges. Journal of Child Neurology, 23(10), 1122–1127. https://doi.org/10.1177/0883073808320758
16. Parental Treatment Refusals - The ASCO Post. (n.d.). Ascopost.com. Retrieved February 16, 2022, from https://ascopost.com/issues/july-25-2019/parental-treatment-refusals/
17. Soe-Soe-Aye. (2011) Informed Consent. Medical Ethics for students: The core and beyond. Melaka Manipal Medical College. Chief Editor Prof Dr Soe Soe Aye & Editorial Board. Published by Hang Tuah Jaya. Ayer Keroh, Melaka. Malaysia.

18. Soe-Soe-Aye. Guidelines on Student Classroom Debate, Student Guidebook, Year 3 (09/2019), Academic session (2021/2022), Faculty of Medicine, Asia Metropolitan University, Muar, Johor, Malaysia
19. Soe-Soe-Aye & Noor MAM. (2018). Classroom Debate as one of the learning strategies in undergraduate Paediatrics and Adolescent Medicine posting: 5 years 'experience at National Defense University of Malaysia. International Journal of Academic Research and Reflection Vol 6 No 1.2018 ISSN 2309-0405.Progressive Academic Publishing Page 49-56
20. Zin, T.& Pai, D R (2011) Open Disclosure. Medical Ethics for students: The core and beyond. Melaka Manipal Medical College. Chief Editor Prof Dr Soe Soe Aye & Editorial Board. Published by Hang Tuah Jaya. Ayer Keroh, Melaka. Malaysia.