

Consent to Treatment During Childhood *The Assessment of Competence and Avoidance of Conflict*

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Recent rulings by the Court of Appeal (re R, 1991; re W, 1992) have again highlighted the complexity of the decisions that have to be made if a child under the age of 16 is to give consent to treatment. This has stimulated healthy debate, reflecting the free society that we live in. The issue is not a simple one, and the arguments for and against children giving consent to treatment tend to be unhelpfully polarised. Giving consent is often seen as an all or nothing ability, where a person is either able to give consent or is incompetent to consent. It makes little sense to have a magic age when children suddenly become competent to give consent. Indeed, in England and Wales the age of majority moved downwards from 21 to 18 years as a result of the Family Law Reform Act 1969, and subsequently many adult rights have been given to children aged 16 years or even younger. For example, the United Nations Convention on the Rights of the Child, now formally adopted by the British government, proposes that every child should have the right to self-determination. This is rather confusing because the child's age is not specified and no account is taken of children who have delayed cognitive development or who are emotionally immature.

The Department of Health and Welsh Office (1990) have proposed a helpful definition of consent, which is the voluntary and continuing permission of the patient to receive a particular treatment, based on adequate knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. This definition of consent is the one used here.

Giving and refusing consent

In 1986 the House of Lords decided in the Gillick case that children under the age of 16 could give valid consent to treatment if they had "sufficient maturity to understand what is involved". Lord Scarman stated that "parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence" (Law Report AC 112, 1986). This has sometimes been taken to mean an immediate transfer of rights once the critical age has been reached. However, the use of the

word 'yield' might imply a more gradual process. Subsequently the 1989 Children Act of England and Wales stated that "if the child is of sufficient understanding to make an informed decision he may refuse to submit to a medical or psychiatric examination or other assessment". The implications of the Children Act (1989) in relation to child psychiatric practice has been helpfully discussed by Jones (1991). The Act moved the argument away from giving consent to the much more challenging position of refusal to give consent. Devereux *et al* (1993) have argued that there should be no difference between giving and withholding consent because the right to give consent is worthless if it is not accompanied by the right to refuse consent. The logic of this position is clear, but it assumes that consent can be conceived in absolute terms and can be considered in isolation from the context in which it is either given or refused. If a child declines to give consent for treatment it might reasonably be assumed that treatment has been refused. However, the refusal could be due to the child's feelings of anxiety or anger. On the other hand the refusal might be related to a limited capacity to understand the nature of the request or simply a misunderstanding about what is required.

The consequences of withholding consent to treatment are usually much more significant and potentially dangerous than simply giving consent – unless one believes that most treatments are either unnecessary or are likely to be more dangerous than the condition for which they were prescribed. Refusal to consent to treatment suggests that the patient has knowledge or beliefs that conflict with expert medical advice. Thus it can be argued that refusing to give consent is a higher order of decision-making than merely giving consent (MaCall-Smith, 1992). A more stringent test should therefore be applied when assessing a child's ability to refuse consent than when assessing competence to consent. This approach allows a child to learn about giving consent before progressing on to the potentially dangerous and highly responsible decision to withhold consent.

The difference between giving and refusing consent has been recognised in rulings at the Court of Appeal by Lord Donaldson (re R, 1991; re W, 1992).

In both cases the Judge ruled that young people under the age of 18 years have no absolute right to give or refuse consent to treatment. Parents, local authorities and others with parental responsibilities also have the right to give and refuse consent. For example an emergency protection order under the Children Act (1989) allows local authorities to exercise the right to give consent on behalf of a child, even if this is against the parents' wishes. Ultimately the inherent jurisdiction of the court gives it the right to impose treatment against a person's wishes. Thus there are shared responsibilities where children and young people are concerned. This means it is possible for a 17-year-old who has sufficient understanding of the issues, and is therefore 'Gillick competent', to refuse treatment and then be overruled by the teenager's parents, the local authority or the court. The rulings by the Court of Appeal have been seen by many as going against the earlier ruling in the Gillick case and they have been strongly criticised (Lawson, 1991; Douglas, 1992).

The whole area of consent in childhood would seem to be in a state of some confusion (Shield & Baum, 1994). In addition to the purely legal, ethical and clinical arguments, there are liberal views that are in marked conflict with the more traditional views about what children should or should not be allowed to do. Rather than pursue this debate here, the focus of this article will be on the more practical clinical issues concerned with assessing a child's competence to give consent to treatment.

The process of giving consent

No doubt there will always be situations where the court has to be asked to decide on treatment issues in difficult cases, but this should be avoided as far as possible (Neville, 1993). There is a tendency for the law to view an issue as if it were frozen in time, whereas the reality is that people keep changing and medical conditions can vary greatly from day to day, especially where children are concerned. In any case, the courts will always have to be advised by clinicians about the nature of the treatment and whether or not a child has a satisfactory understanding. The role of the court should be to set a framework within which children, parents and their doctors can reach their own agreements about treatment.

Children, their parents and doctors all have rights and responsibilities. In addition to the competent child's right to give consent and take responsibility for their own treatment, parents have a responsibility to protect their children from harm. Parents also have the right to give their children guidance and support. At the same time, clinicians would claim the

right to provide the best possible treatment for their patient and they certainly have a responsibility to guide patients towards treatments that they believe are in that person's best interest. Clearly these rights and responsibilities will sometimes be in conflict with each other.

Thus there are inherent contradictions and complexities to be taken into account when young people consent to treatment. Nevertheless, this should not prevent a consensus being achieved. Clinicians are in a key position to lead children and parents towards the goal of effective treatment by providing clear information and communicating it in such a way that it can be adequately understood. However, the mere provision of information is not enough. It needs to be given within the context of a supportive and trusting relationship. Poor communication and a notable absence of trusting relationships between the child, the parents and the doctor is usually at the heart of disputes about consent.

Assessment of competence to consent

A number of factors must be taken into account when assessing a child's ability to consent to treatment. The central issue concerns the child's stage of cognitive development. In order to give valid consent, children must have reached the stage of maturity where they have a clear concept of themselves in relation to other people, including an ability to recognise their own needs and the needs of others. Competent children will have an ability to understand the nature of their disorder and know why treatment is deemed to be necessary. They should be able to understand the significance of the risks and benefits of having or not having the treatment. In addition, the competent child will be able to understand these issues in relation to the passage of time and be fully aware of what might happen in the future as a result of having or foregoing the treatment. Most children below the age of eight years have not yet developed a good understanding of time, nor have they gained a clearly defined self-concept. It is therefore inappropriate to give any responsibility for consent to treatment to children below this age. Children of around 14 years of age are normally able to grasp the more subtle and wider aspects of giving consent and the effect that this might have on themselves and other people. But whatever their age and level of maturity, the views of school-age children should always be sought and taken into account when treatment decisions are made.

It is between the ages of eight and sixteen years where difficulties can arise when deciding if a child has sufficient understanding to give consent. The

context in which consent to treatment is given or refused is of critical importance. The quality of the relationship between the parent and the child is highly influential, as is the doctor-patient relationship. The majority of young people will normally go along with their parents' wishes and do what they advise, but some children will deliberately do the opposite. Which way this goes will be chiefly influenced by the child's emotional state at the time. Relatives and others who play a significant role in the child's life may also be very influential. Grandparents, teachers, other patients, and non-medical staff sometimes play a crucial role in shaping a child's thinking. Consequently it is essential to try to secure a consensus from all the relevant adults concerned about the proposed treatment before obtaining consent from the child. Unless the child's carers are able to reach a reasonable level of agreement, there is an ethical, moral and possibly legal risk of giving a treatment to which the child alone has consented. This risk recedes as children approach adulthood and independence.

Balancing risks and benefits

The next aspect to consider is the nature, risks and benefits of the treatment for which permission is being sought. An emergency procedure for a life-threatening illness is very different from a planned intervention for a cosmetic problem. It follows that the implications of giving or withholding consent will vary according to the risk of significant harm. Alderson investigated 120 school-age children who were to have orthopaedic operations. She concluded that children younger than ten years old were able to grasp the concepts of treatment and the consequences quite well. Indeed, they were sometimes better informed and more able to give informed consent than their parents (Alderson, 1993). However, none of the operations was life-saving and the consequences of refusing consent would have had no immediate adverse effect. Nevertheless, Alderson highlights the risk of underestimating children's abilities to make wise and sensible choices. By excluding young people from the decision-making process, children as young as four or five years old may feel resentful and angry as they grow older, and have to live with the consequences of decisions in which they had no involvement. An interesting finding from Alderson's study was that children put the maturity threshold for consent at 14 years. This was in marked contrast to professionals who put it at 10.3 years.

Clearly, a delicate balance has to be struck between the need for children to be in control of what happens to them and the need to do what is deemed

to be in the child's best interest. There is a danger of using 'in the best interests of the child' as an excuse for poor communication and for failing to take the necessary time to explain the proposed treatment properly. At the same time there is also a risk of placing an unacceptably high level of responsibility on the child which can release parents from their own duty of care; a trend that appears to be increasing in frequency.

In the majority of cases there is unlikely to be much difficulty in deciding what contribution a child can reasonably make to the process of giving consent. Problems only arise if the child or the parents withdraw their consent. Then the key factor is whether or not the child is competent to give consent. A 'Gillick competent' child should be able to override a parent's opinion if the criteria listed above have been carefully assessed and it is concluded that the child does indeed have the ability and the emotional maturity to arrive at a well reasoned and balanced decision. But what if the competent child refuses consent for treatment that could be life-saving? In the case of psychiatric treatment there should be no problem because there is no age bar to the use of the Mental Health Act (1983) England and Wales, (1984) Scotland, although clearly it is less appropriate for children who do not have sufficient understanding to give consent. In the case of children who are not 'Gillick competent' the parents should explain the issues to their children and after listening carefully to what the children have to say on the matter, either give or withhold consent. The responsibility of parents and clinicians to involve children in the decision-making process and to give clear explanations is exactly the same whether a child is at home, subject to a care order, a residence order or subject to guardianship under the terms of mental health legislation.

There will always be cases where conflict arises or where it is unclear whether or not a child below 16 years has sufficient understanding to refuse consent to treatment. In these cases it will be helpful to run through a 'consent checklist' (Table 1) to consider the child's cognitive and emotional state, their relationships, the nature of the illness and its treatment. Every effort should be made to reach a consensus, however protracted this process may be – so long as this does not involve taking unacceptable risks with the child's future health. Failure to obtain consent to treatment does not necessarily mean that treatment has to be given by force. It is usually better to delay treatment until attitudes and relationships have changed – which could just as easily be the professional's attitude as the patient's. If this approach proves to be unsuccessful, it may be helpful

Table 1
A consent checklist

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1. The child's stage of cognitive development
Does the child have a satisfactory understanding of:
 - The nature of the illness?
 - Their own needs and the needs of others?
 - The risks and benefits of treatment?
 - Their own self-concept?
 - The significance of time: past, present, future?
 2. The parent-child relationship
Is it supportive and affectionate?
 3. The doctor-patient relationship
Is there trust and confidence?
 4. The views of significant others
Whose opinion influences the child and how?
 5. The risks and benefits of treatment
What are the risks of treatment or no treatment?
 6. The nature of the illness
How disabling, chronic or life-threatening?
 7. The need for consensus
Is more time or information needed?
Is a second opinion required?
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to request a second opinion from a senior and experienced clinician. If at all possible, the involvement of the courts is best avoided. Nevertheless, the inherent jurisdiction of the High Court in England and Wales is always available to decide the most complex ethical dilemmas. Ultimately, the clinician's common law duty to treat a patient who requires

emergency treatment as a life-saving measure takes precedence over all other considerations. Whatever happens, there can be no substitute for clear explanations, patience and compassion.

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