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Child consent

## Children and consent – the key issues

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## Summary

Gaining a valid consent from a patient is an area of law that has developed in recent years. Based on the principle that patients should have autonomy over their own bodies, and provided an adult has the capacity to make a decision, a patient has the right to give or refuse permission to a healthcare professional who may wish to provide care or treatment to them. The issue however is complicated when dealing with patients under the age of 18. In the first of two articles Angela Smith discusses some of the legal issues in respect of gaining a valid consent applicable to those patients who have not yet reached the age of majority.

## Keywords

Consent, Autonomy, Children, Best Interests, Parental disagreement

## Introduction

Consent lies at the heart of the relationship between a patient and a healthcare professional. It is the responsibility of the professional to advise the patient of treatment options available, but ultimately, the decision as to whether or not to accept or decline treatment is up to the patient. It should further be noted that consent will be relevant to each and every procedure offered and there is no blanket approach when it comes to a patient consenting that covers all treatment. A new consent should be sought as to every intervention that a neuroscience nurse offers.

This principle is enshrined within law (as the healthcare professional may be liable for battery/negligence if they do not gain a valid consent) and also complies with the ethical principle of respect for autonomy (Beauchamp & Childress, 2013). However, whilst this principle applies to adults aged 18 and over who have capacity to make their own decisions, the law is not so clear as regards to those below the age of 18. As far as minors are concerned in England and Wales, the law on consent varies according to the age of the child. Children are seen to go through three stages before they are deemed to be an autonomous adult at age 18. The three stages of childhood in relation to consent are *(i)* children of tender years, *(ii)* Gillick competent child and *(iii)* a child aged 16-17 years. In this article the focus will be on the first stage, children of tender years, and how neuroscience nurses are expected to gain a valid consent for their treatment.

## Children of tender years

The law in England and Wales varies as to the age by which children are granted rights (e.g. a child aged 10 and above can be held criminally liable for their actions whereas the age of consent to sexual activity is 16 years) and this is no different to the applicable law on the age of consent of minors to treatment of medical care. To consider therefore the issues in respect of children of tender years, it is necessary to consider *(i)* who consents to treatment

on behalf of such children; what if there is disagreement between those with parental responsibility; (ii) what if there is a disagreement between those with parental responsibility and the medical profession and (iii) what if those with parental responsibility refuse to give consent? Each will be dealt with separately.

## Consent to treatment of children of tender years

Generally speaking, a person with Parental Responsibility will consent to the treatment and care of a child of tender years. There is no specific age criteria/limit definitive of a child of tender years but will encompass children from birth up to a Gillick competent child (the age of a Gillick competent child will vary depending on the maturity of the child and the circumstances that child is in and will be discussed in depth in the next article). The rights and duties of persons with parental responsibility is formalised within the Children Act 1989. This empowers a person with such responsibility to make most decisions in a child's life, including consenting to medical treatment on a child's behalf.

When considering who has parental responsibility, this will automatically be conferred on the mother of the child and the father of the child (if he was married to the mother at the time of birth, or if they subsequently marry, or, since December 2003, if the father registered as the father on birth certificate). Whilst other persons (such as step-parents or grandparents) may acquire parental responsibility, either through agreement or an order of the court, it is acknowledged that there may be situations whereby a person with parental responsibility is unable to make a decision in respect of treatment. In such situations the Children Act 1989 allows those caring for children to do what is reasonable in the circumstances to promote the child's welfare (s3 (5)). This could arise if for example a child is brought into hospital by a child-minder.

## Disagreement between those with parental responsibility

Whilst parental responsibility may be shared, generally speaking the consent of one person with parental responsibility will be sufficient in order to proceed with treatment, although not necessarily so. It has been held, in *Re J (child's religious upbringing and circumcision)* [2000] that in some instances, the decision should be made by both parties with parental responsibility, and if this cannot be achieved, then the decision has to be made by a court. Whilst the list is not exhaustive, specific instances where it is felt that such agreement would be necessary include sterilisation of a child, change of a child's surname, circumcision of a child and immunisation of a child. In the case of *B (Child)* [2003] (joined cases on appeal from the High Court (*A & D v B & E* [2003])) although the children each lived with their respective mother, both fathers had gained parental responsibility from a court order and required immunisation of their children to take place, against the wishes of the mother in each case. Whilst the court accepted that there may generally be wide scope for parental objection to medical intervention, they considered this to be an issue that related to the welfare of the children and accordingly made orders in favour of immunisation for both

children. Many readers may remember a relatively recent case involving a child, Neon Roberts. In this case Neon's mother Sally opposed the radiotherapy and chemotherapy proposed by medical professionals after removal of a malignant brain tumour. This was contrary to the position of Neon's father who agreed to such treatment. Ultimately, the court agreed that treatment should proceed. The Court in coming to their conclusion, weighed up the advantages and disadvantages (acknowledging the detrimental side-effects) of treatment. Ultimately, in accordance with the key consideration of s1 Children Act 1989 that the welfare of the child is the paramount consideration, the Court concluded that "*One cannot enjoy even a diminished quality of life if one is not alive*" (Bodey J, para.23, *An NHS Trust v SR*).

## Disagreement between those with parental responsibility and the medical profession

The courts are however accepting of the role that parents play when bringing up their children. As Lord Templeman stated in the case of *Re KD (A Minor)(Ward:Termination of Access)* [1988] 1 AC 806, [1988] 2 FLR 139 "*The best person to bring up a child is the natural parent. It matters not whether the parent is wise or foolish, rich or poor, educated or illiterate, provide the child's moral and physical health are not endangered. Public authorities cannot improve on nature.*" However, Lord Oliver, in the same case, illustrated that the rights of parents when bringing up their children are not absolute and whilst they should not be "*gratuitously interfered with and which, if interfered with at all, ought to be so only if the welfare of the child dictates it.*" Therefore, it should be noted that in the case of immunisation referred to above, if both parents had refused consent, then it would not have been referred to a court and the views and wishes of the parents would have been adhered to. In reality therefore, only the most serious cases whereby there is parental disagreement (and where it has previously been decided that joint parental agreement is necessary) or where parents disagree with the medical recommendations and the outcome may be critical for the child, will a case be heard and decided by the courts.

In such cases whereby the parents disagree with medical opinion, and where the issue has to be decided by a judge, the welfare of the child will be the paramount consideration (s1(1) Children Act 1989). In the case of *Re S (A minor)(Medical treatment)* [1993] medical professionals treating a child wished to be able to provide a non-emergency blood transfusion against the wishes of the parents. In this case, the court once again granted the order for a transfusion on the basis that it would be the best option for the child, despite it not being life threatening at that time. Again, in a recent case, which considered whether experimental treatment should be given to Charlie Gard, a terminally ill child, Justice Francis went against the parent's wishes and ordered that treatment should be withdrawn and Charlie be given palliative care only (*Re Gard (A Child)* [2017]). Whilst in both of these cases, the court agreed with the recommendations of the medical professionals, this is not automatically guaranteed. It is vital that an independent judge makes the decision, looking

at what is in the child's best interests, and considering both sides of the argument, acknowledging the rights, duties and responsibilities of the parents who have to care for their child in the long term. In the case of *T (a minor)* [1996] the child suffered from biliary atresia, a life-threatening liver defect. In the absence of transplantation he would not live beyond the age of two to two and a half. Whilst medical opinion was unanimous that it would be in the child's interests to receive a transplant when one became available, both parents (who were both trained as health care professionals and experienced in the care of young sick children) opposed the procedure. The mother's viewpoint was influenced by the fact that the child had undergone a procedure when aged 3 ½ weeks which was unsuccessful and which resulted in pain and distress to the child (both by the procedure itself and the consequential treatment).

Whilst at first instance Justice Connell concluded that the refusal "*is not the conduct of a reasonable parent*" and directed that a transplant would be in the child's best interests, on appeal the decision was reversed. Lady Justice Butler-Sloss considered not the reasonableness of the mother's refusal to consent but the consequences of that refusal and whether it would be in the best interests of the child to direct the mother to commit to a proposed course of action with which she did not agree. The court held that the decision should be left in the hands of the devoted parents (although it should be noted that Lady Butler-Sloss also considered the fact that once the case had been decided and there was no longer pressure being put on the parents, they may change their minds voluntarily as to the treatment).

## Conclusion

Whilst the right of a capable adult to make his or her own decisions in respect of healthcare should always be respected by healthcare professionals, the situation is not so clear cut when dealing with children. Neuroscience nurses should consider that whilst in the majority of cases, consent for treatment to children of tender years will be given by those with parental responsibility, there may be instances whereby these persons are not available to make a decision (where for example a child is in hospital as a result of an accident or emergency and may be being cared for by those without parental responsibility) or where only one person with parental responsibility is available. Similarly, there may be instances whereby consent is disputed between those with parental responsibility or where consent is refused. It is vital therefore that neuroscience nurses are aware of the above principles and the role of the courts to decide matters of dispute when considering care and treatment options for children of tender years.

The next article will focus on older children who may be considered to be "Gillick competent" and 16-17 year old children.

## Keypoints

- Children of tender years are unable to give consent to care and treatment
- The role of those with parental responsibility in respect of children of tender years
- Disagreements between parents and/or medical opinion
- The role of the courts when considering children of tender years

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