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Consent to treatment by minors attending accident and emergency departments: guidelines

L Williams, A Harris, M Thompson, A Brayshaw

Abstract

The absolute right to refuse medical treatment, even if the reasons are irrational, is confined to competent adults. Children under 16 years can give legal consent to treatment in the absence of consent from those with parental responsibility. Children under 18 years do not, however, have an absolute right to consent, or refuse to consent, to treatment. The views of children assume increasing importance with age and maturity. Accident and emergency medical and nursing staff may face difficult decisions when children, or those with parental responsibility, refuse to consent to medical treatment. This paper presents guidelines designed to guide the decision making process in immediately or potentially life threatening conditions and in non-life-threatening. conditions.

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Keywords: consent to treatment; competency; parental responsibility; child

The Children Act (1989) was a milestone in defining the rights of children to participate in decisions about their care and future.

Medical and nursing staff in accident and emergency (A&E) departments may be challenged by children, and by those with parental responsibility for them, who wish to exercise their rights to consent or to refuse to consent to treatment. A working party addressing the issue of "difficult minors" developed guidelines for A&E staff facing such challenges about consent to treatment by minors or by those with parental responsibility.

The guidelines

The guidelines are based upon widespread consultation with the literature and legal experts in the field. Incorporated into flow charts they clarify appropriate action in immediately or potentially life-threatening conditions (fig 1) and in non-life-threatening conditions (fig 2).

Use of the flow charts requires a basic knowledge of child care law which can be included in an accompanying summary sheet for use by A&E staff, as follows.

DEFINITIONS

- Minors are children who have not reached their 18th birthday (Section 1, Family Law Reform Act, 1969).
- Parental responsibility is held by:

(a) a mother
(b) a legal father
–a father retains responsibility after a divorce
–a stepfather does not have parental responsibility, unless he has acquired it by residence order, step-parent adoption, or by being the child's legal guardian
(c) an unmarried father who has parental responsibility by order of the court or by a parental responsibility agreement made with the child's mother in the prescribed manner
(d) anyone with a residence order
(e) a legally appointed guardian
(f) a local authority with a care order
(g) the High Court if the child is a ward of court.

COMPETENCY OF A MINOR

Minors aged 16 and 17 years

Like adults, 16 and 17 year olds are assumed to be competent unless there is a reason to believe otherwise (Section 8, Family Law Reform Act, 1969).

Minors up to 16 years of age

In deciding the competency of a minor to consent to treatment, the complexity of the clinical issue has to be judged.

To be deemed competent the minor must:
–understand the choices available
–understand the expected outcomes and side effects of the choices available
–base the choice on rational decisions
–have the underlying ability to understand
–demonstrate actual understanding
–understand the consequences of not being treated.
A competent minor's consent can be sufficient.

THE PATIENT

- A competent minor under 16 years of age can give legally effective consent to medical treatment.
- The competence of a minor to give consent does not always confer autonomy.
- The refusal of a minor to give consent does not carry the same weight as the competence to give consent.
- Competency to consent to treatment, or to refuse to consent, is judged against criteria which are designed to reflect the complexity of the decision.

PERSONS WITH PARENTAL RESPONSIBILITY

- Those with parental responsibility can override a competent minor's refusal to consent.

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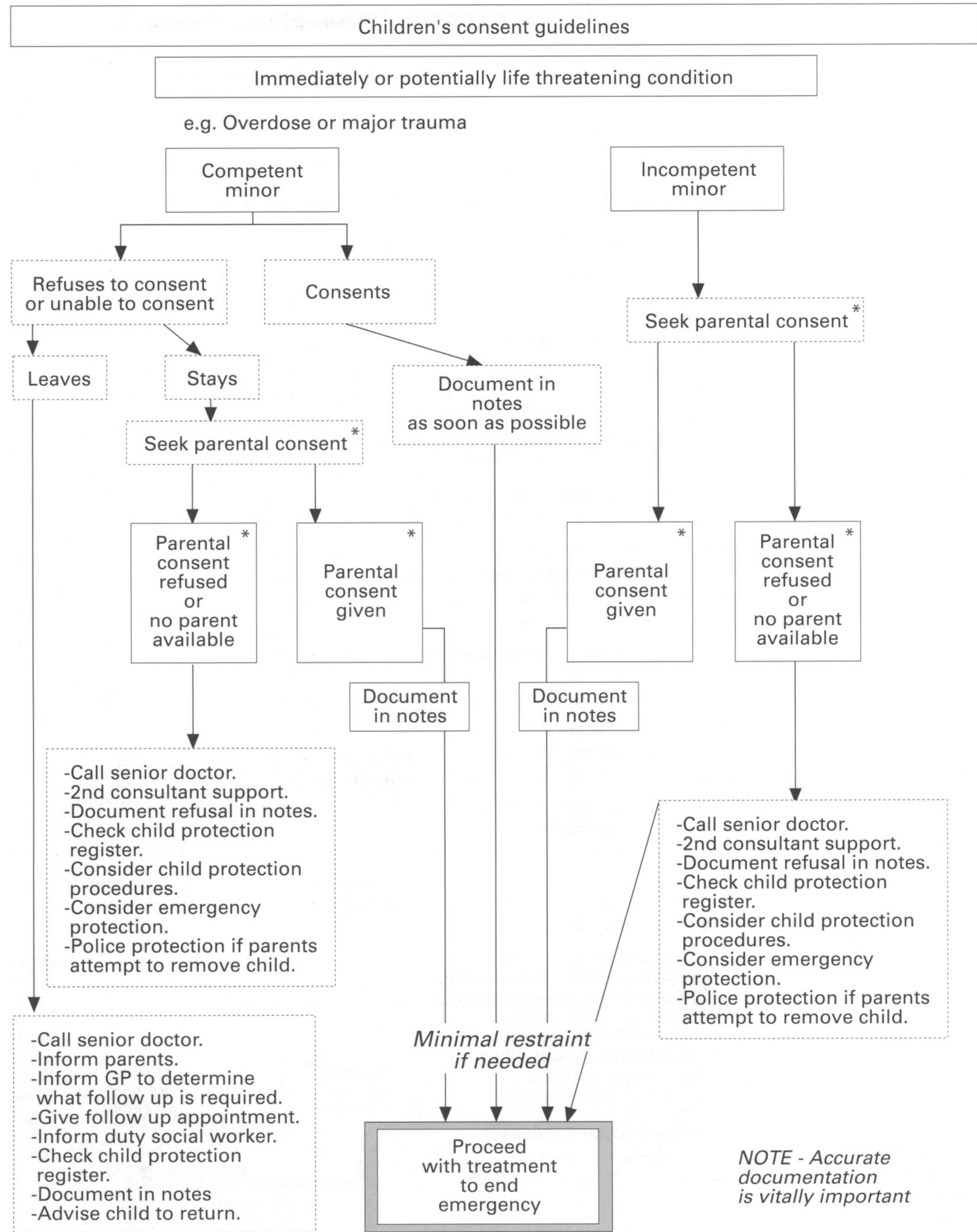

Figure 1 Children's consent guidelines for life threatening conditions.

- Parental responsibility cannot override a competent minor's consent.
- A court can override a competent minor's consent.
- The law does not recognise that parents have the absolute right to consent or not consent to medical decisions regarding their children.
- Only one person with parental responsibility needs to give consent when a competent or incompetent minor refuses consent.
- Consent may be sought from a court where a competent minor refuses to give consent and consent is not forthcoming from those with parental responsibility.
- The consent of a court must be sought in respect of a minor who is a ward of court and who requires treatment.

THE DOCTOR

- In an emergency, a doctor is legally entitled to carry out treatment, even in the absence of consent.
- A doctor may be bound by a duty of care to carry out emergency treatment to safeguard life, even in the absence of consent.
- Where consent is refused by a minor and those with parental responsibility, a doctor

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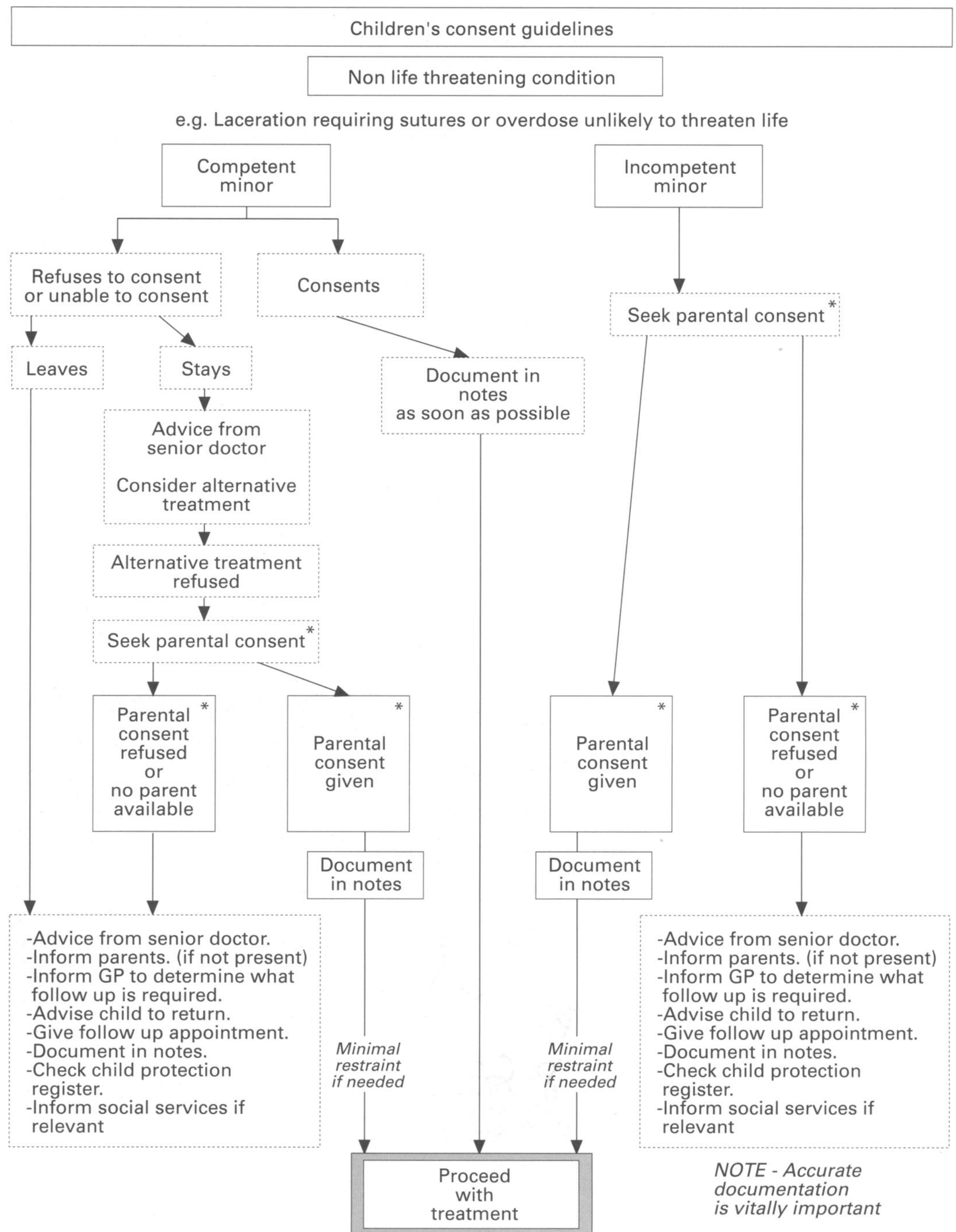

Figure 2 Children's consent guidelines for non-life-threatening conditions.

should only do what is required to safeguard life and end the emergency.

- Where consent is refused by a minor and those with parental responsibility, a doctor should seek the consent of a Court to continue treatment beyond that required to end an emergency.
- Where a competent minor refuses consent, a doctor should seek the consent of those with parental responsibility as soon as the minimum emergency treatment to safeguard life is completed.
- A doctor may need to consider involving child protection procedures where refusal to consent by those with parental responsibility is encountered and the minor is incompetent to give consent.
- A doctor carrying out treatment in a life threatening emergency, and where a competent minor and those with parental responsibility have refused to consent, should obtain the written supporting opinion of the consultant in charge of the service; that consultant should in turn seek the written supporting opinion of a consultant colleague.
- A doctor carrying out treatment in a life threatening emergency, and where a competent minor and those with parental responsibil-

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ity have refused to consent, should obtain a written refusal from those with parental responsibility.

RESTRAINT

Physical restraint is only lawful where it is kept to the minimum necessary for the protection of a minor.

Comment

Implementation of the guidelines requires their approval by legal experts in the hospitals in which they are to be used.

We are grateful to Claire Hadley for her expertise in designing the flow charts and to Ricci Capaldo for typing the manuscript. Without the advice of the other members of the Working Party the guidelines would not have been possible: Tony Saunders, Zam Batti, Chris Hardie, Ruth Dixon, Dennis O'Leary, Jim Isherwood, Susan Lowson, Mike Tomasso.

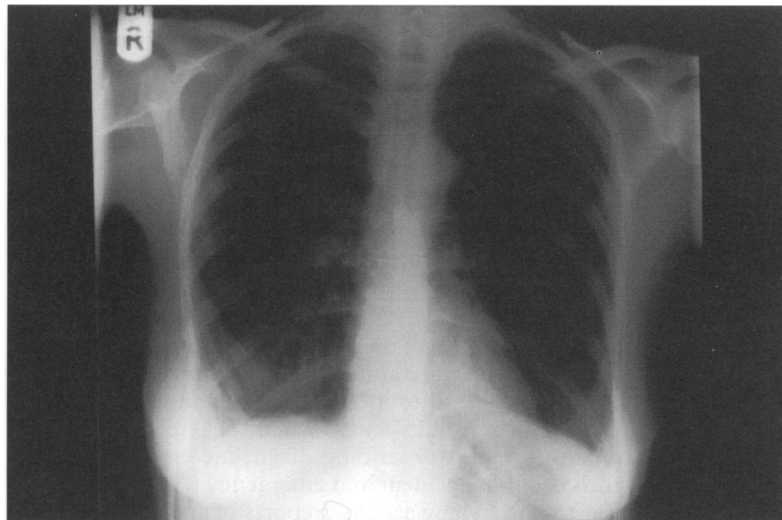
Suggested reading

The Children Act 1989. London: HMSO, 1989.
Hendrick J. *Child care law for health professionals*. Oxford: Radcliffe Medical Press, 1993.

EMERGENCY CASEBOOK

Multiple rib fractures with contralateral pneumothorax

At 1 am, several hours after being involved in a road traffic accident, a 28 year old female presented to an accident and emergency department with right sided chest pain. She had been the restrained front seat passenger of a car involved in a collision with another vehicle, but it was not initially appreciated that this had been a head-on impact.



Rib fractures of the right 6th to 9th ribs are present. The top edge of a left apical pneumothorax is just visible running along the line of the 6th rib.

Physical examination only revealed anterior chest wall tenderness and an initial radiograph demonstrated fractures of the right 6th to 9th ribs. Following treatment she was discharged home with analgesics.

A subsequent *x* ray report also noted a left sided apical pneumothorax with its upper edge running along the line of the 6th rib (figure). The patient was recalled, and successfully treated with a chest drain.

It is unusual for a pneumothorax to be found on the contralateral side to rib fractures. This presumably was a consequence of barotrauma (paper bag effect) at the time of the collision.

This case illustrates the need to make a systemic analysis of all radiographs,[1] and have a clear grasp of the kinematics of injuries.[2] In the early hours of the morning medical staff can be caught unawares by unusual clinical cases, and only by attention to detail can mistakes be avoided.

1 Touquet R, Driscoll P, Nicholson D. Teaching in accident and emergency medicine: 10 commandments of accident and emergency radiology. *BMJ* 1995;310:642-5.
2 Advanced Trauma Life Support Course for Physicians. Chicago, Illinois: American College of Surgeons, 1994.

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