SIMULATED INTERACTIVE MANAGEMENT SERIES

Article 10 Media handling, consent in children, and some one wants you to spend £2 million

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This article in a series on management within the emergency department discusses the rights of children to give consent for treatment and gives suggestions on how to deal with the media.

To understand this article fully you must read the extra information on the journal internet site, www.emjonline.com

See end of article for authors' affiliations

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FEEDBACK

Under performing trainee

Dr Ireland, the SpR who has been under performing, has been advised that he should undertake a further period of training in paediatrics. Objectives of this training have been set and a training unit and two trainers identified, one A&E and one paediatric. It seems that he has agreed to this plan but this has been a difficult problem to manage. In a future time out we examine the processes of appraisal and assessment and how these have been used to handle this problem and how it might have been better managed.

Nurse Holly grievance

Readers of previous articles will remember that Nurse Holly made an allegation of sexual harassment against one of the medical staff. The investigation of the complaint was not in line with the Trust's policy on harassment and thus she has consulted her union and they have lodged a formal Grievance Procedure. Some Trust level directors were involved in the initial handling of the complaint and thus it has become difficult to resolve through the normal Trust Grievance Procedures. It is clear that the Trust's policy was not followed and it should have been. A simple lack of knowledge about policies has resulted in the expenditure of a great deal of management time. Review your own Trust's procedures on Harassment and Grievance. Review how this complaint was initially handled by the St Jude's staff. Critique the management performance.

Assault case and complaint

The complaint was made against a member of staff alleging assault, however there were a number of witnesses who all agreed that the complainant was acting aggressively and that the actions taken by the nurse were justified. A full text of the answer to the complaint is given in the internet section. While the NHS has a policy of "zero tolerance" of violence against staff, this incident reminds us of the problems that all staff face confronting such unacceptable behaviour. Staff may be able to avert most potentially violent incidents, but not all. If restraint is required then staff should be trained in the correct techniques and such events carefully documented.

The media

In the last episode there were two problems involving the media. The first was a damaging article in a local newspaper that heavily criticised the department for missing a case of meningitis. The Trust's public relations officer suggested a statement that was issued to the local media but Mr London thought that the best way to deal with this situation was to say nothing. The staff were upset by this decision as they felt that they should be able to put their side of the story. However, dignified silence is often the best way to make such a story "die". To come out fighting gives the media more opportunity to keep the story running and ultimately cause more damage. This is a fine judgement and there may be times when the media must be challenged. In a story like this it is going to be hard to convince the "public" of the arguments surrounding the difficulty in diagnosing meningitis in the early stages of the disease, natural sympathy lies with the patient/family.

The radio interview went badly wrong. The story about the meningitis case broke that day. Poor Dr York went full of facts and figures about road accidents and found herself very much on the defensive. A transcript of the interview is given in the internet section. Use this or some other scenario to set up a role play with some colleagues. How would you get out of the situation?

TIME OUT—CONSENT IN CHILDREN

Children make up a significant number of cases presenting to emergency departments and often provide a challenge clinically. Increasingly, the knowledge of parents and children about their rights adds to this challenge. Such a case arose at St Jude's recently and here we discuss some of the legal issues surrounding the treatment of children in A&E.

A 12 year old boy with a tetanus prone wound was advised to have a tetanus toxoid immunisation. The child consented but his mother refused. This leads us to examine how our dealings with children have changed over recent years. The rights of competent children to self determination have been recognised and the law has had to reflect this understanding. There are many variations to law in this area, there is even difference between the law in Scotland and the rest of the United Kingdom. It is impossible to cover all the variables in a short article but we will examine the principles involved. A more detailed explanation and discussion on consent and rights issues can be found in the British Medical Association's book *Consent, Rights and Choices in Health Care for Children and Young People*.[1] The introduction of the

Human Rights Act 1998 and its impact on childhood consent, family life, and parental custody has yet to be fully demonstrated and is likely to lead to further uncertainty for clinicians in the future.

Age

In the case illustrated, the patient is a 12 year old boy. Does his age alone render him incompetent or can we assume he is competent? All of us have been children and most have had "discussions" with our parents about whether we are old enough to be allowed to do something. Those of us with children now face the other side of these discussions. Society and the law uses age as a surrogate marker for many less easily assessed qualities; responsibility, experience, intelligence, reasoning, and competence. Age restrictions apply to many things; marriage, driving, buying alcohol, and even going to the cinema but as we all know this is an imperfect system. In the field of medicine this system of assuming cerebral maturity follows chronological age has, quite rightly, been challenged but as a result it has made the practice of medicine more difficult.

In England and Wales the age of majority is 18 years but the law recognises that at the age of 16 a person should be presumed competent to consent.[2] Under the age of 16 it is now accepted that children have different abilities and as such each case needs to be assessed on it merits. The use of age alone as a marker of competency is not acceptable. All 13 year olds are not more competent than all 10 year old children. There are instances when children as young as 5 may be deemed competent to make a medical decision, for example a bright and confident 5 year old might be able to consent to simple cleaning of a graze.

Competence

A working definition of competence could be *understanding the benefits, risks, and complications of a proposed treatment together with awareness of the consequences of refusal of the treatment*. This is assumed of every person over the age of 16 but can be demonstrated in persons under this age in certain circumstances. It is the duty of the attending doctor to recognise the possibility that a minor may be competent and give them the opportunity to demonstrate this.

Using this definition, one sees that competence is a function of many factors such as intelligence and self awareness but also relies on clear, accurate information. This is often a challenge to staff in hospital, many of whom struggle to break down information in such a way as to make it understandable to a young person. This should not be seen as a criticism of individuals, after all, the whole teaching profession exists to explain information to children! Nevertheless, some people are better at explanations than others and if possible these people should talk with the child.

Demonstration of competence in one instance does not necessarily mean that this competence translates to other circumstances for the same child. This will vary depending on the decision to be made and the circumstances. A 13 year old girl may be able to sit on a ward and make a competent decision about chemotherapy, but sitting frightened in the emergency department after an attack by a dog could be unable to take a reasoned judgement on her wound management. Healthcare workers should endeavour to make the circumstances as ideal as possible before taking a judgement on a young person's ability to make a competent, informed choice. It is important to remember that what is being assessed is the ability of the child to make a choice, not necessarily the right choice.

In the example at St Jude's it quickly became clear that the child had some basic knowledge of the subject being discussed and also demonstrated understanding by asking what were felt to be intelligent questions. Rebecca Devon's impressions were later confirmed by her senior Dr York. It is always wise to have more than one person's opinion if the establishment of competence is likely to prove controversial.

Parents

The role of parents in childhood consent issues may lead to confusion. This is a simple summary based on current legal thinking, however, with the introduction of the Human Rights Act there is the possibility that some of these principles will be challenged.

Consent for treatment can be given by any competent child,[3] even if it is against their parent's wishes. This may be an awkward situation clinically but legally speaking this protects the doctor from a charge of battery. A child who is deemed incompetent should have consent given for treatment by a parent, although in a life threatening emergency this can be ignored.

Refusal of treatment by an incompetent child can be over ridden by the consent of a parent, which once again is clinically awkward but legally sound. Refusal of treatment by a competent child cannot be over ridden by a parent, nor by a clinician and will require recourse to the legal system if it is felt that treatment of the child, against their wishes, would be in their best interests.

Parents usually act as advocates and protectors for their children and a child will often look to their parents for advice and support in times of stress. *In practice, if not necessarily in law, it is as important to have a parent's consent as it is to have a child's*. When dealing with a child one is dealing with a family and to disturb the balance of the family is not something to be done lightly. Indeed, it may be seen as an unacceptable side effect of a treatment and influence the proposed line of therapy. In many circumstances there will be time for repeated discussion, explanation, and compromise but this is not always possible in the short-term setting.

The team at St Jude's was faced with a competent child who wanted treatment against a parent's wishes. They decided that the risk of no treatment on the day was too great but did not wish to ride roughshod over the parents. A compromise was reached with antitetanus immunoglobulin being given with review of the child in two days to confirm that he still wanted tetanus toxoid, a schedule that would permit time for discussion without compromising patient care.

Note keeping

As in all areas of medicine, write everything down. If formal consent is required for a treatment, have it in writing signed by the parent or child, as appropriate. If there is any difference in opinion between the doctor, child, or patient on the proposed course of action, write down why this exists and your reasoning for your course of action. In these circumstances the opinion of another (senior) colleague is of great value.

The example at St Jude's has allowed us to consider some aspects of the rights of children but these situations invariably raise more questions than they answer. Here are a few to ponder:

- What would have happened if the child had not returned to the follow up appointment?
- What would you do if the child returned and had changed his mind, apparently under duress?
- How much more competent does a child have to appear when they are refusing the advice of a doctor compared to when they are consenting?
- What would you do if the parent of a child was under 16 years old?

TIME OUT—SPECIAL SUBJECTS

The media

A&E managers are more likely to be involved in contact with the media than any other specialty manager. A&E is a rich

Box 1 Types of media contact

- Local newspaper
  - telephone call
  - interview
  - fly on the wall
- Local radio
  - telephone comment
  - radio interview recorded
  - radio interview live
  - studio phone in/discussion
- Medical popular press
- Medical scientific press
- The internet
- National newspaper/radio/television

source of human interest stories such as long waits, misdiagnosis, births, deaths, and serious accidents. Dealing with the media can be very important to the profile of a department but bad press can be a very negative force.[4]

In all dealings with the media, realise that they are not naturally altruistic organisations. They have a job to inform and entertain an audience and this is their prime concern. Sometimes this can be used to good effect, for example to reinforce public health messages about drink driving or the safe use of fireworks. However, more often they can be damaging to the department and its staff. We live in a world of instant communication so anything you say to the media may be on the national news within one hour. There are some who might revel in this role but everyone should take the up most care in dealings with the press. Almost all hospitals have policies or procedures on press involvement and it is sensible to be aware of this advice. They often entail discussions with the press and media relations officer. They have a background in public relations and are a valuable source of help. It is always best to advise your employer and the press and media relations officer that you are about to make a public statement, they may not like what you have to say but it is best that at least they are aware.

Types of media contact

The media may contact you in many ways and these are summarised in box 1. This section will examine the main types of media contact and the pitfalls inherent in these different approaches.

The telephone

The initial contact by telephone is a time when great care is needed. If you receive a call from the media without warning the best action is to promise to ring back later. Before talking to a journalist, confirm the subject matter, think about your position and, let the hospital management know. Assume that anything you say will be quoted (do not believe in "off the record" conversations, these may work at high levels such as in national politics but not at the level of the individual). Some managers might be more talkative on the telephone than they would be in a face to face interview, beware being drawn into saying more than you want on issues, even if it seems to be innocuous.

The radio

Local radio is the most common form of "media interview" for A&E managers. In most cases the subject matter is very non-threatening and may have positive benefits in emphasising a message. They also present an opportunity to practise your own skills. It is unlikely that this technique in isolation will be effective in changing the public's behaviour or perceptions.

Box 2 Interview techniques: be prepared for the initial question

You must always have an answer to give to the opening question but it does not have to be the answer to that question.

The television

This is the most challenging type of contact. You have to be aware of how you look as well as what you are saying. This type of interview is best left to those with training or a natural gift.

Interview techniques

The most important question is whether you should take part in the interview. Discuss this with colleagues, certainly with your immediate manager or the Trust's public relations officer. Prepare well. Try to pre-empt questions and appropriate replies. Think how you are going to answer the unexpected. How would you have responded to the situation experienced by Dr York (see internet section)?

Listen to the interview techniques of various journalists. National radio and television give you some insight in to the minds of skilled inquisitors and also how professional politicians deal with various situations.

Get off to a good start. An interview will always start with a question. You must always have an answer to give but it does not have to be the answer to the question! Knowing the name of your interviewer gives you the chance to say "Hello John/Victoria" while you think of an answer to the question. This is the opportunity to mould the interview to get your point of view across. Avoid "no comment", "I did not agree to talk on the subject" or other defensive replies. This will give the audience the wrong impression at the outset. Dr York fell into this trap. She went to the interview prepared to talk about accident prevention but the first question was about a mismanaged case. She immediately went on the defensive and dug deeper and deeper holes. The experienced politician would have parried question with a concerned statement and then brought the interview back to the original brief. "This is a sad case and we have every sympathy for the family and an inquiry is underway. However, I think you invited me here to talk about road traffic accidents and what we can do prevent them happening." The journalist might not let go but at least you have made a clear statement that you have been ambushed. If they try to return to the problem you have already dealt with it and have a valid reason for not discussing it further as it is "subject of an inquiry".

This requires quick thinking and practice. Role play with colleagues can give valuable practice but a course in media handling is the best way to gain some confidence and insight into your own strengths and weaknesses in this area.

If the interview is not going well be prepared to bring it to a close in a final way. It is often better to cut your loses than to try and debate complex questions in public. Everyone in acute medical practice is aware of the major difficulty in the diagnosis of meningococcal septicaemia in the early stages of the disease. When standing in the glare of the public, however, it is incredibly difficult to get this across, especially when you are in a defensive position. Public opinion is fickle and easily swayed, it will be guided with emotion and preconceptions rather than by logical argument. One very neat way to do this is to agree, yes this has been a problem, it is well recognised as a difficult area, and you are working with various agencies to reduce the chances of this happening again. However, this is such a difficult area that it is impossible to guarantee that there will never be any problems in the diagnosis of meningococcal diseases.

If you are going to deal with the media then training is highly recommended. There are courses that will prepare you

Box 3 Preparation check list

Preparation

Who is the interviewer?
Confirm the subject matter in detail.
Check with your Trust.
Are you sure you want to do this?
What message do you want to get over?
What is the best way to get the message over?
How can you counter adverse comment?
Try to practise the interview with a colleagues.
The opening question. Possible answers.
Get your point over.
Practise "escape routes".
Training—if there is time try to practise the interview with colleagues or the press officer.
Try to obtain some training in media handling if you want to take on this task.

and give you practice in the techniques. In choosing a course, ensure that it gives you individual practice in the techniques and mock video or taped interviews are especially powerful teaching methods. It is far better to have an embarrassing video of yourself making a mess of a practice interview than making the same mistakes in public.

With some thought and preparation this could be practised as a training task for local groups.

TASKS

- A large amount of money has been made available to rebuild the A&E department. (See emjonline/SIMS10 for details). You have been asked to lead the project. Outline how you are going to manage the different phases of the project from deciding strategic objectives, outline plans, consultation, detailed planning, and managing the building disruption.
- Try some media role play with colleagues. It is usually easy to find some one to take the part of an aggressive interviewer.

Internet information

Transcript of radio interview
Answer to the complaint about alleged assault by a member of staff
Letter from the chief executive outlining the departmental rebuild
St Jude's diary

- Examine your Trust's Harassment and Grievance policy. How should the allegations of sexual harassment have been handled? What could the consequences be for the Trust in that they did not follow policy?
- The local out of hours primary care cooperative has announced that it is planning to discontinue doctor cover for the 0000 to 0800 period but will make "alternative arrangements". The A&E department has not been consulted about this action. What do you do?

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Disclaimer

Most of the characters and situations in this series are entirely fictional and any resemblance to any person or institution is coincidental. A few situations are based on real life but all the names have been changed.

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