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Consent for the paediatric patient

Author information:

Jones ADC, Specialist/ST4 in Paediatric Dentistry, Paediatric Dentistry Department, Liverpool University Hospitals NHS Foundation Trust, Liverpool, United Kingdom.
adcj@liverpool.ac.uk

Hyde JS, Academic Clinical Fellow Dental Core Trainee, School of Dentistry, University of Liverpool, Liverpool, United Kingdom. jamessh@liverpool.ac.uk

Lee S, Consultant in Paediatric Dentistry, Paediatric Dentistry Department, Alder Hey Children's NHS Foundation Trust, Liverpool, United Kingdom.
Sharon.Lee@alderhey.nhs.uk

Albadri S, Professor & Honorary Consultant in Paediatric Dentistry, Paediatric Dentistry Department, School of Dentistry, University of Liverpool, Liverpool, United Kingdom.
sondos@liverpool.ac.uk

Gartshore L, Senior Lecturer & Honorary Consultant in Paediatric Dentistry, Paediatric Dentistry Department, School of Dentistry, University of Liverpool, Liverpool, United Kingdom. lauramg@liverpool.ac.uk

Abstract

Introduction Obtaining valid consent is a fundamental process within dentistry. Written consent must be obtained where treatment involves conscious sedation or a general anaesthetic. For children consent may be provided by a person with parental responsibility.

Materials and methods A retrospective evaluation was completed of 160 children over two United Kingdom (UK) hospital sites with paediatric services. Cases involving conscious sedation or general anaesthetic for dental treatment were selected. Data was obtained to establish whether it was documented that the correct person had provided consent for a child, and whether all possible individuals with parental responsibility for the child were identified at the initial visit. UK national legislation and guidance was reviewed, from which a Parental Responsibility Form (PRF), to determine parental responsibility status for a child, was created and implemented. A second evaluation was then completed.

Results Combined data from both sites confirmed documentation of an appropriate person providing consent in 79% (n=127) of cases in the first evaluation. This improved to 97% (n=155) following implementation of the PRF. All possible individuals who had parental responsibility for the child were identified at the initial visit in 22% (n=35) of cases. This improved to 87% (n=139) following the introduction of the PRF.

Conclusion Use of a PRF improved documentation regarding valid consent for children.

Keywords

Parental consent; consent document; conscious sedation; general anaesthesia

Introduction

Obtaining valid consent is a fundamental process within dentistry. In the United Kingdom (UK), this process is designed to ensure that patients can make informed decisions about their dental care.¹ The age at which children and young people can consent to medical treatments and examination varies across Europe with a range of 14-18 years-of-age or depending on assessment of individual maturity and capacity.²

The UK General Dental Council's (GDC) 'Standards for the Dental Team' states that a GDC registrant must, 'obtain valid consent' and 'must obtain written consent where treatment involves conscious sedation or general anaesthetic'.¹

In England and Wales, patients aged 18 years are classed as adults and can consent to their own treatment unless they are deemed to lack capacity. This is the same for patients aged 16-17 years, who are classed as 'young people'. However, in some instances, albeit rarely in dentistry, if a 16-17 year old with capacity refuses to give consent, this may be overridden by a court or a person with parental responsibility (PR). Those aged less than 16 years are classed as 'children'.³ The consent process for children differs from that of adults or young people.

Three scenarios exist of how consent can be obtained for a child (under 16 years) in the UK:

- a child can consent for treatment if they are deemed to be Gillick competent⁴
- a person with PR can provide consent
- a child can be treated in an emergency situation whereby treatment is deemed to be vital for the survival or health of the child by acting in the child's best interest where consent by someone with PR cannot be sought.³

Gillick v West Norfolk and Wisbech Area Health Authority 1985 was a seminal legal case in the UK pertaining to consent for medical treatment for children.⁴ It outlines circumstances where it is legally accepted for an individual under the age of 16 to provide consent for their own medical treatment. If an individual is deemed to be ‘Gillick competent’ and provides consent, then consent from a person with PR is not needed or valid.

A fully inclusive list of individuals who may possess PR for a child (Table 1) is based on the following UK Acts of Parliament:

- Children Act 1989⁵
- Adoption and Children Act 2002⁶
- Children and Families Act 2014⁷
- Human Fertilisation and Embryology Act 2008⁸

The authors acknowledge that applying this legislation to determine who has PR can be complicated due to different family circumstances and the intricacies of court orders in the UK.⁹ In addition, a child may be under the care of a local authority and referred to as a looked after child. They may be living with a foster carer. A foster carer will not have PR for a fostered child without a court order, however a local authority may delegate authority to the foster carer to make certain decisions about routine dental treatment.

Previous studies have shown that documentation of who has provided consent for a child and whether they have PR is not always accurate.^{10,11} Furthermore, carers and clinicians may be unaware of the legislation outlining who has PR. A recent study has shown that knowledge of clinicians in a UK orthodontic department was incomplete in this area.¹² Consent forms often have a ‘relationship to child’ section to be completed by the accompanying adult, however, this does not address whether the person completing the form has PR for the child.

Identifying who has PR for the child at the initial visit helps to standardise obtaining consent with the advantages being that:

- 1) It allows any potential problems with consent to be identified early so that they can be addressed;
- 2) It provides a written record which can be referred to at any subsequent visit (if the treatment plan is altered or if written consent must be sought at a later date).

Good record keeping is essential for safe and effective care. In the UK, National Health Service (NHS) England and NHS Improvement have published dental record keeping guidance which highlights the importance of obtaining and documenting key information in a consistent way.¹³

Therefore the primary aim of this study was to determine whether the consent process for children was correctly documented in 100% of cases for those having treatment under conscious sedation (CS) or general anaesthetic (GA) as per GDC standards.¹ This included, where relevant, that the PR status of adults accompanying children for dental appointments was correctly documented in clinical records. A secondary aim was to establish whether all the possible people with PR for each child were identified at the child's initial visit.

Materials and Methods

This project was registered with two local hospital clinical audit management systems. It followed an audit methodology where a first cycle of data was collected and compared against a standard. Where results fell below the agreed standard, measures were

implemented, and a second cycle of data collection and analysis was carried out to assess whether the implementation improved the process.

Data collection

Retrospective data collection was completed of clinical records obtained from two UK hospitals with paediatric dental services. CS and GA operating lists were generated electronically from hospital data and cases selected. Cases included patients seen by multiple clinicians of different levels of experience. Cycle 1 data were collected from those operating lists taking place between August 2016-January 2017. Cycle 2 data were then collected following the same method above from operating lists taking place between November 2017-March 2018. The following criteria were applied:

Inclusion criteria:

- Patient aged less than 16 years at the time of the procedure

Exclusion criteria:

- Patient aged 16 years or above at the time of the procedure
- Patient had previously been included in the study (if the patient attended for treatment over multiple visits, only data from the most recent visit within the data collection period were used)

If the case met the inclusion criteria the clinical records were used to obtain the necessary data using a piloted data collection template until 160 cases (80 per unit) were obtained. It was felt that this sample would be representative of total cases seen based on the frequency of

different categories of PR arising with cases within the departments. The data were analysed for descriptive statistics and compared against the pre-specified standards.

Results

Cycle 1

160 patients (85 male, 75 female) were identified with a mean age of 7.96 years (range: 2-15 years, standard deviation: 3.24). In 79% (n=127) of cases it was documented that the correct person provided consent. Secondary outcome data showed that all those with PR for the child were established at the initial visit in 22% (n=35) of cases (table 2).

The 100% target was not met.

Measures implemented

Following cycle 1, the findings were disseminated to the clinical teams at both units. Some clinicians reported finding it difficult to discuss this sensitive topic with accompanying adults and highlighted complexities in identifying who had PR. Staff training was provided on consent for children. In addition, a Parental Responsibility Form (PRF) was piloted with engagement from carers and clinicians and implemented at both units (figure 1). This form itemised the ways in which an individual may have PR for a child. The names of all individuals with PR for the child were stated on the form and which category (A-L) applied to them. The PRF was then to be completed by the accompanying adult at the initial visit prior to the child entering the clinic.

Cycle 2

160 patients (77 male, 83 female) were identified with a mean age of 7.83 years (range: 2-15 years, standard deviation: 3.38). In 97% (n=155) of cases it was documented that the correct person provided consent. Secondary outcome data showed that all those with PR for the child were established at the initial visit in 87% (n=139) of cases (table 2).

No patients were documented as Gillick competent and there was no documentation that treatment was carried out as an emergency where valid consent could not be sought in any cases.

The results improved for both the primary and secondary outcomes, however, the 100% target was not met. The birth mother was the most commonly identified individual as having PR in both cycles (figure 2). Figure 3 shows the reasons why when consent was documented incorrectly.

Discussion

This study highlights the possible challenges that may be encountered when completing and documenting consent for children, in line with professional standards.¹ In this study, when a father provided consent, it was not always established if he had PR. Unlike for the birth mother a father may not automatically have PR. Although this may have been checked verbally, it had not been documented in the records. This is similar to the finding from another UK based study which showed that in some cases consent had been provided by a father who did not possess PR.¹¹

Another reason for failing to meet the standard was not being able to identify who had provided consent. This was often due to the 'relationship to child' section on the written

consent form being left blank, with no further documentation as to who had provided consent. It has previously been reported that omissions when completing written consent forms include: the person's name, signature, date, and relationship to the child of the person providing consent.¹⁰

Despite perceived complexities of establishing the identity of those with PR, it is vital that clinicians who are involved in the consent process are aware of the law. A previous study reported that clinicians may lack knowledge in this area.¹⁴ The staff training provided in this study highlighted deficiencies in knowledge as to the legal standpoint in some more complex scenarios. The subsequent improvement in documentation may suggest that a better understanding of the legal principles improved the consent process.

Anecdotally within the units, clinicians reported difficulties in having conversations of a sensitive nature regarding a child's background and conjectured as to how this may contribute to poor documentation in establishing PR. Raising this topic often requires diplomacy. In addition, carers may be unaware of legislation pertaining to consent. A previous study showed that more than 80% of carers thought that cohabitation was sufficient to provide consent.¹¹ The PRF provides a summary of legislation for the accompanying carer.

No cases included in this study involved treating a child in an emergency situation where parental consent could not be sought and treatment was vital for the survival or health of the child. There are few life-threatening situations in dentistry, however, this may be important when considering re-implanting an avulsed tooth, managing a child with a large facial swelling, or a child with severe, uncontrolled pain. In addition, no patient was deemed to be Gillick competent. Therefore, documentation of these two aspects of consent could not be assessed. However, it is important that in these cases documentation is accurate and clear.

Discrepancies were apparent between the two units studied, particularly regarding whether PR was established at the initial visit. At Unit A, a standard new patient assessment sheet was used. This form had a section prompting the clinician to enquire about PR and who the child had attended with. Unit B used a plain sheet of clinical note paper with no prompt to discuss this further. It has previously been shown, for assessments, that a proforma helped the process.¹⁵ Therefore it is feasible that this lack of written prompt may have accounted for this difference.

Seeking evidence for all cases including birth and marriage certificates is not necessary and, in most cases, clinicians take the accompanying carer's word at face value. However, it may be useful to seek evidence in complex cases. For one case in each cycle, PR was demonstrated by a court order. It is advisable that documented evidence of court orders is sought when applicable. There is no local or national UK guidance regarding obtaining documentation or when liaising with a social care team to obtain consent for a looked after child. For the units in this study, the social care team of a looked after child would be contacted to determine who has PR and the best approach for obtaining consent. If consent was to be provided by the social care team then the discussion regarding the proposed treatment options would be carried out verbally with them via telephone. Subsequently, if a treatment plan was agreed upon then the appropriate paperwork would be sent by post or electronically by secure email to be completed by them and returned. This would usually be completed by the service manager. Alternatively if consent was to be provided for a looked after child by a parent who still retains PR, the clinical team would request that the social care team facilitate contact with the parent. Communication may be via a face-to-face, virtual, or telephone appointment to discuss details relevant to the consent process and completion of the appropriate paperwork. The authors would recommend establishing a relationship with their local social care teams and a standard operating procedure when dealing with relevant

cases. Irrespective of these difficulties, it is imperative that the subject of PR is discussed. It has been recognised that children may be attending with a person who has no legal authority to consent for the child.¹⁶ Similarly, in this study there were cases highlighted where it was unknown whether the person who signed the consent form did in fact have PR. This shows the importance of establishing who the patient has attended with, without making any assumptions. The PRF provides a standardised way of establishing who has PR for every child patient.

Cases may arise where a person with PR does not agree to all or part of the recommended treatment of a child. In such a situation finding out the reasons for any underpinning views and trying to address any concerns or questions is paramount. Such opinions could be due to their personal, societal, or religious views. All efforts should be made to achieve agreement or a compromise that remains in the patient's best interest. If such agreement cannot be achieved then the authors would recommend contacting their indemnity provider or local legal team for advice. If there is a refusal to provide consent for a child who is not Gillick competent and there are concerns as to the child's wellbeing then local safeguarding procedures would need to be followed.

The consent of a Gillick competent child cannot be overridden by someone with PR, but can be by the courts.¹⁷ Conversely, if a Gillick competent child refuses to provide consent then this can also be superseded by a person with PR or by the courts.¹⁸

Although this study focussed on the documentation of consent it is important to consider that consent is a process and not just the signing of a form. Several other investigations and procedures for child patients may take place without the use of a written consent form.

Although these were not analysed as part of this study it is equally important that consent is sought and documented correctly for these cases including who has PR if applicable and who

has provided consent. The PRF provides an effective and standardised way of doing this. A modified version of the PRF developed in this study has been adopted in the orthodontic department at another hospital in England.¹²

It is a limitation of this study that it is based on a small sample size. Logistics surrounding paper-based clinical records at Unit A meant that some case records could not be obtained. This has the potential to have missed important findings.

Since the PRF was implemented application of UK legislation means that it must now be amended. In England Category C can be simplified to 'Father named on birth certificate'. If a child was born before 01/12/2003 and the father was named on the birth certificate he would not automatically have PR. However, children born before this date will now be 18 years or older and classed as an adult, therefore, consent from a person with PR no longer applies. A future multicentre study is suggested to provide a more complete picture of how consent is being sought for children across the UK.

Conclusion

Identifying all relevant information about who can provide consent for a child, providing staff training and introducing a PRF has standardised and improved the documentation process of obtaining consent for children. It is recommended that colleagues reflect on their case records to consider whether it can be established if the correct persons with PR can be identified to provide consent for children under their care.

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Tables:

Table 1 Individuals who may possess parental responsibility (to be included in the introduction)

Table 2 Summary of data for Outcome 1 and Outcome 2 (to be included after the first paragraph under the heading 'Cycle 2')

Figures:

Figure 1 Parental Responsibility Form (to be included where figure 1 is mentioned in the text)

Figure 2 Individuals who provided consent when it could be established who had PR from the records (to be included where figure 2 is mentioned in the text)

Figure 3 Individuals who provided consent in the cases with incorrect documentation (to be included where figure 3 is mentioned in the text)