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The accompanying adult: authority to give consent in the UK

SEEMA MADHUR LATA LAL[1], SUSAN PAREKH[2], CAROL MASON[3] & GRAHAM ROBERTS[4]

[1]School of Oral Health, Fiji School of Medicine, Hoodless House, Suva, Fiji Islands, [2]Unit of Paediatric Dentistry, UCL Eastman Dental Institute, [3]Great Ormond Street Hospital NHS Trust, and [4]Kings College Dental Institute, London, UK

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Background. Children may be accompanied by various people when attending for dental treatment. Before treatment is started, there is a legal requirement that the operator obtain informed consent for the proposed procedure. In the case of minors, the person authorized to give consent (parental responsibility) is usually a parent.

Aim. To ascertain if accompanying persons of children attending the Department of Paediatric Dentistry at the Eastman Dental Hospital, London were empowered to give consent for the child's dental treatment.

Design. A total of 250 accompanying persons of children attending were selected, over a 6-month period. A questionnaire was used to establish whether the accompanying person(s) were authorized to give consent.

Result. The study showed that 12% of accompanying persons had no legal authority to give consent for the child's dental treatment.

Conclusion. Clinicians need to be aware of the status of persons accompanying children to ensure valid consent is obtained.

Introduction

Obtaining consent from the patient is essential before treatment can be started. For children, this consent should normally be obtained from the parent. On many occasions, parents are unable or unwilling to attend the dental surgery with their child and send another person to act on their behalf. This creates potential problems as the accompanying person(s) may not possess legal authority to give consent for the child.

The child patient and consent

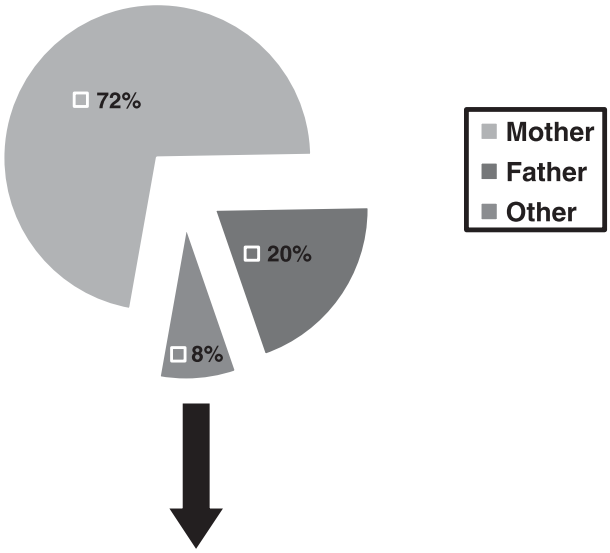
In the UK, treatment of children under the age of 16 traditionally required parental consent. Since 1985, the question of Gillick competence has dictated the way that consent is obtained from all patients, including minors. It is recognized that children are competent to give legally valid consent if they have attained sufficient intelligence to fully understand the nature of the procedure and the consequences of accepting or rejecting the recommended treatment[1]. The accompanying adult, usually a parent, may participate in the process of consent if they have parental responsibility, but it is important to be aware of the circumstances where this applies.

There are two types of consent, implied and expressed. Implied consent is obtained when a patient makes an appointment and presents for examination, by compliant actions, and their continued acceptance of treatment. Expressed consent includes verbal (oral) consent, which is adequate for routine treatment such as fillings and prophylaxis, provided that full records are kept, and written consent, which is necessary in case of extensive intervention, procedures involving risks, and where general anaesthesia or sedation is being used[2].

Parental responsibility

The Children Act of 1989 brought in the concept of 'parental responsibility'. This is defined as 'all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property'[3]. Mothers and married parents have parental

Correspondence to:
Susan Parekh, Unit of Paediatric Dentistry, UCL Eastman Dental Institute, 256 Grays Inn Road, London WC1X 8LD, UK. E-mail: s.parekh@eastman.ucl.ac.uk



Stepmother	Stepfather	Aunt	Grandmother	Grandfather	Sister	Brother	Cousin	Friend	Total
1	4	1	5	1	3	3	1	1	20

Fig. 1. Relationship of accompanying person(s). The pie chart signifies the percentage of different types of accompanying persons of children attending the Eastman dental hospital. The table provides a break down of the 'others' category.

responsibility, but unmarried fathers do not, unless they have a court order or formal agreement with the mother. Step-parents, foster carers, and relatives do not automatically acquire parental responsibility by marrying or caring for a child, although guardians or local authorities can be granted parental responsibility by the courts.

Aims

The objectives of this study were (i) to determine if the accompanying person(s) has the legal authority to give consent and (ii) to determine the knowledge and awareness of the accompanying person(s) regarding consent, and the types of consent.

Design

This study was carried out in the Unit of Paediatric Dentistry at the Eastman Dental Hospital (EDH), part of the University College London Hospitals (UCLH) NHS Trust. Ethical approval was obtained from the local ethics committee. The subjects of the study were the accompanying person(s) of attending children, over a 6-month period. All of these were offered a letter of explanation, and after at least 5 min, were invited to participate by completing an anonymous questionnaire. To maintain anonymity, the subjects were asked to leave the completed questionnaire in a sealed box.

The questions were mainly closed questions with specific choices, to enable completion with minimum explanation and for ease of data analysis (Table 1). The questionnaire investigated the relationship of the accompanying person to the child and their knowledge of the two types of consent: implied and expressed (oral and written). The responses were then coded and analysed using SPSS version 10.0 (SPSS Inc., Chicago, IL, USA) to calculate frequency distributions.

Results

A total of 278 questionnaires were returned, with 250 (90%) complete and included in the analysis. It was found that 239 (96%) of the accompanying persons did not need help completing the questionnaires. From the sample, 65 (26%) of accompanying persons were attending EDH for the first time and 185 (74%) attending on more than one occasion. Of the 250 children attending the department, 123 (49%) were girls and 127 (51%) were boys; the mean age was 9.9 years and ranged from 1.2 to 18.6 years. There were 179 mothers (72%) and 51 fathers (20%), and 20 (8%) were other relations (Fig. 1).

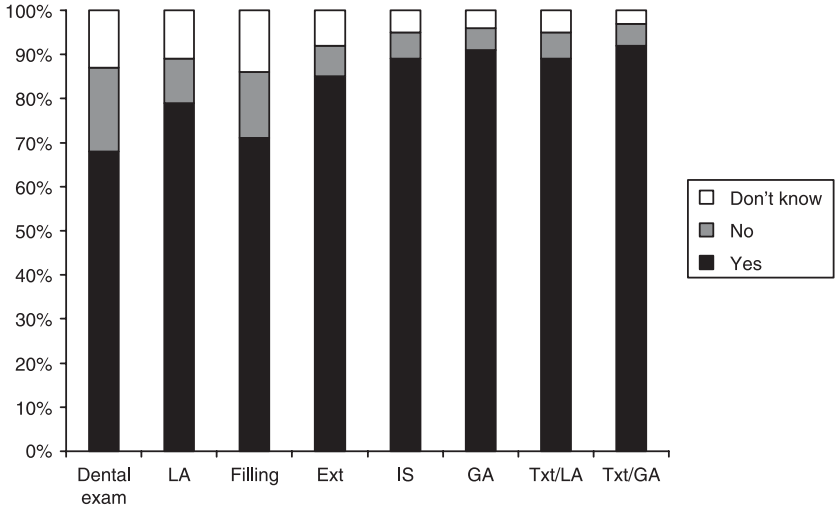


Fig. 2. Consent required for dental procedures.

Authority of accompanying person(s) to give consent

All the 179 (72%) of accompanying mothers had parental responsibility to give consent for their child's dental care. Of the 51 accompanying fathers who attended with children, 41 (80%) possessed parental responsibility and 10 (20%) did not. None of the other relations had parental responsibility. Therefore, of the total sample, 30 (12%) of accompanying persons did not possess legal authority to give consent.

Knowledge of consent

Of the accompanying persons, 230 (92%) were familiar with consent, with 151(60%) aware of the three types of consent. Knowledge of written consent was most common, with 224 (90%) of respondents indicating awareness. Of the accompanying persons who were familiar with the word 'consent' 57 (25%) were attending for the first time, with the remainder having attended on more than one occasion 173 (75%).

Consent for dental procedures

The majority (68%) of accompanying persons stated that consent had to be obtained for almost all forms of dental care (Fig. 2). Specifically, 223 (85%) of accompanying persons stated that a full explanation should be provided for treatment provided with local anaesthesia, and 229 (92%) for treatment under general anaesthesia.

Child's involvement in discussions

From the total sample, 235 (93%) children were under the age of 16 and 15 (7%) were over 16. Of the accompanying persons of children under 16 years of age, 199 (80%) stated that the child should be involved in discussions involving his or her dental care, 25 (10%) felt the child should not be involved and 11 (3%) stated 'don't know'. All the accompanying persons of children over 16 stated they should be involved in discussions regarding their dental care, therefore in total, 214 (85%) felt children and young people should be involved in the discussions. There was no significant difference in who the accompanying persons were and whether the child should be involved in discussions regarding their dental care.

Discussion

The overall participation of the accompanying persons in this study was good, with 278 questionnaires received, of which 250 were properly completed. There were on average two refusals per session, with common reasons noted including accompanying persons with very young or upset children, running late for the child's appointment, those who refused because they

Table 1. The Accompanying Adult: Authority to Give Consent

Please circle the appropriate response						
1	Age of child _____					
2	Date of birth of child _____			Yes	No	Don't know
3	Is this your first visit to the Children's Department					
4	What is your relationship to the child that you have brought for assessment or treatment today?					
	Mother	Father	Stepmother	Stepfather	Aunt	Uncle
	Grandmother	Grandfather	Sister	Brother	Cousin	Friend
	Social worker	Foster parents	Interpreter	Other		
			(Please specify)_____			
5	Do you have special arrangements with the court to look after this child?					
				Yes	No	Don't know
6	If the child has been adopted is this a legal adoption?			Yes	No	Don't know
7	Please state your marital status:					
	Married	Single	Divorced	Separated	Widowed	Not applicable
8	MOTHERS ONLY TO ANSWER					
	Are you married to the father?			Yes	No	Not applicable
	If yes, date of marriage _____					
9	FATHERS ONLY TO ANSWER					
	Are you married to the mother?			Yes	No	Not applicable
	If yes, date of marriage _____					
10	Are you familiar with the word consent?			Yes	No	Don't know
11	If yes, which type of consent do you know?					
	A Implied			Yes	No	Don't know
	B Verbal			Yes	No	Don't know
	C Written			Yes	No	Don't know
	D All three			Yes	No	Don't know
	E None at all			Yes	No	Don't know
12	Were you aware of the different forms of consent before today?			Yes	No	Don't know
13	Do you need to give consent for your child to have a dental examination?			Yes	No	Don't know
14	Do you need to give consent for your child to have a local anaesthetic injection (needle in the gums)?			Yes	No	Don't know
15	Do you need to give consent for your child to have a filling?			Yes	No	Don't know
16	Do you need to give consent for your child to have a tooth (teeth) out?			Yes	No	Don't know
17	Do you need to give consent for your child to have sedation (medicine or gas and air) as part of their dental treatment?			Yes	No	Don't know
18	Do you need to give consent for your child to have a general anaesthetic (put the child to sleep)?			Yes	No	Don't know

felt the questions were not related to the dental care of the child they were accompanying, or those who did not understand the English language. As participation in this study was voluntary, no detailed records were kept of the exact number of refusals.

This study showed that 30 (12%) of accompanying persons did not have legal authority to give consent. In this study, three (1.2%) were unmarried fathers and none had made any attempt to obtain parental responsibility under the provisions of the Children Act of 1989. The other seven fathers did not indicate the date of their marriage; therefore an assumption was made that they did not possess parental responsibility. If these seven fathers are assumed

to be married, the total number of accompanying persons without parental responsibility would be 23 (9.2%). Of the other accompanying persons, none had a care order or had legally adopted the child, and therefore did not have parental responsibility. Recent amendments to the Children Act allow unmarried fathers parental responsibility for children born after 1 December 2003, provided both parents register the birth together[4].

The responses showed that the accompanying persons had a good knowledge of consent, with 151 (60%) familiar with the different types. In this study, 223 (85%) stated that a full explanation should be provided for treatment with local anaesthesia, and 229 (92%) for treatment under general anaesthesia.

There have been few studies regarding consent in children reported in published works, especially with respect to dental treatment, although it has been shown that children aged 8–13 years want to be more involved in consenting to their dental treatment[5]. A previous study carried out at the Eastman Dental Hospital showed that 40% of written consent obtained for outpatient general anaesthesia was invalid, and stressed the need for repeating consent prior to carrying out the actual treatment[6]. However, none of these studies investigated the legal status of the accompanying person.

In this study, 214 (85%) of accompanying persons stated that the child should be involved in decisions regarding their care. This is in keeping with the evolving autonomy of children and encourages children to prepare to take responsibility for their own health, both for the study and in the future.

Some suggestions to aid the process of valid consent in children include

1 The use of a preappointment information sheet informing who legally has parental responsibility.

2 Clinical management – ensuring an adult with parental responsibility attends with the child, particularly for the discussion of the proposed treatment.

3 Increasing the awareness among dentists of the Children Acts of 1989 and 2002 and its implications for providing care to children.

The recording of personal information for registration forms should include details to assess the legal authority of the accompanying persons. As these forms are usually completed in waiting rooms, this saves dentists from verbally obtaining such information and thus avoiding placing dentists and accompanying persons in a difficult situation. The ease of recruiting for this study demonstrates that accompanying persons would be willing to disclose personal details if they have sufficient explanation about its significance

What this paper adds
- Knowledge of consent in the UK.
- Authority of accompanying persons to give consent.

Why this paper is important to paediatric dentists
- Check status of accompanying person.
- Accompanying persons want children involved in discussions.

Conclusions

Of the accompanying persons of the children attending the Department of Paediatric Dentistry, 12% did not have parental responsibility to give consent for the child's dental care, therefore, consent obtained from such persons would not be considered valid. The potential of legal action for carrying out treatment after obtaining invalid consent should be seriously considered.

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