

# British Society of Paediatric Dentistry: a policy document on consent and the use of physical intervention in the dental care of children

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documents produced by the BSPD represent a majority view, based on a consideration of currently available evidence. They are produced to provide guidance with the intention that the policy be regularly reviewed and updated to take account of changing views and developments.

## Introduction

Valid consent to treatment can only be given by an individual who has the legal capacity to give consent. In some instances valid consent to the treatment of another can be given by an individual acting as a proxy on behalf of the other person, in others the proxy can signal their agreement or grant permission for treatment to go ahead.

There are a number of grey areas related to consent and child patients because of the different jurisdictions across the UK. Before looking at the various possible situations that can arise it is well to take time to consider some of the underlying principles that clinicians should bear in mind, at all times and in all parts of the United Kingdom, namely, the role of ethics and the purpose of consent<sup>1,2</sup>.

This document aims to consider the inextricably linked issues of consent and physical intervention ('restraint'). Consent is a process without which treatment *should not* be carried out. 'Restraint' (current terminology is physical intervention) is an intervention without which treatment, for some, *could not* be car-

ried out. Given that the latter requires the former, it is essential that the process of consent is thoroughly understood.

## Room for ethical thought?

Old-fashioned ethics is an oft-neglected area of thought in this age of rule-book regulation. The basic, guiding principles of the profession should be kept in clear focus by the clinician seeking to make the right decision: (i) non-maleficence; first do no harm; (ii) act in the best interests of the patient; and (iii) respect the patient's right to refuse.

Balancing this last point with the other principles on occasions poses a dilemma but the following should be asked: (i) is what you are proposing really in the patient's best interest? (ii) is the patient happy to go ahead? (iii) if not, is there an alternative? (iv) if there is no alternative what will *really* be the outcome if you *do not* proceed with treatment?

In many cases *not* proceeding with treatment at that moment in time will have no immediate adverse outcome for the patient and treatment may be able to proceed with more success at some later date. In most instances, paediatric dentistry does not have to deal routinely with cases where the patient will die if they do not have their dental procedure undertaken.

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However, there are cases where the patient is going to suffer undue pain and distress if treatment is not provided as planned, so the clinician may feel that they have very little choice but to seek to proceed with treatment despite what the patient wishes. Having weighed up the ethical issues for the patient, the clinician should then seek valid consent for the treatment proposed.

### The twin purposes of consent

Consent can be considered as having two major purposes: (i) *Clinical purpose* – the confidence, co-operation and, critically, the agreement of the patient will contribute to a successful administration of treatment and a satisfactory outcome for everyone; and (ii) *Legal purpose* – evidence that the clinician has sought, and been given, permission to intervene and affect the physical integrity of the patient.

Put simply, consent means that the patient knows what your intentions are and has agreed to them. Valid consent does not exist if the patient does not know what is planned, or knows but has not agreed<sup>3</sup>.

The central importance of valid consent can perhaps be appreciated by consideration of the following points: even with the best planning, preparation and care, things can go wrong, accidents can happen, outcomes may be less than ideal. The impact of this on the clinician's position will depend upon the quality of the consent process.

Whatever procedure a clinician undertakes, the consent process to which they work should be clearly documented and the patient's notes should include a record of all discussions and decisions about treatment, including the treatment options available. The consent process should be considered as a safety check. It aims to keep the patient safe from unauthorized or unwanted treatments and keep the clinician safe from accusations of executing such treatments.

When considering physical intervention for a young patient, as part of the induction process for general anaesthesia (GA) for example, discussion of the nature and use of such physical intervention should form part of the

consent process with the relevant parties along with the actual clinical dental care planned.

### Who can give consent for a child patient?

This will depend upon: (i) the age of the patient; (ii) their level of understanding relative to the complexity and implications of the treatment proposed; (iii) who else with an interest in the child is available in the circumstances to take part in the decision-making process; and (iv) the legislation in place within the country of residence.

As is widely known, the component parts of the UK are governed by different legal systems and laws which overlap one another to a certain extent in effect, if not in actual words. This can be potentially confusing. However, if the clinician considers first the ethical position, then considers the extent to which the child can understand and make a rational decision about their care, and finally seeks the views of all those who would be reasonably regarded as having an interest in the welfare of the child, then they will have gone a long way to doing the 'right' thing for their patient.

### Children and consent to medical treatment in England and Wales

The age of consent to treatment is taken as 18 years in English Law. Young people aged between 16 and 17 years can give consent to treatment, if they are regarded as having sufficient competence so to do. Refusal to have treatment at this age can be over-ruled by parents and by the courts, irrespective of competence<sup>4,5</sup>. Furthermore, consent given to treatment by a patient at this age can be appealed and be over-ruled by the courts. There is no statutory provision in England and Wales governing the rights of those under 16 years to give consent for medical (dental) treatment but the operational practice has developed through case law.

'Gillick competence' (sometimes given as 'Fraser competence') describes the now standard test used to assess the capacity of those less than 16 years of age to consent to

medical/dental treatment<sup>6</sup>. It is based on an assessment of the child's understanding, maturity and intelligence. This acknowledges that capacity to consent will vary depending on the complexity of issues at stake. Thus a child may be 'Gillick competent' for some procedures, dental examination or fissure sealing but not for others, for example, surgical extractions.

English case law would now seem to support the approach of prioritizing the 'welfare' of the child over any 'right' to decide about whether or not to accept medical treatment in respect of a child patient<sup>7</sup>. This approach essentially gives precedence to the patient's best interests, in other words, if a child makes the 'right' decision, his or her wishes are to be respected.

Whilst this test clarifies the position in relation to consent by competent children under 16 years of age, it is less clear when it relates to *refusal* of treatment by a 'Gillick competent' child, particularly where a person with parental responsibility has made it clear that they wish treatment to proceed. In these circumstances, clinicians should take legal advice. The courts (but not parents) can over-rule both consent and refusal of consent to medical treatment if it is deemed to be in the child's 'best interests'.

The Mental Capacity Act (2005)<sup>8</sup> does not generally apply to children under 16 years or young people between 16 and 17 years of age except in some circumstances. However, a Court of Protection can make decisions about a child under 16 years, in cases of neglect or ill treatment. For young people aged 16 to 17 years of age who lack capacity, most of the Act applies to them as with adults, with the exception of: (i) advance decisions to refuse treatment; (ii) lasting powers of attorney; and (iii) statutory wills made by the court.

In order to determine that a person lacks capacity, a two-stage test needs to be applied which considers: (i) is there an impairment of, or disturbance in, the functioning of the person's mind or brain? (ii) is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

The Family Law reform Act (1969)<sup>9</sup> assumes that young people have the legal capacity to agree to routine medical and surgical procedures, including associated adjuncts like general anaesthesia, with the exception of rare conditions when the young person would be assumed to lack capacity in such instances.

### Children and consent to medical treatment in Scotland

In Scotland, there is a statutory framework in relation to giving consent for medical (or dental) care in children under the age of 16 years: The *Age of Legal Capacity (Scotland) Act 1991*<sup>10</sup>. Essentially, this states that once an individual reaches their sixteenth birthday the presumption is that they are, in the eyes of the law, competent to make their own decisions in respect of health care. In other words, they are adults. Prior to reaching this age, they may have capacity to make their own decisions with regard to giving, or withholding, consent to medical or dental care, dependent upon: (i) the nature or complexity of the treatment proposed; (ii) their level of understanding of the risks, benefits and implications of the treatment and any available alternatives; and (iii) the implications of not having treatment.

In effect, the extent to which a child can give or withhold consent will be directly proportional to their age and level of understanding and inversely proportional to the potential significance of the treatment, that is, 'Gillick competent'. If a child is considered to have capacity to consent on their own behalf in relation to an intervention, then the parents will no longer have any right to give consent in this area. It is however, considered good practice to involve the parents in the decision-making process as far as possible, although the child may have the final say.

As a practical example, consider the pre-cooperative 4-year-old child who refuses to quietly accept a GA induction. It would be unreasonable to expect the child to be involved in the decision about whether or not to proceed with GA. By contrast, the

highly anxious but intelligent, articulate 14 year-old who steadfastly refuses to proceed with GA may well be able to make that decision, despite what parents feel is appropriate for their child. At all times, the clinician must respect the patient's right to refuse. This patient would not be forced to have treatment if they were aged 16 years.

Should the GA go ahead if the 14-year-old gives their consent but the parents do not approve or do not even know? If it is a justifiable clinical decision, treatment is clearly necessary, intervention is in the patient's best interests and capacity unequivocally rests with the patient then, legally, the answer a court would be likely to come up with will be 'yes'. But the wise clinician will take every reasonable step to involve all potentially interested parties in this decision as it is from this direction that future problems or challenges to the decision may come and it is in no-one's interest to need recourse to the courts in deciding a clinical matter.

#### **Adults consenting on behalf of children: parents**

For the greater part of childhood, it will be up to the adult(s) with responsibility for the child to make decisions and give consent to medical and dental treatment. In the vast majority of cases it is the parents who have this role. Parents have an essential role to play in decision-making since they are responsible for their children and this gives rise to the legal concept of 'parental responsibility'<sup>11</sup>.

#### **Parental responsibility**

This refers to the raft of rights, responsibilities, duties, powers, and authority that parents hold in respect of their children. Parental responsibility however, is not given solely to parents, nor do all parents have 'parental responsibility' in the legal sense.

#### **Who has parental responsibility?**

For children born prior to the following dates: (i) 1st December 2003 (England and

Wales); (ii) 15th April 2002 (Northern Ireland); and (iii) 4th May 2006 (Scotland).

(i) Both parents have parental responsibility if they were married at the time of the child's conception or at some time subsequently; (ii) if the parents have never been married, only the mother automatically has parental responsibility; and (iii) an unmarried father can acquire responsibility by, for example, a registered parental responsibility agreement with the mother, or via a parental responsibility order from the court.

For children born on or after those dates: both parents will have parental responsibility if they are registered on the child's birth certificate irrespective of whether or not they are married.

Where a child has been formally adopted, the adoptive parents are the legal parents and have parental responsibility. Where a child has been born as a consequence of some form of assisted reproduction, rules under the *Human Fertilisation and Embryology Act 1990*<sup>12</sup> set out the legal status of the child's parentage.

A person who is not the child's parent can assume parental responsibility by: (i) being appointed the child's legal guardian (for example, if a parent dies); and (ii) being granted a residence order in their favour.

Local authorities take on parental responsibility while a child is in care or the subject of a supervision order but this is shared with the parents who should be involved wherever possible. Parental responsibility will rest with parents until a child is 18 years of age (16 in Scotland). Parental responsibility is not lost if parents divorce or separate (provided both parents had parental responsibility prior to the divorce or separation). Parental responsibility continues to be held by the parents even if a child is in custody or care but it can be restricted by a court order and will be lost if the child is adopted.

#### **Parental dissent**

Usually only one parent needs to give their consent to treatment. However, if the proposed treatment is irreversible and is not medically necessary, for example, cosmetic

surgery or some forms of orthodontic treatment, when would be sensible to seek the agreement of both parents. In such a case where one parent agrees to a treatment and the other parent does not, the clinician has to try and achieve agreement and ultimately to weigh up what is in the child's best interests. If a recommendation is made that treatment should proceed, the dissenting parent may still wish the clinician to reverse their decision. Where such a dispute exists, and where treatment is controversial and/or elective, the clinician must seek the authority of the courts before proceeding with treatment.

### **Scope and limitations of parental responsibility**

The rights of parents in respect of their child exist for, and must be exercised in pursuance of, the best interests of the child. They are for the benefit of the child, not the parent. Parental responsibility includes the right to consent to treatment on behalf of their children, provided the treatment is in the best interests of the child. Those with parental responsibility have no right to insist on treatment, which is not in the best interests of the child, nor should they obstruct an intervention which is clearly required by the child. Parents have no right to insist that treatment, which is not clinically necessary, should proceed. If this is insisted upon, the case should be referred for a second opinion.

Parental responsibility also entails the right to access a child's health records, although, if the child has the capacity to give consent, the child must first give their consent. Access to the records by a parent however, must not be granted if it conflicts with a child's best interests or if a clinician has given an undertaking to the child not to disclose any aspect of their treatment, unless of course such a failure to disclose would be contrary to the best interests of the patient.

For a separated parent who requests access to a child's health record, the clinician does not have to seek the consent of the other parent but may do so, if it is in the child's best interests.

If a clinician feels that the parent's decision is not in the best interest of the child then

they must provide emergency care only, that which is essential to preserve life or prevent a serious deterioration, whilst applying to the court for their view.

Disagreements between the parents and the treating clinician may need to be resolved by referral to the Official Solicitor, who will make an application to the courts. Where parents withhold consent for treatment that is in the child's best interests (for example a blood transfusion for a child where the parent is a Jehovah's Witness) it is likely that referral to the court would result in this decision being overruled. The court will regard the interests of the child as paramount and be guided by the various provisions of The Children's Act (1989)<sup>13</sup>, The Human Rights Act (1998)<sup>14</sup>, The Mental Capacity Act (2005)<sup>8</sup> and the UN Convention on the Rights of the Child<sup>15</sup>.

Under common law, a person with parental responsibility is generally able to give consent to the young person of 16–17 years of age receiving treatment where the young person lacks capacity. However, if a young person lacks capacity, treatment can be provided whether or not a person with parental responsibility consents to care. The Mental Capacity Act<sup>8</sup> allow for the carrying out of treatment and care provided it is in the best interests of the young person but the event will only receive protection from legal action if it is believed that the person lacks capacity.

### **Delegation of responsibility: consent by relatives and others**

The various Children's Acts<sup>13</sup> provide that any person who has care of a child, be it a child minder or a grandparent may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'. Parents can also delegate such authority in their absence. It would not be considered reasonable under the Acts if the carer knew that the person with parental responsibility would be likely in the circumstances to object to treatment being provided.

In Scotland, the primacy of known parental wishes has statutory force and attempts

should be made to ascertain what these are if at all possible. This approach should be employed in other jurisdictions as a matter of good practice.

Although a local authority with a care order for a child may have parental responsibility this is in fact shared with the parent and steps should be taken to seek their views and assent to the treatment proposed. In those cases where the child is in voluntary care the parental responsibility rests with the parent, not the local authority. The wishes of parents should be ascertained when treating children in foster care.

Any adults acting *in loco parentis* or with care and control of the child (such as child-minders) also have limited rights to give consent on the child's behalf but should only be considered in instances where essential care is required urgently. Once again the caveat in respect of medical history accuracy should be borne in mind and only the minimum intervention necessary should be considered.

In all cases, treatment in the absence of a clear indication of parental wishes should only proceed if the child's life is in danger or if the condition would deteriorate irretrievably as a consequence of non-treatment. Where treatment is not required as a matter of urgency, the clinician should seek legal advice on the best way to proceed.

### Children and consent for research

Important principles enshrined in the Mental Capacity Act<sup>8</sup> are that research can only be justified if there is a strong likelihood that it will yield meaningful results, and that humans are required for the conduct of that research. It is paramount that the benefits to the individual and Society outweigh any risks to the individual. The selection process must be fair and such subjects must be treated with dignity.

### Consent for use of physical intervention

The person duly identified as the source of consent for the child patient must be informed of the nature and purpose of any proposed physical intervention, the risks and benefits, any appropriate alternatives and the

implications of *not* proceeding with the physical intervention. In this sense, physical intervention should be viewed as one of the components of the treatment and subject to the same consent process as any other clinical intervention.

The adult representative of the child should be fully aware of the fact that physical intervention may, or is likely to, be used and also the manner in which it will be applied. If they are unhappy with this, and are fully aware of the potential consequences of not proceeding with their child's dental treatment, then this must be respected and treatment should not go ahead. This should be carefully documented in the patient's notes.

### Justification for physical intervention

Ideally all dental care for children should be provided under local anaesthesia using routine behaviour management techniques, such as 'Tell-Show-Do', to achieve a satisfactory outcome. There will, however, always be children who do not respond to this approach: pre-cooperative children; those with challenging behaviour who may or may not have an accompanying disability; as well as those children who present for emergency care where pain, fear, and shock override the child's normal coping mechanisms.

Within the UK, the majority of dentists working in this field would consider alternative approaches to this management issue, for example, some form of conscious sedation. In some cultures, the use of physical intervention, such as holding or even physically containing the child is deemed to be acceptable.

The Scottish Intercollegiate Guideline Network document on safe sedation of children undergoing diagnostic and therapeutic procedures<sup>16</sup> states that 'there is no place for physical restraint or hand over mouth (HOM) techniques in the dental treatment of children'.

However, there is a dilemma facing clinicians in the management of an uncooperative (struggling) child who needs to be held in some way, if a necessary operative intervention is to be safely and effectively administered.

Essentially, the use of physical intervention in the management of a child is about forcibly providing treatment for a patient who has withheld their permission for that treatment. Given that this is a major infringement of an individual's right to liberty it is important that the rules governing such an intervention are clearly understood by those working in this area.

Under the Mental Capacity Act<sup>8</sup>, physical intervention will only be exempt from liability if the person who takes the action believes that, for the individual who lacks capacity, physical intervention is necessary to protect that individual from harm. Additionally, the extent of the physical intervention must be proportionate to the likelihood and seriousness of the potential harm.

### General principles governing physical intervention

All those charged with care of a child have a 'Duty of Care' to that child, to promote their well-being as well as protecting and supporting their rights and best interests. These roles need to be discharged within the legal framework of the jurisdiction in which the professional is working. At all times, the *interests* of the child are paramount and all actions should be taken in pursuance of this fact. This does not necessarily mean that the child's *wishes* at that time are paramount but rather that the child's interests are explored and given due consideration alongside the views of others who have a legitimate place in the decision-making process.

The term physical intervention covers a number of options; it may be defined as: 'The positive application of force with the intention of over-powering the child'<sup>17</sup>. Such a definition obviously applies to action taken against the wishes of the child. In contrast, '*holding still*' (immobilising a child) may be with the agreement of the child and can be distinguished from physical intervention by the intent and degree of force required. It may, for example, be used in order to help a child accomplish a procedure that may be difficult or painful. Finally, '*containing/preventing from leaving*' are forms of physical interven-

tion or barriers that are aimed at preventing the child from harming themselves, others or property.

Implicit in these three approaches is the concept of 'de-escalation' where a risk assessment is undertaken of the situation and techniques—both verbal and non-verbal, used to calm a situation<sup>18</sup>. An example in paediatric dentistry would be the tactic of whispering in a crying child's ear in an attempt to achieve some calm in order to re-establish dialogue.

### Child factors

In this context, 'physical interventions', '*holding still*' and '*containing*' need to be applied with: (i) due consideration for the rights of the child, in particular, *the actual necessity to accomplish the procedure*. This is important when a seeming emergency situation precludes consideration of alternative approaches; (ii) the minimum necessary to accomplish the procedure, whilst aiming for a minimum level, if any, of psychological distress to the patient<sup>19</sup>; (iii) full preparation of the child and parent/guardian but cognisant of the fact that a parent/guardian may not wish to be present and respecting that right; and (iv) consideration of the legal framework and the necessity to involve the courts, where applicable.

### Staff factors

Consideration needs to be given to: (i) only using the techniques as a last resort where other behaviour management strategies have failed and never for the convenience of the professional; (ii) pre-empting the need for physical intervention by exploring alternative forms of pain and behaviour management, such as conscious sedation<sup>16</sup>; (iii) selecting a mechanism that is appropriate for the age of child and intervention planned, building in distraction as part of the technique; (iv) carrying out a risk assessment first; (v) ensuring that an appropriate policy in place for the setting, which is part of the induction process of all relevant staff, including the anaesthetic team; (vi) delivery of regular and updated training for designated staff; (vii) obtaining

consent, where possible from the child or if not, the parent/guardian's permission and the child's agreement; (viii) having a mechanism in place so that other staff can be part of the decision-making, especially if they disagree with the decision made; (ix) supporting the whole family throughout the entire process; and (x) documentation and audit of the processes of physical intervention.

### Physical intervention: salient points

All professionals and families have a duty of care to those for whom they have a responsibility and are required to act in the child's 'best interests'. Physical interventions (restraint, holding still or containing) should only be used as management techniques where there is a clear need to undertake a procedure for the child. Alternative approaches must always have been considered and, if clinically feasible, time set aside to explore these options further.

The physical intervention must always be of the minimum necessary to accomplish the task, only likely to cause minimal or no psychological distress and never for the convenience of the professional. A debriefing should take place with child and family after the procedure. Any such intervention must have the parent's permission and if possible, the child's assent, unless the child is competent to consent, which should be recorded in the clinical notes along with the nature of the intervention and its justification. Finally, no one should undertake any form of physical intervention without the appropriate training.

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