Journal of the Intensive Care Society
2015, Vol. 16(2) 137–141

DOI: 10.1177/1751143714568543
jics.sagepub.com

Medico-legal issues for intensivists caring for children in a District General Hospital

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Abstract

Anaesthetists and intensivists are often called upon to assist with the care of acutely unwell children presenting to district general hospitals. Treatment is usually provided with the consent of a parent but it may be required to treat the child using the doctrine of necessity. In this article we discuss aspects of the law, as it relates to children, to enable teams, who predominately treat sick adults, understand the legal framework surrounding the treatment of sick children.

Keywords

Medico-legal, law, paediatric, district general hospital, intensive care

Interestingly, there is no legal definition of what a child is in the United Kingdom. The UN Convention on the Rights of the Child states that a child 'means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier.' The UK government ratified this in 1991.

Anaesthetists and intensivists are often called upon to assist with the care of acutely unwell children presenting to district general hospitals (DGH). Treatment is usually provided with the consent of a parent or in the child's best interests under the doctrine of necessity. Difficulties may be encountered when it may not be clear what the best interests of the child may be. Parents may refuse or demand treatment for their child when the responsible health professionals may have opposing views.

The law governing who has parental responsibility to give valid consent is complex. Health professionals caring for children must also understand their responsibilities with child safeguarding matters. This article will look at medico-legal principles in relation to paediatric patients and address some of the dilemmas that may be encountered.

Health professionals caring for acutely unwell children in DGH's play a crucial role in their initial management prior to transfer to tertiary centres. These children may be normally healthy but presenting with an acute illness or patients with a chronic condition presenting with an exacerbation or acute deterioration. The Royal College of Paediatrics and Child Health estimate at least 12 in 10,000 children in the United Kingdom are living with a life-threatening illness.[1] It has been reported that DGH staff perform the majority of intubations and insertion of invasive lines of acutely unwell children.[2] On the other hand, the Tanner report of 2006 recommended the centralisation of paediatric services in order to improve patient outcomes.[3] As such, it is not surprising that a recent review of case workload in a DGH demonstrated a relatively low exposure to the management of critically unwell children, an average of eight patients per consultant over a 12 months period.[4]

The challenges of caring for these children extend beyond the clinical management but also require a sound understanding of the relevant medico-legal principles.

Consent

Treatment provided to any patient must be with their consent, failure to do so may result in a charge of assault or battery. This is more complicated with children for several reasons. Young children are unable to consent to treatment and so rely on their parents to consent on their behalf. Not all parents have legal responsibility to consent on behalf of their child and this is discussed in more detail. As a child develops they become more intellectually mature, increasingly independent of their parents and have a greater ability to understand the issues involved with their healthcare. When caring for children information regarding

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their treatment should be shared with them in an age appropriate manner so that they can share decisions about their care.[5] Parental access to the child should also be maintained unless the best interest's of the child requires the protection of their confidentiality.

The law considers consenting to treatment and refusal of treatment slightly differently. Generally speaking, a child over the age of 16 years is deemed competent to accept treatment but in order to refuse treatment the child must be of 18 years of age.

The landmark case in English law, *Gillick*, which occurred in 1986, involved a mother taking her local authority to court to stop doctors giving children under 16 years of age contraceptive advise.[6] The Law Lords found in favour of the original judgment:[7]

> . . . whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent.

In order to have the ability to consent to treatment, the child must have sufficient maturity to understand what is involved in the treatment. During the case, specific guidelines were issued by Lord Fraser in relation to contraceptive advise for children under 16 years.[6]

This principle has been developed further by the Mental Capacity Act which states:[8] A person must be assumed to have capacity unless it is established that he lacks capacity. and A lack of capacity cannot be established merely by reference to . . . a person's age.

Parental responsibility

When obtaining consent, clinicians must know whether the person they are speaking to has the legal authority to do so.

Parental responsibility is defined by the Children Act 1989 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.'[9] This means parents have responsibility to make important decisions in relation to the child and this includes decisions relating to their medical care. Who has parental responsibility is a complex area and differs depending on where in the United Kingdom the child's birth was registered as outlined in Table 1.[10]

Essentially, all mothers and most fathers have responsibilities towards their child. A mother will automatically have parental responsibility for their child from birth. The situation is more complex with fathers but in general, a father also has parental responsibility providing he is married to the child's mother at the time of the birth or, after a certain date depending on where in the United Kingdom the child is born, or, the unmarried father is named on the birth certificate.

Where there is parental disagreement, in an emergency, clinicians may proceed in the best interests of the child. In an elective situation, agreement should be sought between parents. If this is not possible, the parent dissenting to treatment must obtain a court order to prevent the treatment. This does not apply in Scotland where any person with parental responsibility can exercise their rights.

Refusal of treatment

Whilst *Gillick* demonstrated a right to a young persons' autonomy to accept treatment, the law does not afford children the same right to refuse treatment. Children are required to have a greater understanding of the issues surrounding their care when they refuse treatment. Parents, or the court, retain the legal authority to consent to treatment on behalf of their child and valid consent from whatever source is sufficient to permit treatment to occur lawfully, whether the child agrees or not.

Disputes

A challenging scenario arises when there is disagreement between doctors and parents. Parents of a child with a chronic illness may have a different understanding of their child's condition and different thoughts regarding futility of treatment to a doctor who has only just met the patient in the accident and emergency department. Concepts of futility also evolve with time as medical treatments advance and we gain a greater understanding of disease processes.

An important principle regarding withholding lifesaving treatment was established in 1981 in the case Re B.[11] The case involved a baby, Alexandra, suffering from Down's syndrome. She was born with duodenal atresia and required a simple operation to save her life. The parents did not want to proceed with surgery as they felt the complication offered their child an escape from a life with Down's syndrome. The operation was ordered to proceed by the Court of Appeal in the best interests of the child.

When determining the best interests for the child a balancing exercise must be performed. For a child with severe abnormalities, their best interests may well be served by keeping them comfortable and withholding life-prolonging treatment. Consideration must be made of standard medical practice of the condition concerned and the views of the parents.

The situation is different for a child who, for example, presents to the emergency department after a trauma, where treatment is initiated but once all the investigations and appropriate interventions have taken place is determined to have non-survivable injuries. In this situation, the courts have ruled that

Table 1. Legal definitions of parental responsibility.

UK country where birth is registered	
England & Wales	Married - both have parental responsibility and retain this if they later divorce - applies if both jointly adopt a child Unmarried - legal responsibility is obtained by i) jointly registering the birth of the child with the mother (after 1 December 2003); or ii) a parental responsibility agreement with the mother; or iii) a parental responsibility order from a court
Scotland	Married - both have parental responsibility providing he is married to the mother at the time of conception or any time afterwards Unmarried - father has parental responsibility if he is named on the child's birth certificate (from 4 May 2006)
Northern Ireland	Married - both have parental responsibility if the father is married to the mother at the time of the child's birth - if they marry after the child's birth, a father has parental responsibility if he lives in Northern Ireland at the time of the marriage Unmarried - a father has parental responsibility if he is named, or becomes named, on the child's birth certificate (from 15 April 2002)
Births registered outside of the United Kingdom	If a child is born overseas and comes to live in the United Kingdom, parental responsibility is determined by the UK country where they now reside
Same-sex parents	Civil partners - both have parental responsibility Non-civil partners - legal responsibility is obtained by the second parent by i) a parent responsibility agreement ii) becoming a civil partner of the other parent iii) jointly registering the birth
Other	Step parents, foster parents and grandparents do not automatically have parental responsibility but can apply to the courts

discontinuing life-supportive treatment is no different to not instituting it in the first place. Article 3 of the Human Rights Act entails a right to die with dignity.[12]

Parents who are Jehovah's Witness's may refuse blood transfusions for their child as they are a violation of their religious beliefs. In Re S (1993) a young child underwent treatment for T-cell leukaemia.[13] Transfusions of blood products were required to improve the success rate of the treatment. The courts ordered the transfusion in the interests of the child. Although the parents have rights to a family life and religious freedom,[14] these must be balanced with the best interest of the child.

In English common law, parents are only required to provide adequate care for their children. A parent can consent or object to treatment, but any disagreement with doctors that cannot be resolved using multidisciplinary mediation, as suggested by the GMC,[15] must be referred to the courts to determine the most appropriate process of care. This was reaffirmed by *Glass v UK*.[16] This does not apply in an emergency, unless there is time for an emergency application to the courts (or parental neglect, inability to find parents). Therefore, doctors may transfuse blood to a child admitted to A&E bleeding to death even if the parents refuse.

Parental demands for treatment and best interests

It is established in law that patients are entitled to refuse treatment; however, they cannot demand treatment. This applies also to parents who may make demands for treatment for their child. This can be difficult to manage and, if so, it is necessary to give a detailed explanation of the medical reasons why treatment is not indicated and have an appreciation of the reasons for the parent's opposition.

In *An NHS Trust v MB*, a baby suffered with a terminal condition, spinal muscular atrophy.[17] His parents disagreed with doctors to give sedation that would have hastened his death as they were hopeful his condition would improve and believed he could communicate with them in a very limited way. The courts stated continuing ventilation was in his best interests and refused to authorise the doctors to turn off his ventilator to allow him die peacefully. The Supreme Court has considered a similar case, in which, although relating to an adult, the Court followed a similar logic.[18] The logic is that as the parent (or relative, in the case of an adult) has known the patient for a substantially longer time than the clinical team, they are in a better position to determine the best interests than the clinical team. We are not aware of case law where individuals with parental responsibility have taken differing views.

The case of Charlotte Wyatt went to court on multiple occasions.[19] Charlotte, born at 26 weeks, required ventilation for most of her first three months of life. She had severe brain damage and poor respiratory reserve. Her parents were keen for all treatment options to be pursued including a tracheostomy if this was indicated. Her doctors disagreed with such aggressive treatment as it would only prolong the process of her dying. The courts found in favour of her medical team by considering Charlottes best interests as opposed to using the tolerability test. This decision was later reversed when her condition had improved and it was determined that any decision about her treatment and best interests should be made at that time.

Withholding or withdrawing life sustaining treatment

The GMC has provided guidance where life-sustaining treatment may be withheld or withdrawn.[1] Five situations are described:

(i) The 'Brain Dead' Child
(ii) The 'Permanent Vegetative' State
(iii) The 'No Chance' Situation
(iv) The 'No Purpose' Situation
(v) The 'Unbearable' Situation

These situations may be encountered during resuscitation scenarios where junior doctors are often the initial responders. If there is uncertainty about the degree of impairment, disagreement amongst staff or next-of-kin, or the scenario does not fit with the above situations, treatment should be given to protect the child's life until a senior doctor can make a decision as to whether or not treatment is futile. This is often a shared decision as part of a multidisciplinary team. Cases can be discussed with the regional Paediatric Intensive Care Unit (PICU) who will have greater experience of dealing with these dilemmas.

Parents with particularly strong religious beliefs may object to the withdrawal of life-saving treatment from their child. In a study of nearly 300 deaths at a PICU, 17 cases were identified where it was revealed that a strong religious belief affected the family's response to their child's critical illness.[20] Eleven of these resulted in protracted discussions that led the authors to conclude that a system to allow rapid access to the courts should be available to these patients similar to that offered to cases involving Jehovah's Witnesses refusing life-saving blood transfusion for their child.

If the focus of treatment changes from active to palliative, then just as with an adult patient, there should be the consideration of organ donation. This is an extremely sensitive area, where there is no case law. It is recommended that the DGH team liaises closely with their local PICU. As with adults, the close involvement of a Specialist Nurse for Organ Donation (SNOD) is very helpful.

Safeguarding

Vulnerable children may be encountered in the emergency department when being resuscitated after sustaining a life-threatening injury. If intentional trauma is suspected all health professionals are required to refer the matter to the relevant safeguarding personnel within their hospital.[21] This is of particular note if the child subsequently dies as a result of their admission, and if there are other children in the household.

Deprivation of liberty

Providing there was consent from an individual with parental responsibility, the situation of Deprivation of Liberty Safeguarding does not apply. However, if the clinical team is acting in the best interests of the child and there is no consent, then this must be considered, although it remains unclear as to whether this would apply in practice. The reader is referred to a recent consideration of DoLS in critical care.[22]

Summary

Anaesthetists and intensivists caring for critically unwell children presenting to DGH's for emergency treatment or resuscitation must have a clear understanding of the relevant medico-legal issues. If there is any uncertainty, treatment should be provided under the doctrine of necessity in the child's best interests until clarification can be obtained.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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