Who can consent to a child’s or young person’s treatment?
The following are legally entitled to give consent to medical treatment of a child or young person:

- a competent child or young person (see Card 2 on assessing competence)
- a parent or other person or agency with parental responsibility where the decision is in the best interests of the child (see Cards 3 and 5 on parental responsibility and best interests)
- a court
- an appointed proxy (in Scotland where the patient is over 16 and unable to make decisions for him or herself) (see Card 12 on mental capacity); or
- a person caring for a child, for example a grandparent or child minder, may do what is reasonable in the circumstances to safeguard or promote the child’s welfare (see Card 3 on parental responsibility). In Scotland, the primacy of any known wishes of the parents in these situations has statutory force. If a carer brings a child for treatment, steps should be taken to ascertain the parents’ views, and if there is doubt about authority to proceed, doctors should seek legal advice.
Are there any procedures a young person over 16 years old is not presumed to be competent to consent to?

In England, Wales and Northern Ireland there are some rare procedures – for example, live organ donation, some non-therapeutic procedures and research – where the presumption of competence for 16-17 year olds does not apply. A 16-17 year old is only deemed competent if Gillick competent (see Card 2 on assessing competence). These exceptions do not apply to Scotland where a young person over the age of 16 is treated as an adult.

If a competent young person can consent to treatment, does it also follow that s/he can refuse treatment?

No, not always. In England, Wales and Northern Ireland, a competent refusal can be overruled by a court or by a person with parental responsibility. Health professionals faced with an informed refusal of a treatment they believe to be beneficial should take legal advice – for example a refusal of life-saving treatment or treatment that would prevent permanent injury. The reasons why the child or young person has refused should be discussed beforehand to ensure that the refusal is not based on inaccurate perceptions. In Scotland it seems likely, from current case law and statute, that a competent refusal cannot be overridden by any other person, carer or court, even if that treatment is necessary to save or prolong life. This matter is not beyond doubt and legal advice should be sought where such situations arise.

The same principles apply to advance decisions to refuse treatment. In UK jurisdictions where a young person’s contemporaneous refusal of treatment may
not be determinative, it follows that advance decisions to refuse treatment made by young people cannot be legally binding on health professionals.

**Can doctors provide treatment against a child’s or young person’s wishes?**

If a child or young person refuses treatment, just because consent from a parent, or from a court, makes providing treatment lawful does not mean that it inevitably has to be given. Doctors must look at whether the harms associated with imposing treatment on a patient who refuses, whether competently or not, should play a part in the decision about proceeding. How critical the treatment is, whether alternative less invasive treatments are available, and whether it is possible to allow time for further discussion with the patient, are all factors to be weighed. As much time as is practicable should be taken for discussion, and treatment delayed if that is possible without jeopardising its likely success (see Card 7 on the use of restraint). Doctors must be careful not to apply undue pressure (see Card 2 on assessing competence).

**Can a person with parental responsibility refuse treatment?**

Refusal by those with parental responsibility is not necessarily determinative if treatment is considered in the child’s or young person’s best interests, a competent young person consents to treatment, or the court approves treatment. For example, where children need blood products to prevent death or serious deterioration, a refusal by a parent who is a Jehovah’s Witness is unlikely to be binding on doctors. In such situations, where possible, legal advice should be sought (see Cards 5 and 6 on best interests and disputes).
In an emergency, where consent is unavailable, on what basis can a child or young person be treated?

In an emergency, where consent is unavailable, for example when the patient is unable to communicate his or her wishes and where nobody with parental responsibility is available, it is legally and ethically appropriate for health professionals to proceed with treatment necessary to preserve the life, health or wellbeing of the patient. An emergency is best described as a situation where the requirement for treatment is so pressing that there is not time to refer the matter to court.

If such an emergency involves administering a treatment to which the child and/or family is known to object, for example the administration of blood to a Jehovah’s Witness, viable alternatives should be explored if time allows. In extreme situations, however, health professionals are advised to take all essential steps to stabilise the patient. Legal advice may be needed once emergency action has been taken.

Key advice