

Taking and making decisions for children in dentistry

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In dentistry one rarely deals with life-or-death decision-making, however important human values are at stake during the course of any dental treatment. These include preventing pain, preserving and restoring oral function for normal speech and eating, preserving and restoring the patient's physical appearance, and promoting a sense of control over and responsibility for his or her own health.¹ The dental management and treatment of children can be challenging to the practicing dentist in many ways including dealing with ethical issues related to the best interests of the child, obtaining valid consent or assent, surrogate decision making and access to care.

THE MORAL STATUS OF THE CHILD

The Declaration of Human Rights states that the child must be recognised as a person with the basic rights of all human beings to be free and equal in dignity and rights.² Therefore, all health-care professionals must be dedicated to the respect of the life and dignity of the child as an entity of full value at each stage of development. This is particularly important where the more children are dependent on the protection and the support of their parents or others, the more the health professional should focus on the interests and needs of child. In partnership with parents and guardians, all health professionals have a duty to enhance, encourage, protect and promote children's development from the dependency of infancy to the autonomy of adults.³ Parents are given the ethical and legal responsibility to make decisions for their children provided that they do so in the best interests of the child.⁴ The Convention also provides that children should have access to the best available standards of health care, the right to information, the right not to be subjected to inhuman or degrading treatment and the right to privacy. Children are right owners, even if they are not able to express their rights. Everyone dealing with such right has the duty to promote them and to give voice to them.³ The South African Constitution provides that "a child's best interests are paramount in every matter concerning a child".⁵

THE NATIONAL HEALTH ACT

The National Health Act No. 61 of 2003 in Section 8(1)⁶ makes provision for users of health services to have the right to participate in any decision affecting their personal health or treatment (NHA) and in Section 8(2)(b)⁷ this right is extended to children who are sufficiently mature to

understand the nature and effect of the health service even though they may not have the legal capacity to consent.⁷ In such circumstances the child must be consulted, but their parent or guardian will have to give the necessary consent. When eliciting informed consent, the National Health Act of No. 61 of 2003, Section 6(2)⁸, requires that the following information be given to the patient:

- Range of diagnostic procedures and treatment options available
- Benefits, risks, costs and consequences associated with each option
- User's right to refuse care, in which case the dentist should explain the implications, risks and obligations of such refusal
- Furthermore, this information must be provided in a language that the patient understands and in a manner that takes into account the patient's literacy level.

While the National Health Act does not specifically mention consent by children it is self-evident that the provisions apply to children who have the legal capacity to consent to medical treatment.⁹

ETHICAL JUSTIFICATION FOR OBTAINING CONSENT/ASSENT

Traditional moral theory and ethical principles justify the imperative to obtain consent/assent for medical treatment. Autonomy is the right to self-determination. It refers to the right of every individual to make decisions for him/herself and to determine what is in their best interests. In health care this would mean allowing the patient to make the final decision regarding his/her treatment, after all the necessary and relevant information had been provided. Furthermore, by encouraging active participation of individuals in the decision-making processes that are intended to restore their health, compliance for treatment is often improved. The universal need to obtain consent/assent also involves treating people justly and protects patients from the physical and psychological harms which may occur as a result of illness or its treatment. The broader social benefits of obtaining valid consent/assent include the fostering of the dentist-patient relationship which is based on partnership, mutual trust, understanding and respect.³

The traditional ethical principles and moral theories are usually used for persons who have the capacity to make their own decisions. It should not be used for patients who are incompetent or lack capacity as a result of their being immature, incapacitated, ignorant, coerced into a decision or exploited.¹⁰ In accordance with all sections of the Children's Act (Act 38 of 2005,¹¹ any child seeking dental

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treatment or surgery must consent to treatment or surgery and practitioners now need to actively involve children in making and taking decisions about their own oral health care. This has required a paradigm shift in the attitudes of health professionals to the moral status of children and the moral claims which they may make on society.³

THE CHILD'S ROLE IN DENTAL DECISION MAKING

The Children's Act (Act 38 of 2005)¹¹

The Children's Act (Act 38 of 2005) that came into effect on 1 April 2010 lowered the age at which a minor can consent to dental and surgical treatment and any child seeking dental treatment or surgery must consent to treatment or surgery.

For dental treatment the Children's Act 38 of 2005 Section 129(2) provides that a child may consent to his or her own dental treatment (i) if they are over the age of 12 years and (ii) if the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment. For surgical operations, the Children's Act 38 of 2005 Section 129(3) provides that a child may consent to the performance of a surgical procedure on himself or herself (i) if he/she is over 12 years of age (ii) is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and (iii) if he/she is duly assisted by his or her parent or guardian. Practitioners must ensure that prior to surgery the child's consent is obtained in writing and must be completed by the practitioner performing the surgery or by a representative of the institution where the procedure is carried out and must be signed by the child. The parent or guardian who assists the child must assent to this in writing.¹²

In instances where a child is under 12, or over 12 years of age but lacks the maturity to make an informed decision or is unable to understand the benefits, risks, social and other implications of the treatment or surgical operation, then in terms of Section 129 (4) and (5), a parent, guardian or care-giver of the child may consent to dental treatment or surgical operation.

THE HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

The Health Professions Council of South Africa¹³ in their guidelines related to the ethical considerations in seeking of children's informed consent state that:

- 9.5.1 Health care practitioners must assess a child's capacity to decide whether to consent to or refuse a proposed investigation or treatment before they provide it.
- 9.5.2 In general, a competent child will be able to understand the nature, purpose and possible consequences of the proposed investigation or treatment, as well as the consequences of non-treatment.
- 9.5.3 A health care practitioner's assessment must take account of the following:
 - 9.5.3.1 A minor with sufficient maturity over the age of 12 years can be treated as an adult and is legally competent to decide on all forms of treatment, and medical and surgical procedures.
- 9.5.5 Where a child is not legally competent to give or withhold informed consent, the parent or guardian may authorise investigations or treatment which are in the child's best interests. Such parent or guardian

may also refuse any intervention, where they consider that refusal to be in the child's best interests, but health care practitioners are not bound by such a refusal and may seek a ruling from the court.

- 9.5.6 In an emergency where there is no time to contact the parent or guardian and the health care practitioners consider that it is in the child's best interests to proceed, they may treat the child, provided it is limited to treatment which is reasonably required in that emergency. In such circumstances in State Hospitals consent must be given by the clinical manager.

Furthermore, the HPCSA provides that in deciding what options may be reasonably considered as being in the best interests of a patient who lacks capacity to decide, health care practitioners should take into account:

- 10.1.1 The options for investigation or treatment which are clinically indicated;
- 10.1.2 Any evidence of the patient's previously expressed preferences, including an advance statement;
- 10.1.3 Their own and the health care team's knowledge of the patient's background, such as cultural, religious or employment considerations;
- 10.1.4 Views about the patient's preferences given by a third party who may have other knowledge of the patient, for example, the patient's partner, family, carer, or a person with parental responsibility;
- 10.1.5 Which option least restricts the patient's future choices, where more than one option (including non-treatment) seems reasonable in the patient's best interests.¹³

THE MORAL AND LEGAL AUTHORITY OF THE PARENT OR SURROGATE DECISION MAKER

Surrogate decision making is often a practical necessity and ensures that the interests of the incompetent individual are represented. In making decisions for another person, a surrogate must make choices based on the individual's previous preferences, if they are known ('substituted judgement').¹⁴ The fact that parents generally bear the consequences of treatment choices for their children support the presumption that they will take decisions with the child's 'best interest' in mind.¹⁵ The 'best interest' principle includes what a reasonable person might choose under similar circumstances and is often applied in situations of special need and where people do not have capacity to take decisions for themselves. It is a way of enabling a clinician to provide treatment that would generally be regarded as being in the best interests of patients who are not capable of making such decisions themselves. The question then arises as to who determines what is in the best interest and if there is a disagreement between parent and provider with an interest in the welfare of the patient? In most cases the law will usually set a particular age over which patients may provide consent for treatment and this can be different to the age of majority when the law recognises a person as an adult.

Parents are usually regarded as acting in the best interests of their children and decision making for children is a shared process between parents and health professionals.¹⁶ Regardless of the parent's request, the dentists' primary ethical, moral and legal duty is to the child, and the dentist is not obligated to acquiesce to treatment if it is unreasonable or not in the child's best interest. It must be noted that parents giving consent on behalf of their child, must meet the criteria for informed consent in terms of their own capacity for reasoning and understanding and their voluntariness.¹⁴

CHILDREN'S ASSENT TO CARE

Informed consent means approval of the legal representative of the child or of the competent child for medical interventions following appropriate information. Informed assent means a child's agreement for medical procedures in circumstances where he or she is not legally authorised or has insufficient understanding to be competent to give full consent.³ The American Academy of Paediatrics¹⁷ defines four aspects of assent for the clinical context: (i) helping the child to achieve a developmentally appropriate awareness of the nature of his or her condition, (ii) telling the patient what he or she can expect from the tests and proposed treatment, (iii) making a clinical assessment of the child's understanding of the situation and the factors influencing his or her response and (iv) soliciting an expression of the child's willingness to accept the proposed care.

As the child matures, the shared decision making of the parents and the health professional becomes more complex. When applied to medical or dental treatment consent or assent involves more than just agreement that a diagnostic test or a therapeutic procedure can be done. It is an active participatory process that involves a patient receiving information about the proposed procedure at a pace and a level which they can comprehend and the ability to use that information to make a voluntary choice as to whether to undergo that procedure. A child's cooperation may be more easily obtained if he or she understands the treatment planned. Such honesty will show respect to the child and it will enhance qualities of partnership, mutual understanding and trust which underline the dentist-patient relationship.³

The legal purpose of consent of the patient is to safeguard his or her autonomy or right to self-determination. However, practitioners should also carefully listen to the opinion and wishes of children who are not able to give full consent and should obtain their assent. The dentist has an ethical and legal responsibility to determine the ability and competence of the child to give his or her consent or assent. Although consent/assent is often perceived as one-off event, it is better regarded as an ongoing process.³

REFUSAL OF CONSENT TO HEALTH SERVICES BY CHILDREN

The capacity to take and make decisions is intimately involved with cognitive and emotional development. Whether or not a refusal of consent to health care by children under the age of 18 years is legally valid depends on the age of the child and the nature of the health service. Letting a child exercise autonomy in medical decision making depends on his or her own capacity and the decision to be made and it can be argued that competence is decision-specific i.e., the riskier the procedure or consequences of refusing it, the greater the level of competence that must be demonstrated by the decision maker.¹⁵ According to Piaget's classic work on the cognitive development of the child, the ability to reason abstractly and to understand and predict future consequences of an action does not occur until the ages of 11 and 14 years.¹⁸ By age of 15 years, the cognitive capabilities of the normal adolescent are similar to an adult.

In South Africa, children under the age of 18 years may not consent or refuse consent to an operation,¹⁹ unless it is a termination of pregnancy. Children under the age of 18 years but over the age of 14 years may, however, refuse consent to medical treatment. Although children under the age of 14 years have the right to participate in any decision affecting their personal health and treatment, they are not legally competent to refuse or to consent to medical treatment. Even though such children do not have the legal capacity to refuse treatment they must still be given the information required by

the National Health Act to enable them to participate in the decision-making process.⁶ If children under the age of 14 years refuse to consent to treatment they should be counselled by the practitioner provider regarding the implications, risks and consequences of their refusal. If after such counselling they still refuse care, they should only be treated against their will, and with the consent of their parents or guardian, where it is in their best interests because lack of such treatment may result in death or irreversible damage to their health.²⁰

Children aged 14 years or older are legally competent to consent to medical treatment *without* the assistance of their parents or guardians.²¹ They are also legally competent to refuse medical treatment. Provided that the child is sufficiently mature to understand the nature and effect of the refusal of treatment, and the implications, risks and obligations of such refusal have been explained, understood and accepted, the refusal should be respected.²⁰

CONCLUDING REMARKS

Making and taking decisions on behalf of a child is fraught with ethical complexities relating to autonomy, obtaining informed consent, assent and parental permission. In addition, the dental practitioner needs to be cognisant of the best interests of the child, the moral and legal authority of the parents or surrogate decision maker and the evolving capacity of the child to make decisions about their care and management.

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