Jackie Vasey discusses the ethical and legal dilemmas facing health professionals who work with children and young adults

Key words:
Consent & refusal to treatment
Moral principles
Paternalism

Consent & refusal: selective respect for a young person’s autonomy

Nurses regularly face ethical and legal dilemmas when caring for young people (Griswold & Griswold, 2000). A potential area of concern for nurses can be in supporting young people in decisions regarding consent to and refusal of treatment. In order to guide nurses and other health care practitioners in decision making, Beauchamp and Childress (2001) have developed a set of principles that attempt to provide an analytical framework representing the general values underlying rules in the common morality. Beauchamp & Childress (2001) proceed to describe these as clusters of moral principles or four prima facie moral obligations or commitments, which are; respect for autonomy, justice, beneficence and non-maleficence. Gillon (1986) proposes that the four prima facie moral principles help bring order and understanding to our medico - moral judgments in modern day healthcare. The prima facie obligation of respect for the principle of autonomy will form the framework for this discussion, as this would appear to be the most relevant prima facie principle, of those described by Beauchamp and Childress (2001).

Crittenden (1990) and Collins et al. (1997) define autonomy as being the need to express ones authentic self, taking responsibility for ones own behaviour, relinquishing dependence on parents and making decisions regarding ones own life. Whilst Glasper & Richardson (2006) define autonomy as “self-determination”, it is the determination of the point at which a young person relinquishes dependence on their parents and demonstrates self determination that creates the dilemma.

Recent changes to legislation (Children Act, 1989; United Nations, 1989) have resulted in the rights of children and young people being recognised and protected to ensure that their views are taken into consideration. According to Casey (2007), in principle, there is no longer a question of whether a child has the right to participate in decisions concerning what happens to them. However, Casey (2007) goes on to question whether those decisions are respected in practice and maintains that managing a competent child’s refusal remains a grey area.

The British Medical Association (2001) suggest that there is a growing awareness of the ability of children to make decisions providing they have been given age - appropriate information. According to Gillon (1986) doing things to someone without their consent constitutes over-riding their autonomy. It would seem that treating a young person who has refused that treatment, goes one step further than this, as not only has treatment been provided without their consent, but also against their expressed wishes. According to Harris (1985) and Miller (2003) this is a clear example of paternalism. For nurses, enforcing treatment in young people who have refused that treatment is clearly in conflict with the principles of the nurse’s role in acting as an advocate for the young person (Glasper & Richardson, 2006) and is ethically and legally questionable. Applying physical force in enforcing treatment may be legally tested by human rights legislation in the future, according to Didcock (2006), who goes on to propose that all people have the fundamental right to decide what happens to their own bodies.

The age at which young people become autonomous appears to be governed by the law. According to the Department of Health (DH, 2001) the law states that young people under 16 years cannot provide valid consent, unless they have been assessed as “Gillick” competent or competent according to Frazer guidelines. The terms “Gillick” competence and competent according to “Frazer” guidelines are used interchangeably (Wheeler, 2006). The case law relates to a case involving Mrs Gillick (Gillick v West Norfolk and Wisbech AHA, 1986, cited by Parekh, 2007), who challenged her local health authority’s decision to allow young people under 16 •
Refugee health care professionals who are in contact with refugee populations have legal duties to ensure that the individual is fully informed of all aspects of the treatment process. In this context, it is important to consider the legal requirements and ethical considerations surrounding consent and autonomy in the context of refugee health care.
In conclusion, it has become apparent that within health care there is selective respect for the principle of autonomy in young people (Stokes & Drake-Lee, 1998; Parekh, 2007) with regards to consent and refusal of treatment. This can result in difficulties for the nurse who is attempting to maintain the principles of family centred care and at the same time acting as advocate for that young person, in situations where there is disagreement between health care professional, those with parental responsibility and the young person (DH, 2003). In addition to this, the nurse can be placed in a predicament where, on one hand the nurse is striving to promote the rights of the young person and on the other, is trying to justify to a young person that, whilst that young person can consent to treatment, if they are assessed as being “Gillick” competent (Wheeler, 2006) they are not afforded the same respect in relation to refusal of treatment. Some possible explanations for this anomaly have been proposed. However, it is clear that this does not constitute a rational explanation for the paternalistic approach of healthcare professionals who may impose their views when it suits them (Miller, 2003).

References


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