

New flexi doc,
you talk ... doc listens.



0–18 years: guidance for all doctors

General
Medical
Council

Regulating doctors
Ensuring good medical practice

0–18 years: guidance for all doctors

The duties of a doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
 - Keep your professional knowledge and skills up to date
 - Recognise and work within the limits of your competence
 - Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
 - Treat patients politely and considerately
 - Respect patients' right to confidentiality
- Work in partnership with patients
 - Listen to patients and respond to their concerns and preferences
 - Give patients the information they want or need in a way they can understand
 - Respect patients' right to reach decisions with you about their treatment and care
 - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
 - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
 - Never discriminate unfairly against patients or colleagues
 - Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

0–18 years: guidance for all doctors

Being registered with the General Medical Council gives you certain rights and privileges. In return, you must meet the standards of competence, care and conduct set out in all our guidance.

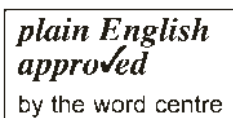
Our booklet *Good Medical Practice* describes what is expected of all doctors registered with the GMC. The guidance that follows, which is for all doctors, develops the duties and principles set out in *Good Medical Practice* and in our other guidance. It focuses on children and young people from birth until their 18th birthday (see Appendix 1).

In *0–18 years: guidance for all doctors*, the terms 'you must' and 'you should' are used in the following ways:

- 'You must' is used for an overriding duty or principle
- 'You should' is used when we are providing an explanation of how you will meet the overriding duty
- 'You should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can comply with the guidance.

Serious or persistent failure to follow this guidance will put your registration at risk.

0–18 years: guidance for all doctors comes into effect on 15 October 2007.



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Introduction

- 1 This guidance is for all doctors, but it may also be useful for children, young people*, those with an interest in their care, and anyone else who wants to know what guidance doctors are given.
- 2 The guidance is for all doctors, whether or not they routinely see children and young people as patients. Doctors should also be aware of the needs and welfare of children and young people when they see patients:
 - (a) who are parents or carers*
 - (b) who are cared for by children or young people, or
 - (c) who may represent a danger to children or young people.
- 3 *Good Medical Practice* states that doctors must safeguard and protect the health and well-being of children and young people. Well-being includes treating children and young people as individuals and respecting their views, as well as considering their physical and emotional welfare.
- 4 When treating children and young people, doctors must also consider parents and others close to them; but their patient must be the doctor's first concern.
- 5 When treating adults who care for, or pose risks to, children and young people, the adult patient must be the doctor's first concern; but doctors must also consider and act in the best interests of children and young people.

* See Appendix 1 for who we mean by children and young people and Appendix 2 for guidance on who has parental responsibility and roles of parents and carers.

- 6 Children and young people may be particularly vulnerable and need to be protected from harm; they can often find it difficult accessing services or defending their rights; and they often rely on others for their well-being. They may have particular communication needs and may need help to make decisions.
- 7 Children and young people are individuals with rights that should be respected. This means listening to them and taking into account what they have to say about things that affect them. It also means respecting their decisions and confidentiality.
- 8 Doctors should always act in the best interests of children and young people. This should be the guiding principle in all decisions which may affect them. But identifying their best interests is not always easy. This is particularly the case in relation to treatment that does not have proven health benefits or when competent young people refuse treatment that is clearly in their medical interests. There can also be a conflict between child protection and confidentiality, both of which are vitally important to the welfare of children and young people.
- 9 Reaching satisfactory answers to these challenging questions may mean considering a number of difficult ethical and legal issues. The purpose of this guidance is to help doctors balance competing interests and make decisions that are ethical, lawful and for the good of children and young people.

- 10** The law relating to children and young people is complex and differs across the UK. Doctors who have children and young people as patients will need some understanding of the law as it applies where they practise. Summaries of the law contained in this guidance cannot be a substitute for up-to-date legal advice in individual cases.¹
- 11** When in doubt as to their responsibilities, doctors should seek the advice of experienced colleagues, named or designated doctors for child protection, or professional or regulatory bodies.

Assessing best interests

- 12** An assessment of best interests will include what is clinically indicated in a particular case. You should also consider:
- (a) the views of the child or young person, so far as they can express them, including any previously expressed preferences
 - (b) the views of parents
 - (c) the views of others close to the child or young person
 - (d) the cultural, religious or other beliefs and values of the child or parents²
 - (e) the views of other healthcare professionals involved in providing care to the child or young person, and of any other professionals who have an interest in their welfare
 - (f) which choice, if there is more than one, will least restrict the child or young person's future options.
- 13** This list is not exhaustive. The weight you attach to each point will depend on the circumstances, and you should consider any other relevant information. You should not make unjustified assumptions about a child or young person's best interests based on irrelevant or discriminatory factors, such as their behaviour, appearance or disability.

Communication

- 14** Effective communication between doctors and children and young people is essential to the provision of good care. You should find out what children, young people and their parents want and need to know, what issues are important to them, and what opinions or fears they have about their health or treatment. In particular you should:
- (a) involve children and young people in discussions about their care
 - (b) be honest and open with them and their parents, while respecting confidentiality
 - (c) listen to and respect their views about their health, and respond to their concerns and preferences
 - (d) explain things using language or other forms of communication they can understand
 - (e) consider how you and they use non-verbal communication, and the surroundings in which you meet them
 - (f) give them opportunities to ask questions, and answer these honestly and to the best of your ability
 - (g) do all you can to make open and truthful discussion possible, taking into account that this can be helped or hindered by the involvement of parents or other people
 - (h) give them the same time and respect that you would give to adult patients.
- 15** You should make it clear that you are available to see children and young people on their own if that is what they want. You should avoid giving the impression (whether directly, through reception staff or in any other way) that they cannot access services without a parent. You should think carefully about the effect the presence of a chaperone³ can have. Their presence can deter young people from being frank and from asking for help.

- 16** You should take children and young people's views seriously and not dismiss or appear to dismiss their concerns or contributions. Disabled children and young people can feel particularly disadvantaged in this respect.
- 17** Children and young people usually want or need to know about their illnesses and what is likely to happen to them in the future. You should provide information that is easy to understand and appropriate to their age and maturity about:
- (a) their conditions
 - (b) the purpose of investigations and treatments you propose and what that involves, including pain, anaesthetics and stays in hospital
 - (c) the chances of success and the risks of different treatment options, including not having treatment
 - (d) who will be mainly responsible for and involved in their care
 - (e) their right to change their minds or to ask for a second opinion.
- 18** You should not overburden children and young people or their parents, but give them information at an appropriate time and pace, and check their understanding of key points.
- 19** You should talk directly and listen to children and young people who are able to take part in discussions about their care. Young people who are able to understand what is being said and who can speak for themselves resent being spoken about when they are present. But younger children might not be able to understand what their illness or proposed treatment is likely to involve, even when explained in straightforward terms.

- 20** You should only keep the type of information described in paragraph 17 from children or young people if:
- (a) it would cause them serious harm (and not just upset them or make them more likely to want to refuse treatment)
 - (b) they ask you to, because they would prefer someone else to make decisions for them.
- 21** You have the same duty of confidentiality to children and young people as you have to adults. But parents often want and need information about their children's care so that they can make decisions or provide care and support. Children and young people are usually happy for information to be shared with their parents. This sharing of information is often in the best interests of children and young people, particularly if their health would benefit from special care or ongoing treatment, such as a special diet or regular medication. Parents are usually the best judges of their children's best interests and should make important decisions up until children are able to make their own decisions. You should share relevant information with parents in accordance with the law and the guidance in paragraphs 27, 28 and 42 to 55.

Making decisions

- 22** You can provide medical treatment to a child or young person with their consent if they are competent to give it, or with the consent of a parent or the court.⁴ You can provide emergency treatment without consent to save the life of, or prevent serious deterioration in the health of, a child or young person.
- 23** You should involve children and young people as much as possible in decisions about their care, even when they are not able to make decisions on their own.

Assessing the capacity to consent

- 24** You must decide whether a young person is able to understand the nature, purpose and possible consequences of investigations or treatments you propose, as well as the consequences of not having treatment. Only if they are able to understand, retain, use and weigh this information, and communicate their decision to others can they consent to that investigation or treatment.⁵ That means you must make sure that all relevant information has been provided and thoroughly discussed before deciding whether or not a child or young person has the capacity to consent.

- 25** The capacity to consent depends more on young people's ability to understand and weigh up options than on age. When assessing a young person's capacity to consent, you should bear in mind that:
- (a)** at 16 a young person can be presumed to have the capacity to consent (see paragraphs 30 to 33)
 - (b)** a young person under 16 may have the capacity to consent, depending on their maturity and ability to understand what is involved.⁶
- 26** It is important that you assess maturity and understanding on an individual basis and with regard to the complexity and importance of the decision to be made. You should remember that a young person who has the capacity to consent to straightforward, relatively risk-free treatment may not necessarily have the capacity to consent to complex treatment involving high risks or serious consequences.* The capacity to consent can also be affected by their physical and emotional development and by changes in their health and treatment.

* See paragraphs 70–71 for guidance on advice and treatment for contraception, abortion and sexually transmitted infections.

Children and young people who lack the capacity to consent

- 27** If a child lacks the capacity to consent, you should ask for their parent's consent. It is usually sufficient to have consent from one parent. If parents cannot agree and disputes cannot be resolved informally, you should seek legal advice about whether you should apply to the court.⁷
- 28** The legal framework for the treatment of 16- and 17-year-olds who lack the capacity to consent differs across the UK:
- (a) In England, Wales and Northern Ireland, parents can consent to investigations and treatment that are in the young person's best interests
 - (b) In England and Wales, treatment can also be provided in the young person's best interests without parental consent, although the views of parents may be important in assessing the young person's best interests (see paragraphs 12 and 13)⁸
 - (c) In Northern Ireland, treatment can be provided in the young person's best interests if a parent cannot be contacted, although you should seek legal advice about applying for court approval for significant (other than emergency) interventions
 - (d) In Scotland, 16- and 17-year-olds who do not have the capacity to consent are treated as adults who lack capacity and treatment may be given to safeguard or promote their health.⁹

Young people who have the capacity to consent

- 29** You should encourage young people to involve their parents in making important decisions, but you should usually abide by any decision they have the capacity to make themselves (see paragraphs 30 to 33 and paragraphs 46 to 52). You should also consider involving other members of the multi-disciplinary team, an independent advocate or a named or designated doctor for child protection if their involvement would help young people in making decisions.

If a young person refuses treatment

- 30** Respect for young people's views is important in making decisions about their care. If they refuse treatment, particularly treatment that could save their life or prevent serious deterioration in their health, this presents a challenge that you need to consider carefully.
- 31** Parents cannot override the competent consent of a young person to treatment that you consider is in their best interests. But you can rely on parental consent when a child lacks the capacity to consent. In Scotland parents cannot authorise treatment a competent young person has refused.¹⁰ In England, Wales and Northern Ireland, the law on parents overriding young people's competent refusal is complex.¹¹ You should seek legal advice if you think treatment is in the best interests of a competent young person who refuses.¹²

- 32** You must carefully weigh up the harm to the rights of children and young people of overriding their refusal against the benefits of treatment, so that decisions can be taken in their best interests.¹³ In these circumstances, you should consider involving other members of the multi-disciplinary team, an independent advocate, or a named or designated doctor for child protection. Legal advice may be helpful in deciding whether you should apply to the court to resolve disputes about best interests that cannot be resolved informally.
- 33** You should also consider involving these same colleagues before seeking legal advice if parents refuse treatment that is clearly in the best interests of a child or young person who lacks capacity, or if both a young person with capacity and their parents refuse such treatment.¹⁴

For further guidance on these issues see GMC guidance on consent and withholding and withdrawing life-prolonging treatments.

Procedures undertaken mainly for religious, cultural, social or emotional reasons

- 34** Both the GMC and the law permit doctors to undertake procedures that do not offer immediate or obvious therapeutic benefits for children or young people, so long as they are in their best interests (see paragraphs 12 and 13) and performed with consent (see paragraph 27).

- 35** To assess their best interests you should consider the religious and cultural beliefs and values of the child or young person and their parents as well as any social, psychological and emotional benefits. This may be relevant in circumcision of male children for religious or cultural reasons¹⁵, or surgical correction of physical characteristics that do not endanger the child's life or health.

Research

- 36** Research¹⁶ involving children and young people can benefit all children; but they may be vulnerable because they cannot always recognise their best interests, express their needs or defend their rights.
- 37** Children or young people should be involved in research only when research on adults cannot provide the same benefits. They can be involved in research that has either:
- (a)** potential benefits for children or young people generally, as long as the research does not go against their best interests or involves only minimal or low risk of harm (this would be research that involves, for example, asking questions or taking blood samples, the assessment of the risk depending on the view of the child or young person), or
 - (b)** potential therapeutic benefits for them that outweigh any foreseeable risks, which should be kept as low as possible.

- 38 Children and young people should not usually be involved in research if they object or appear to object in either words or actions, even if their parents consent. If they are able to consent for themselves, you should still consider involving their parents, depending on the nature of the research.¹⁷
- 39 You must not put pressure on children, young people or their parents to consent to research in the expectation of therapeutic, financial or any other benefit.
- 40 Before involving children or young people in research, you should seek advice and get the necessary approval from a relevant research ethics committee, the Medical Research Council¹⁸ or a medical royal college.¹⁹

For further information see GMC guidance on research.

Donation, transplantation, organ and tissue storage and use

- 41 *The Human Tissue Act 2004* and *Human Tissue (Scotland) Act 2006* were passed following inquiries into the storage of children's organs and tissue without the proper consent. The Acts make consent central to the lawful storage and use of children and young people's organs and tissue, and to the removal of such material after death. The Human Tissue Authority regulates and issues codes of practice on activities covered by the Act in England, Wales and Northern Ireland. Scottish ministers have those powers in Scotland.

Principles of confidentiality

- 42** Respecting patient confidentiality is an essential part of good care; this applies when the patient is a child or young person as well as when the patient is an adult. Without the trust that confidentiality brings, children and young people might not seek medical care and advice, or they might not tell you all the facts needed to provide good care.
- 43** The same duties of confidentiality apply when using, sharing or disclosing information about children and young people as about adults. You should:
- (a) disclose information that identifies the patient only if this is necessary to achieve the purpose of the disclosure – in all other cases you should anonymise²⁰ the information before disclosing it
 - (b) inform the patient* about the possible uses of their information, including how it could be used to provide their care and for clinical audit
 - (c) ask for the patient's* consent before disclosing information that could identify them, if the information is needed for any other purpose, other than in the exceptional circumstances described in this guidance
 - (d) keep disclosures to the minimum necessary.

For further information see GMC guidance on confidentiality.²¹

* or, where appropriate, those with parental responsibility for the patient

Sharing information with the consent of the child or young person

- 44** Sharing information with the right people can help to protect children and young people from harm and ensure that they get the help they need. It can also reduce the number of times they are asked the same questions by different professionals. By asking for their consent to share relevant information, you are showing them respect and involving them in decisions about their care.
- 45** If children and young people are able to take part in decision-making, you should explain why you need to share information, and ask for their consent. They will usually be happy for you to talk to their parents and others involved in their care or treatment.

Sharing information without consent

- 46** If a child or young person does not agree to disclosure there are still circumstances in which you should disclose information:
- (a)** when there is an overriding public interest in the disclosure
 - (b)** when you judge that the disclosure is in the best interests of a child or young person who does not have the maturity or understanding to make a decision about disclosure
 - (c)** when disclosure is required by law.

Public interest

- 47** You can disclose, without consent, information that identifies the child or young person, in the public interest. A disclosure is in the public interest if the benefits which are likely to arise from the release of information outweigh both the child or young person's interest in keeping the information confidential and society's interest in maintaining trust between doctors and patients. You must make this judgement case by case, by weighing up the various interests involved.
- 48** When considering whether disclosure would be justified you should:
- (a)** tell the child or young person what you propose to disclose and why, unless that would undermine the purpose or place the child or young person at increased risk of harm
 - (b)** ask for consent to the disclosure, if you judge the young person to be competent to make the decision, unless it is not practical to do so.

- 49** If a child or young person refuses consent, or if it is not practical to ask for consent, you should consider the benefits and possible harms that may arise from disclosure. You should consider any views given by the child or young person on why you should not disclose the information. But you should disclose information if this is necessary to protect the child or young person, or someone else, from risk of death or serious harm. Such cases may arise, for example, if:
- (a) a child or young person is at risk of neglect or sexual, physical or emotional abuse (see paragraphs 56 to 63)
 - (b) the information would help in the prevention, detection or prosecution of serious crime, usually crime against the person²²
 - (c) a child or young person is involved in behaviour that might put them or others at risk of serious harm, such as serious addiction, self-harm or joy-riding.
- 50** If you judge that disclosure is justified, you should disclose the information promptly to an appropriate person or authority and record your discussions and reasons. If you judge that disclosure is not justified, you should record your reasons for not disclosing.

Disclosures when a child lacks the capacity to consent

- 51** Children will usually be accompanied by parents or other adults involved in their care, and you can usually tell if a child agrees to information being shared by their behaviour. Occasionally, children who lack the capacity to consent will share information with you on the understanding that their parents are not informed. You should usually try to persuade the child to involve a parent in such circumstances. If they refuse and you consider it is necessary in the child's best interests for the information to be shared (for example, to enable a parent to make an important decision, or to provide proper care for the child), you can disclose information to parents or appropriate authorities. You should record your discussions and reasons for sharing the information.

Disclosures required by law

- 52** You must disclose information as required by law. You must also disclose information when directed to do so by a court.²³

Access to medical records by children, young people and their parents

- 53** Young people with capacity have the legal right to access their own health records and can allow or prevent access by others, including their parents.* In Scotland, anyone aged 12 or over is legally presumed to have such capacity. A child might of course achieve capacity earlier or later. In any event you should usually let children access their own health records. But they should not be given access to information that would cause them serious harm or any information about another person without the other person's consent.
- 54** You should let parents access their child's medical records if the child or young person consents, or lacks capacity, and it does not go against the child's best interests. If the records contain information given by the child or young person in confidence you should not normally disclose the information without their consent.²⁴
- 55** Divorce or separation does not affect parental responsibility and you should allow both parents reasonable access to their children's health records.

* There are circumstances in which disclosures may be made to parents and others without consent (see paragraphs 46–52).

Child protection

- 56** Doctors play a crucial role in protecting children from abuse and neglect. You may be told or notice things that teachers and social workers, for example, may not. You may have access to confidential information that causes you to have concern for the safety or well-being of children.
- 57** Early identification of risks can help children and young people get the care and support they need to be healthy, safe and happy, and to achieve their potential.
- 58** If you work with children or young people, you should have the knowledge and skills to identify abuse and neglect.²⁵ You should be aware of the use of frameworks for assessing children and young people's needs, the work of Local Safeguarding Children's Boards and Child Protection Committees, and policies, procedures and organisations that work to protect children and promote their welfare.
- 59** Children, young people and parents may not want you to disclose information about them if they think they will be denied help, blamed or made to feel ashamed. They might have had bad experiences or fear contact with the police or social services. You should help them understand the importance and benefits of sharing information. But you must not delay sharing relevant information with an appropriate person or authority if delay would increase the risk to the child or young person or to other children or young people.

- 60** Confidentiality is important and information sharing should be proportionate to the risk of harm. You may share some limited information, with consent if possible, to decide if there is a risk that would justify further disclosures. A risk might only become apparent when a number of people with niggling concerns share them. If in any doubt about whether to share information, you should seek advice from an experienced colleague, a named or designated doctor for child protection, or a Caldicott Guardian. You can also seek advice from a professional body, defence organisation or the GMC. You will be able to justify raising a concern, even if it turns out to be groundless, if you have done so honestly, promptly, on the basis of reasonable belief, and through the appropriate channels.
- 61** Your first concern must be the safety of children and young people. You must inform an appropriate person or authority promptly of any reasonable concern that children or young people are at risk of abuse or neglect, when that is in a child's best interests or necessary to protect other children or young people.²⁶ You must be able to justify a decision not to share such a concern, having taken advice from a named or designated doctor for child protection or an experienced colleague, or a defence or professional body. You should record your concerns, discussions and reasons for not sharing information in these circumstances.

- 62** You should participate fully in child protection procedures, attend meetings whenever practical and co-operate with requests for information about child abuse and neglect. This includes Serious Case Reviews set up to identify why a child has been seriously harmed, to learn lessons from mistakes and to improve systems and services for children and their families. When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent, or if it is not possible to ask for consent. You must be prepared to justify your decision not to share information in such cases.
- 63** You should make sure that there are clear and well-understood policies and procedures for sharing information with agencies you work with closely or often. You should have an understanding of the roles, policies and practices of other agencies and professionals. This includes understanding the circumstances in which they consider disclosure to be justified. Teachers, social workers, police, youth offending teams and others all have different relationships with children and young people. They also have different cultures, policies and guidance on sharing information. You should understand and respect these differences but remember the particular responsibilities you have as a doctor and the importance of trust in your relationship with your patients.

Sexual activity

- 64** A confidential sexual health service is essential for the welfare of children and young people. Concern about confidentiality is the biggest deterrent to young people asking for sexual health advice.²⁷ That in turn presents dangers to young people's own health and to that of the community, particularly other young people.
- 65** You can disclose relevant information when this is in the public interest (see paragraphs 47 to 50). If a child or young person is involved in abusive or seriously harmful sexual activity, you must protect them by sharing relevant information with appropriate people or agencies, such as the police or social services, quickly and professionally.
- 66** You should consider each case on its merits and take into account young people's behaviour, living circumstances, maturity, serious learning disabilities, and any other factors that might make them particularly vulnerable.
- 67** You should usually share information about sexual activity involving children under 13, who are considered in law to be unable to consent.²⁸ You should discuss a decision not to disclose with a named or designated doctor for child protection and record your decision and the reasons for it.

- 68** You should usually share information about abusive or seriously harmful sexual activity involving any child or young person, including that which involves:
- (a) a young person too immature to understand or consent
 - (b) big differences in age, maturity or power between sexual partners
 - (c) a young person's sexual partner having a position of trust
 - (d) force or the threat of force, emotional or psychological pressure, bribery or payment, either to engage in sexual activity or to keep it secret
 - (e) drugs or alcohol used to influence a young person to engage in sexual activity when they otherwise would not
 - (f) a person known to the police or child protection agencies as having had abusive relationships with children or young people.²⁹
- 69** You may not be able to judge if a relationship is abusive without knowing the identity of a young person's sexual partner, which the young person might not want to reveal. If you are concerned that a relationship is abusive, you should carefully balance the benefits of knowing a sexual partner's identity against the potential loss of trust in asking for or sharing such information.

Contraception, abortion and sexually transmitted infections (STIs)

- 70** You can provide contraceptive, abortion³⁰ and STI advice and treatment, without parental knowledge or consent, to young people under 16 provided that:
- (a) they understand all aspects of the advice and its implications
 - (b) you cannot persuade the young person to tell their parents or to allow you to tell them
 - (c) in relation to contraception and STIs, the young person is very likely to have sex with or without such treatment
 - (d) their physical or mental health is likely to suffer unless they receive such advice or treatment, and
 - (e) it is in the best interests of the young person to receive the advice and treatment without parental knowledge or consent.³¹
- 71** You should keep consultations confidential even if you decide not to provide advice or treatment (for example, if your patient does not understand your advice or the implications of treatment), other than in the exceptional circumstances outlined in paragraphs 46 to 52 and paragraphs 64 to 69.

Conscientious objections

- 72** If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see another doctor. You should make sure that information about alternative services is readily available to all patients. Children and young people in particular may have difficulty in making alternative arrangements themselves, so you must make sure that arrangements are made for another suitably qualified colleague to take over your role as quickly as possible.³²

Suitability to work with children and young people

- 73** Children are not miniature adults. Good clinical care for children relies on specially trained clinical staff together with equipment, facilities and an environment appropriate to children's needs. If you have children and young people as patients, you should make sure you have the appropriate training and experience in the clinical care of children in your specialty. You should take steps to make sure that, wherever possible, you and members of your team have access to the appropriate premises, equipment and other resources necessary to provide good care. If you also have adults as patients, you should audit separately the care you provide to children and young people.³³
- 74** If you are responsible for recruiting or employing people, or if you otherwise control who can work with children or young people in your care, you should make sure that their suitability is checked. NHS Employers (part of the NHS Confederation) issues advice on good employment practice, including pre- and post-employment, Criminal Records Bureau, alert notice, vetting and barring scheme and other checks.
- 75** You should follow the GMC's guidance on raising concerns about patient safety if you have concerns that children or young people are, or may be, at risk of harm because of a colleague's conduct, performance or health.

Complaints

- 76** You should always take children and young people's complaints seriously. You should help them to complain if their rights or interests have been denied or abused, or if they are unhappy with the care they have received or because they have been denied care.

Prescribing medicines

- 77** If you prescribe medicines for children, you should be familiar with the current guidance published in the British National Formulary for Children.

For further information see GMC guidance on good practice in prescribing medicines.

Appendix 1

Who are children and young people?

Children and young people are a diverse group with many different needs. This guidance is concerned with children and young people from birth until their 18th birthday. References to 'children' usually mean younger children who lack the maturity and understanding to make important decisions for themselves. Older or more experienced children who can make these decisions are referred to as 'young people'. At 16 it is legally presumed that young people have the ability to make decisions about their own care.

Appendix 2

Parents and parental responsibility

References to 'parents' in this guidance usually mean those with parental responsibility for the child or young person in question.

Parental responsibility means the rights and responsibilities that parents have in law for their child, including the right to consent to medical treatment for them, up to the age of 18 in England, Wales and Northern Ireland and 16 in Scotland.

Mothers and married fathers have parental responsibility. So do unmarried fathers of children born since 15 April 2002 in Northern Ireland, since 1 December 2003 in England and Wales and since 4 May 2006 in Scotland, as long as the father is named on the child's birth certificate.

Unmarried fathers whose children were born before these dates, or afterwards if they are not named on the child's birth certificate, do not automatically have parental responsibility. They can acquire parental responsibility by way of a Parental Responsibility Agreement with the child's mother or by getting a Parental Responsibility Order from the courts. Married step-parents and registered civil partners can acquire parental responsibility in the same ways.

Parents do not lose parental responsibility if they divorce. If a child is taken into local authority care parents share parental responsibility with the local authority. Parents lose parental responsibility if a child is adopted. Parental responsibility can be restricted by court order.

Adoptive parents have parental responsibility, as do those appointed as a child's testamentary guardian, special guardian or those given a residence order. Local authorities have parental responsibility while a child is subject to a care order.

You may need to get legal advice when in doubt about who has parental responsibility.

The only parental responsibility that continues until 18 in Scotland is the provision of guidance to the child (see *s.1(1)(b)(ii)* and *s.1(2)(b) Children (Scotland) Act 1995*). The Act refers to parental rights and responsibilities (PRR); reference to parental responsibilities in this guidance means PRR in Scotland.

People without parental responsibility, but who have care of a child, may do what is reasonable in all the circumstances of the case to safeguard or promote the child's welfare. This may include step-parents, grandparents and childminders. You can rely on their consent if they are authorised by the parents. But you should make sure that their decisions are in line with those of the parents, particularly in relation to contentious or important decisions.

Other sources of information and guidance

Best Practice Guidance for Doctors and other Health Professionals on the provision of Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health (Department of Health, 2004)

Child protection companion (Royal College of Paediatrics and Child Health, 2006)

The Common Assessment Framework for children & young people: Practitioners' and Managers' guides (both HM Government, 2006)

Common Core of Skills and Knowledge for the Children's Workforce (Department for Education and Skills, 2005)

Consent, rights and choices in health care for children and young people (British Medical Association, 2001)

Declaration of Helsinki (World Medical Association, 1964, as amended)

Delivering a Healthy Future – An Action Framework for Children and Young People's Health in Scotland (Scottish Executive, 2007)

Doctors' responsibilities in child protection cases (British Medical Association, 2004)

Getting it Right for Every Child (Scottish Executive, 2006)

Guidelines for the ethical conduct of medical research involving children (Royal College of Paediatrics and Child Health: Ethics Advisory Committee in Archives of Disease in Childhood, February 2000, Vol 82, No 2, pp177–182)

Information sharing: Practitioners' guide (HM Government, 2006)

The Law and Ethics of Male Circumcision – Guidance for Doctors (British Medical Association, 2004)

Medical Research Involving Children
(Medical Research Council, 2004)

*National Service Framework for
Children, Young People and Maternity
Services* (Department of Health, 2004)

*National Service Framework for
Children, Young People and Maternity
Services in Wales* (Welsh Assembly
Government, 2005)

NHS Confidentiality Code of Practice
(Department of Health, 2003)

*Safeguarding Children and Young
People: Roles and Competences for
Health Care Staff* (Royal College of
Paediatrics and Child Health, 2006)

*Safeguarding Children: Working
Together under the Children Act 2004*
(Welsh Assembly Government, 2007)

Seeking Consent: Working with Children
(Department of Health, 2001)

Seeking Consent: Working with Children
(Department of Health, Social Services
and Public Safety, 2003)

*UN Convention on the Rights of the
Child* (United Nations, 1989)

*What to do if you're worried a child
is being abused* (Department of
Health, 2003)

Working together to safeguard children
(Department for Education and
Skills, 2006)

*You're Welcome quality criteria: making
health services young people friendly*
(Department of Health, 2007)

Legislation and case law

*Adults with Incapacity (Scotland)
Act 2000*

*Age of Legal Capacity (Scotland)
Act 1991*

*Age of Majority Act 1969, Section 4
(Northern Ireland)*

Children (Scotland) Act 1995

*Children Act (Northern Ireland)
Order 1995*

Children Acts 1989 and 2004

Family Law Reform Act 1969

*Gillick v West Norfolk and Wisbech
AHA [1986] AC 112*

Houston (applicant) [1996] 32 BMLR 93

Mental Capacity Act 2005

*Medicines for Human Use
(Clinical Trials) Regulations 2004*

*R (on the application of Sue Axon) v
Secretary of State for Health & Anor
[2006] EWHC 37 (Admin), [2006]
1 FCR 175*

*Re A (A Minor) (Wardship: Medical
Treatment) [1993] 1 FLR 386*

*Re C (Welfare of Child: Immunisation)
[2003] EWCA Civ 1148, [2003] 2
FLR 1095*

*Re J (specific issue order: child's
religious upbringing and circumcision)
[2000] 1 FLR 571*

*Re P (medical treatment: best interests)
[2004] 2 FLR 1117*

Re R (a minor) [1991] 4 All ER 177

*Re W (A Minor) (Medical Treatment:
Court's Jurisdiction) [1993] Fam 64,
[1992] 4 All ER 627 CA*

*South Glamorgan County Council
v W & B [1993] 1 FLR 574*

Useful links

Charitable umbrella groups

Children in Northern Ireland – regional umbrella organisation for the children’s voluntary sector in Northern Ireland

Children in Scotland – national agency for voluntary, statutory and professional organisations and individuals working with children and their families in Scotland

Children in Wales – national umbrella children’s organisation in Wales

National Children’s Bureau – umbrella body for organisations working with children and young people in England and Northern Ireland

Information and practical resources for children, young people and professionals

Every Child Matters – information and guidance from the UK Government about its approach to the well-being of children and young people

Health Rights Information Scotland has published guidance specifically for under 16s on consent and confidentiality for the Scottish Executive Health Department

Brook – national voluntary sector provider of free and confidential sexual health advice and services specifically for young people; publishes guidance, leaflets and posters for health professionals, children and young people on a variety of subjects

Connexions – information and advice for young people aged 13–19

Legal resources

Children First for Health – health and hospital web resource providing age-appropriate information for children, young people and their families

The Children's Legal Centre – independent national charity concerned with law and policy affecting children and young people

Scottish Child Law Centre – promotes knowledge and use of Scots law and children's rights for the benefit of children and young people in Scotland

Children's Law Centre (Northern Ireland) – is developing a comprehensive and accessible advice service on children's rights and the law

Children's Commissioners

Children's Commissioners have been appointed for all four home countries. They look after the interests and promote and safeguard the rights of children and young people. Their specific roles and responsibilities vary, but they are important sources of information, advice and advocacy for children and young people.

- Children's Commissioner for England (and non-devolved issues across UK)
- Children's Commissioner for Wales
- Scotland's Commissioner for Children and Young People
- Northern Ireland Commissioner for Children and Young People

Endnotes

- ¹ Medical defence bodies and employers' solicitors may be able to give legal advice where there is uncertainty about how a particular decision might be viewed in law. The case law surrounding treatment of very ill neonates (infants at any time during the first 28 days of life) is particularly complex. You should consider GMC guidance on withholding and withdrawing life-prolonging treatments and obtain specialist legal advice as necessary in this area.
- ² See *Re A (A minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.
- ³ See GMC guidance on maintaining boundaries.
- ⁴ Mental health legislation provides another legal basis for the treatment of children and young people with mental health disorders.
- ⁵ See *Assessment of Mental Capacity: Guidance for Doctors and Lawyers* (BMA; Law Society, 2004).
- ⁶ *Family Law Reform Act 1969; Age of Majority Act 1969 (Northern Ireland); Age of Legal Capacity (Scotland) Act 1991; Mental Capacity Act 2005; Gillick v West Norfolk and Wisbech AHA* [1986] AC 112.
- ⁷ See *Re C (Welfare of Child: Immunisation)* [2003] EWCA Civ 1148, [2003] 2 FLR 1095 and paragraph 34–35 for guidance on procedures undertaken primarily for religious, cultural, social or emotional reasons.

⁸ When a person with parental responsibility is not available, for example. See *s.5 Mental Capacity Act 2005* and *Chapters 5 and 12 of the Mental Capacity Act Code of Practice*. If parents are available, but cannot agree with one another or are thought not to be acting in the best interests of the young person, legal advice should be sought about applying to the court to resolve disputes that cannot be resolved informally. If the young person has a mental disorder (whether or not they also lack capacity) you should consider the provisions of the mental health legislation.

⁹ See *Adults with Incapacity (Scotland) Act 2000*.

¹⁰ See *Houston (applicant)* [1996] 32 BMLR 93.

¹¹ See *Re R (a minor)* [1991] 4 All ER 177.

¹² *Children Act 1989*, *Children Act (Northern Ireland) Order 1995* and *Children Act (Scotland) 1995* give competent young people statutory rights to refuse medical or psychiatric assessments or examinations directed by the court or a children's hearing for purposes of an interim care, supervision, child protection or emergency protection order or, in Scotland, a supervision requirement, assessment, protection or place of safety order. A young person's refusal can be overridden in England, Wales and Northern Ireland by the inherent jurisdiction of the High Court (see *South Glamorgan County Council v W & B* [1993] 1 FLR 574). The position is less clear in Scotland; see *Age of Legal Capacity (Scotland) Act 1991*.

¹³ See *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, [1992] 4 All ER 627 CA.

¹⁴ See *Re P (Medical Treatment: Best Interests)* [2004] 2 FLR 1117.

¹⁵ See forthcoming GMC guidance on personal beliefs and medical practice; *The law and ethics of male circumcision – guidance for doctors* (BMA, 2006); *Religious circumcision of male children: standards of care* (British Association of Paediatric Surgeons (BAPS), 2001), and *Statement on Male Circumcision* (BAPS, Royal College of Nursing, Royal College of Paediatrics and Child Health, Royal College of Surgeons of England and Royal College of Anaesthetists, 2001). Female genital mutilation (sometimes referred to as female circumcision) is a serious crime and a child protection issue, whether undertaken in the UK or abroad.

¹⁶ See the definition in GMC guidance, *Research: the role and responsibilities of doctors*. This guidance does not apply to clinical audit which involves no experimental study.

¹⁷ See the World Medical Association *Declaration of Helsinki and Medicines for Human Use (Clinical Trials) Regulations 2004*, which requires parental consent to complement even competent under-16s' agreement to involvement in trials.

¹⁸ See *Medical Research Involving Children* (Medical Research Council, 2004).

¹⁹ See *Guidelines for the ethical conduct of medical research involving children* (Royal College of Paediatrics and Child Health: Ethics Advisory Committee in Archives of Disease in Childhood, February 2000, Vol 82, No 2, p 177–182).

²⁰ See GMC guidance on confidentiality.

²¹ See also *Working Together to Safeguard Children and Information Sharing: Practitioners' Guide* (both HM Government, 2006) for governmental guidance for England.

²² The NHS *Confidentiality Code of Practice* explains that 'the definition of serious crime is not entirely clear. Murder, manslaughter, rape, treason, kidnapping, child abuse or other cases where individuals have suffered serious harm may all warrant breaching confidentiality.

'Serious harm to the security of the state or to public order and crimes that involve substantial financial gain or loss will also generally fall within this category. In contrast, theft, fraud or damage to property where loss or damage is less substantial would generally not warrant breach of confidence.' It goes on to explain that less serious crimes, such as 'comparatively minor prescription fraud' might be linked to serious harm, such as drug abuse, which may justify disclosure.

²³ See GMC guidance on confidentiality, which sets out some key elements of the law on confidentiality.

²⁴ Information obtained as a result of examinations or investigations to which children or young people consented in the expectation of confidentiality should not normally be disclosed without consent either. See s.5(3) of *The Data Protection (Subject Access Modification) (Health) Order 2000*. See also paragraphs 46–52 on disclosing information without consent.

²⁵ See *Safeguarding Children and Young People: Roles and Competences for Health Care Staff* (RCPCH, 2006).

²⁶ A patient may no longer be in danger and request that you do not share information about past abuse, for example. Disclosure might still be justified if the abuser remains a risk to other children.

²⁷ *Best Practice Guidance for Doctors and other Health Professionals on the provision of Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health* (Department of Health, 2004).

²⁸ The law governing sexual offences is different in Northern Ireland, where you should also have regard to s.5 of the *Criminal Law Act (Northern Ireland) 1967*, which places a duty on everyone to report relevant offences to the police unless they have a reasonable excuse.

²⁹ *Working Together to Safeguard Children* (HM Government, 2006) includes advice and a list of considerations (at 5.27) to be taken into account when assessing risk in underage sex. See also *Working Together: Q&A on sexual activity of under 16s and under 13s* (Department for Education and Skills, 2006), *Children and Families: Safer from Sexual Crime – The Sexual Offences Act 2003* (Home Office, 2004) and the *Confidentiality and young people toolkit* (Royal College of General Practitioners, 2000).

³⁰ The *Abortion Act 1967* does not extend to Northern Ireland and the grounds on which abortion may be carried out are more restrictive than in the rest of the UK.

³¹ *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112. See also *R (on the application of Sue Axon) v The Secretary of State for Health & Anor* [2006] EWHC 37 (Admin), [2006] 1 FCR 175 and *Best Practice Guidance for Doctors and other Health Professionals on the provision of Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health* (Department of Health, 2004).

³² See *Best Practice Guidance for Doctors and other Health Professionals on the provision of Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health* (Department of Health, 2004).

³³ *National Service Framework* (Department of Health, 2003); *Children's surgery – a first class service* (Royal College of Surgeons of England, 2000); *Common Core Skills and Knowledge for the Children's Workforce* (Department for Education and Skills, 2005).

Competition winners

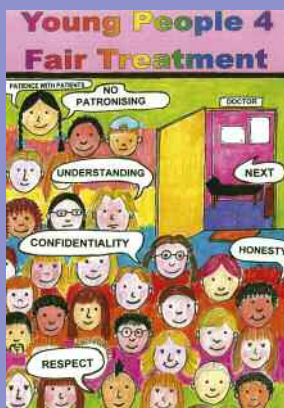
These were the winning entries from each of the UK countries in our poster competition for children and young people. The overall winner, Paul McAleenan, also designed the cover of the booklet.



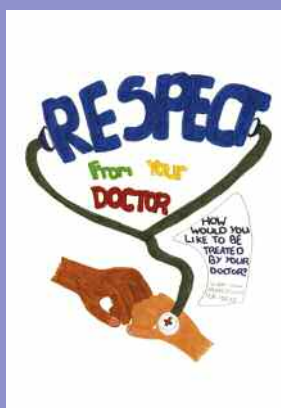
Paul McAleenan, Northern Ireland



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