Who wears the braces? A practical application of adolescent consent

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PRACTICE

IN BRIEF

- Discusses the issues involved in the consent process with particular reference to the adolescent patient.
- Demonstrates the importance of capacity as one of three elements essential to a valid consent process.
- Provides a practical approach to testing for capacity of an adolescent patient.

The presentation of alternative treatment plans and the discussion of these options with the adolescent patient is a routine part of both general dental and specialist orthodontic practice. This article will cover the issues involved in obtaining consent for treatment from the adolescent patient and suggests a practical means, if appropriate, to ensure that these patients can give and withdraw consent for their own treatment.

INTRODUCTION

In the UK, the majority of orthodontic treatment provided within the National Health Service (NHS) begins at adolescence. The World Health Organisation defines adolescence as the 'second decade of life, 10 to 19 years',[1] and this phase of life has been described as 'the most challenging of all developmental periods'.[2] The word adolescent is derived from the Latin word *adolescere,* which means to 'grow up', although the transition from childhood to adulthood may occur at different rates, both between different individuals and within the same individual in terms of mind, body and spirit.

Current practice usually involves parental consent for orthodontic treatment. In this article, the authors will consider the scenario in which an adolescent (under 16 years of age) wearing appliances wishes to terminate their orthodontic treatment against their parents' wishes and discusses whether their request be accepted.

LEGAL BACKGROUND

In 1974 the Department of Health and Social Services issued guidelines concerning the provision of contraceptive advice and treatment to girls under the age of 16 years.[3] In essence it placed the responsibility of deciding whether these girls should receive this advice and treatment upon individual doctors. Victoria Gillick, the mother of five daughters, challenged this, maintaining that the local health authority could not provide contraception or abortion treatment to her daughters without her knowledge until they reached the age of 16. This led to the famous Gillick case, in which Mrs Gillick was unsuccessful as the majority of the Law Lords found the guidelines to be lawful.[4] This case, therefore, established that a patient under the age of 16 could lawfully consent to medical advice and treatment once they had 'sufficient maturity and understanding'. From the legal perspective, it would follow that a healthcare professional, such as an orthodontist, would not be at risk from a civil action of battery or criminal prosecution if they were to treat a Gillick competent adolescent.[5]

However, there are also some practical aspects of gaining consent that need to be addressed. These are probably best discussed by considering the following simple scenario.

Scenario

A 14-year-old girl attends the orthodontic practice for a routine adjustment of her fixed appliances which she has been wearing for over 12 months. She asks the orthodontist to remove the appliances as she does not want to continue with treatment. She understands that there will be some spaces and says that she will wear the retainers at night time. Her mother, who is accompanying her, is keen for her daughter to continue with treatment and wants to achieve the ideal result. Is the refusal of the 14-year-old patient to continue with treatment seen as withdrawal of consent?

Tripartite relationship

Gabe *et al.* have suggested that as there are usually three individuals (child, parent and clinician) present in the paediatric outpatient clinical setting; this may lead to two of them entering into a coalition.[6] A coalition may form between the parent and the clinician with the parent requesting that treatment be carried out on their child against the child's wishes. It could be argued that this coalition would be acting against the patient's autonomy and their preferences. However, others might credit the same coalition with respecting Article 8 of the European Convention of Human Rights for the parent, 'the right to respect for his private and family life'.[7]

The other coalition that may form is that between the patient and the clinician, where the clinician respects the patient's autonomy and accepts their consent for treatment. Respecting the adolescent's autonomy will help to gain their respect and trust so perhaps leading to better compliance from the adolescent during other medical or dental treatment. At some point during the 'growing up' period there has to be the transfer of autonomy from the parent to the adolescent. Bevan has described two categories of rights for children.[8] The first is protective rights, which is the right for the child to have protection and assistance while developing. The second right is one of self-assertion, such as the right to make decisions. As Elliston has commented, this will often naturally lead to conflict between the right to protection and the right to self-assertion, and one may need to take priority.[9] In the case of our scenario

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if the orthodontist finds the patient to be Gillick competent, the right of self-assertion would take priority over protection.

It can be a difficult time within family life during the inevitable transitional period where a parent moves from being the decision maker to one of an advisor to their children as they begin to become autonomous decision makers. There will be a certain amount of overlap between the two rights, as 'the ability to exercise autonomy does not spontaneously arise whatever the legal set age of adulthood'.[9]

From a parent's perspective these self-assertive rights need to be respected because if a parent makes all the decisions for their child until they reach the age of 18, it is likely that they would have failed in their responsibility to educate them to look after themselves.[10] Children have also been shown to want to be more involved in consenting to dental treatment[11] and, therefore, it would seem appropriate for the orthodontist to actively encourage the adolescent patient to be an active participant in the process.

One common-sense approach could be to ensure that the levels of involvement in decision making for children and adolescents could be incremental. The first step involves the sharing of information with the child, followed by a shared decision-making strategy between the parent and the child, finally leading to the adolescent having autonomous decision-making ability.[12]

At some point an adolescent may choose a decision that is not in accordance with the choices of their parents or their orthodontist. Care should be taken at this point that 'any estimation of a child's maturity ought to be made independently of an evaluation of the child's opinion'.[13] This is in order to guard against the risk of discounting the patient's opinion if it is deemed to be 'wrong'. As Butler Sloss LJ commented: 'the view of the patient may reflect a difference in values (between the patient and the clinician or their family) rather than an absence of competence'.[14]

There is of course the coalition of the parent and the patient where they request treatment that the orthodontist may not feel is clinically appropriate, and here the refusal for treatment may be on the part of the orthodontist. This requires that the orthodontist remain true to their clinical training, maintain their professional standards and provide treatment that is within their level of competence and which they believe to be beneficial for the patient. In these circumstances it would be wise to remember that there are many other orthodontists who may be able to help the patient and their parents achieve their clinical goals rather than embark upon a treatment plan that does not fit with one's own clinical training.

By acknowledging these possible coalitions it raises the unique situation of consent being made available from either the adolescent or the parent. The article will continue to examine adolescent consent.

CONSENT

In order for consent to be valid the adolescent must:

1. Provide consent voluntarily AND
2. Be given sufficient information for them to be able to make a decision AND
3. Have the capacity to consent with an understanding of any information given to them.

If, for example, one of the conditions placed upon the consent was then to be breached then this could lead to consent being less effective or in legal terms, vitiated.

1. Provide consent voluntarily

For the consent of the adolescent patient to be valid there should be no coercion, persuasion or manipulation.[15] Coercion occurs if there is a threat of harm or force that may occur to the adolescent, leading them to vary their choice of treatment.

Persuasion is the most likely form of influence and is not always detrimental to the patient as it may convince them to have treatment that will be of benefit to them. Healthcare professionals, relatives and friends may all have persuasive power and in reality patients of all ages can be influenced in their choices. A small study of patient cooperation during orthodontic treatment found that parental attitudes to treatment served as the best predictors of cooperation, demonstrated by care of the appliance, particularly during the first few months of appliance therapy.[16] By the end of treatment, however, the adolescent's own views were shown to be the most salient predictors of adherence to care of the appliance.

In our scenario, persuasion may be in the form of the mother influencing the treatment option chosen due to numerous unspoken reasons. For example, the parent may be worried about the consequences of removing the appliances before treatment is complete. The patient may be disappointed with the result in the future and may blame the parent for 'allowing' them to have the appliances removed. Remedial treatment of the result may incur additional costs, which the patient may expect the parent to pay. The parent may also feel that the time and effort already expended for the first part of the treatment has been wasted. Even though the treatment for the adolescent may be free of charge under the NHS, there is the indirect cost of travel and the time missed from work for the parent to consider.[17]

The parent, or in this scenario the mother, may also have concerns about the patient being at risk from dental disease if the treatment is not completed; for example, deterioration in oral health in areas of untreated crowding. Previous research into the decision-making process involved in seeking healthcare on behalf of children has shown that maternal perceptions of child health and maternal emotional status influence the volume of child healthcare use, as measured by the number of healthcare visits.[18] Although this was an American study and considered the uptake of healthcare rather than dental or even orthodontic care, it would seem reasonable to expect that the maternal emotional status and perception of health could influence the decision to continue with treatment.

Beauchamp and Childress have described manipulation as a form of influence that is neither coercive nor persuasive,[15] and suggest that, in dentistry, the most likely form of manipulation will involve the information imparted to the patient by the clinical team. If we revisit our 14-year-old patient, the orthodontist could perhaps persuade the patient by their body language and tone of voice when describing one treatment option against another. This could have occurred during the consent process or conditions could have been attached that made the patient more likely to undertake treatment. An example would be '*orthodontic treatment will not take long and it will be really easy*'. As with persuasion, manipulation can affect a patient, regardless of their current age. Care should be taken then that all treatment options are discussed in a fair and controlled manner without any undue influence from the orthodontist to ensure that the adolescent in this scenario provided consent on a voluntary basis.

2. Be given sufficient information to be able to make a decision

The second criterion for being able to give valid consent is that sufficient information should be given to the patient. The question arises – just how much is sufficient information? And how should it be provided?

The two standards commonly applied to the amount of information provided are the professional community standard and the reasonable person standard. The former refers to the amount of information that dentists in the same community would give to their patients. This standard is frequently being replaced by the reasonable person standard – enough information needs to

be provided to allow a patient to make an informed decision and also, having that information, would a reasonably prudent person undergo the procedure knowing what the patient knew?[19]

The guidance provided by the General Dental Council states: 'that you should give patients the information they want and need, in a way they can use, so that they are able to make informed decisions about their care'.[20] Article 13 of the United Nations on the Rights of the Child states: 'The child shall have the right to freedom of expressing; this right includes the freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of child's choice'.[21]

Dental education has been shown to reduce anxiety among children and hence the provision of adequate information leads to fewer refusals of treatment required for dental health and better compliance.[22] The importance of providing information in a format that is acceptable to the patient has been discussed extensively,[23,24] and this principle should be applied to adolescents, as for all patients. Since information can now be relayed in many forms it would be interesting to consider whether certain formats are more appropriate for this age group than others. Contemporary use of social media by healthcare professionals involves analysis of sites such as Twitter to help identify and hopefully address any misunderstandings and fears.[25] Adolescents are now using online resources as a way of obtaining health information easily and anonymously[26] and health-related organisations are responding using social media sites, such as Facebook, to help disseminate information. While this is an understandable and laudable approach, this could still be perceived as 'Establishment' rather than acceptable within an adolescent peer group.

Even though social media may prove to be the ideal medium for adolescents to access information on dental health matters, care should also be taken, as there can be information online that is inaccurate and misleading.[27] Therefore, it may be beneficial to guide patients towards certain sites that contain evidence-based information, although this does not really embrace the more ad hoc nature of online research that could be expected from the adolescent patient.

3. Have the capacity to consent with an understanding of any information given

The third requirement for consent to be valid is the capacity to consent. In the first instance, due to the status of our patient, in that they are only 14 years old, they are deemed incompetent to consent. The dentist must give the patient the opportunity to demonstrate that they are Gillick competent in order to have the capacity to consent.

If we return to the Gillick case, their Lordships did not entirely agree on what they thought the extent of understanding the adolescent should have in order to be Gillick competent. Lord Scarman felt that: 'it is not enough that she should understand the nature of the advice which is being given: she must also have sufficient maturity to understand what is involved'.[4] Our 14-year-old is required to have a 'full understanding', which requires a consideration of both capability to understand in addition to actual understanding.[28]

i) Capability to understand

The 'capability to understand' confirms that that our 14-year-old adolescent can follow the information given by the dentist. Comprehension of this information can be separated into several factors as outlined by Shaw:[29]

- That there is a decision to be made
- That decisions have consequences
- The nature of the illness/condition
- The nature of the recommended intervention and any alternatives
- Risks and benefits of intervention or no intervention
- Longer term consequences of each option.

A means of checking 'capability to understand' is by asking the patient to repeat general information in his or her own words. For example, in this case the patient's main concern is that they no longer wish to wear their braces and may feel that the teeth look acceptable. However, there may also be other hidden problems within the malocclusion that would benefit from treatment, of which the patient is unaware. For example, an unerupted ectopic tooth may still require surgical intervention to reduce a risk to adjacent teeth, which may involve a general anaesthetic with its associated risks. Equally, orthodontic treatment with alignment of the teeth and correction of increased overbite but without full correction of an increased overjet may result in the development of a deep traumatic overbite following relapse. For the adolescent to show capability to understand, it is helpful for the patient to be able to answer simple check questions following the explanation, such as 'What would happen to your teeth if you did not brush them properly?' or 'What do you think might happen if we remove the braces?'

ii) Actual understanding

The 'actual understanding' involves the adolescent transferring that information to his or her own personal situation and then being able to reach a decision. With any joint decision making, the authors are aware that while the clinician is the most informed within the tripartite of orthodontist-parent-adolescent regarding treatment options, the parent or the adolescent patient may be the most informed about the patient's perceived health needs and desires. The transference of this information back to the clinician is crucial to informing the joint decision-making process and will also involve the patient dealing with any emotional implications.

It could be argued that greater intellectual capacity is required to make an informed decision than the actual seriousness of the treatment. In this scenario, treatment may have involved the removal of healthy teeth and a further 12 months of regular visits to the orthodontist. It will also require patient compliance with oral health measures in the care of the teeth and appliance. 'Actual understanding' will involve them balancing the risks and benefits of discontinuing treatment to their own situation, and how this and different treatment options may have an impact on them emotionally. Again this can be tested with the use of appropriate questions such as 'How long would you have to wear a retainer for after the braces are removed?', 'What would you do if you did not like the spaces between your teeth when the braces are removed?', and 'How could you clean your teeth next to those spaces?'

It would appear that the adolescent, in principle, is able to give consent voluntarily. This is because they have been provided with sufficient information for them to be able to make a decision and may have the capacity to consent in terms of capability to understand and actual understanding. However, they are still only 14 years old.

Does age matter?

Studies have shown that 14-year-olds can demonstrate a level of competence equivalent to that of adults.[30] If age is used as a sole factor to judge whether children have the capacity to consent or participate in conversations concerning their health, it could easily disadvantage those who are competent. It would appear this is particularly relevant when the child has attained knowledge of their condition through their experiences. Alderson investigated children who had chronic conditions and were about to undergo a non-life threatening orthopaedic operation.[31] Her research discovered that even children under the age of ten already

had an understanding of treatment options and their consequences.

In this scenario our patient has undergone at least 12 months of orthodontic treatment, so they will be aware of the nature of that particular treatment and the consequences of their previous 'choice' to have the treatment. They will possibly understand the feeling of having a recent 'gap' within their mouth following the loss of any permanent or even recent exfoliation of primary teeth. They may also understand what this would look like if they discontinued treatment at this stage, without undergoing full orthodontic space closure. By comparison, an adult who has had a complete dentition for many years, but now requires an extraction, may not be as equipped in making this decision.

Observance of siblings undergoing treatment may contribute to the knowledge base of the patient and this may or may not influence the decision to undergo treatment. If the clinician discovers that sibling experience is being taken into account, it is important to briefly check that the treatment proposed for the patient in the chair is indeed similar to that experienced by the sibling in order to avoid any misunderstanding. If the sibling has undergone a similar treatment plan this could certainly aid the patient's understanding of the risks and benefits, such that their age becomes less important than their understanding of the plan.

A practical approach

There has been a suggestion that the second stage of the test for capacity in the Mental Capacity Act (2005)[32] should be extended to those under the age of 16.[10] Adults are assumed to have capacity until otherwise proven; however, O'Brien suggests that adolescents must be able to demonstrate that they have capacity when providing consent.[33]

In order for an adolescent to be able to consent the orthodontist could use the template of the Mental Capacity Act in determining capacity, namely:

1. Is the adolescent able to understand the information relevant to the decision that needs to be made?
2. Can the adolescent retain the information that has been given?
3. Can the adolescent use that information in helping them to make a decision?
4. Is the adolescent able to communicate their decision? This does not necessarily have to be done verbally. It can be done by sign language, the use of pictures or any other means.

The advantage of using this template as a test is that it is practical and can be performed in the dental clinic. It is good practice and should, in the authors' opinions, be used and recorded as having been used when explaining any treatment to patients. Even though the starting point for each age group may be different, since adults are, unlike children, routinely assumed to have capacity, the capacity test for both children and adults would be the same.[9] The test would allow a case-by-case approach to be considered whenever addressing adolescent consent. The advantage of this test, O'Brien comments, is that the more serious the decision the more 'intelligent and mature a child must be'.[33] The use of this test also allows the adolescent's previous experiences to be taken into account as previously discussed, which may mean that certain individuals are more likely to understand the relevant information in their decision-making process. It has also been noted that by asking adolescents to prove their capacity, it would remind the judiciary in any future rulings that this test for capacity is functional rather than outcome based.[33]

The disadvantages of using this test appear minimal. It adds an extra few minutes to the consent procedure and requires an extra line or two of record keeping. It may be helpful to view consent as an on-going process throughout the treatment and the use of this test of capacity could be appropriate throughout. In principle, a parent could initially provide consent for a child who then developed to become capable of providing or, as in this scenario, of withdrawing consent for treatment. If the test is applied in a heavy-handed manner it may appear to actively discourage a caring parent from taking part in treatment discussion and could create a barrier between the parent and the orthodontist. However, with practice and careful application, the authors have found it to be a practical approach. It allows for a detailed consideration of the options by the patient and the parent, with the patient taking responsibility for the final decision. Of course for this scenario, it would be the authors' preference for either the parent to convince the patient to complete treatment as planned, or for the patient to convince the parent that it is best to have the appliances removed. This allows the orthodontist to either complete treatment or remove the appliances with the reassurance that the approach is acceptable to both parent and patient. This is not always the case. If the patient's withdrawal of consent is ignored, there may be an increased risk to oral health if the patient stops caring for the appliances.

In this scenario of the 14-year-old patient, it would, therefore, be acceptable to determine capacity using the template and record the conversation in the notes. Discussion of the cessation of treatment in such detail with the patient and the parent may lead to the parent changing their mind once they see how committed their child is to discontinuing treatment. It may also be prudent, if the patient is willing, to allow a short 'cooling-off' period of perhaps 2 weeks in order to confirm complete understanding of the consequences and to remove the appliances at that later stage. However, from the evidence submitted within this article, it would appear that if the patient has proved capacity, she would also be able to withdraw consent for her own orthodontic treatment, regardless of her age and parental feelings towards discontinuation.

CONCLUSION

The arguments for the voice of the adolescent within the consent process appear to support the concept of adolescent consent and withdrawal of that consent, regardless of age. In order for treatment to proceed smoothly it would seem prudent to involve the parent in the process, but ultimately adolescent consent, if provided voluntarily in the presence of sufficient information and capacity to consent, would appear to be valid.

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