

Children and young people tool kit



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About this tool kit

Questions about children and young people are a significant area of ethical enquiry for the British Medical Association (BMA) with doctors facing ever more complex dilemmas. High profile cases around child protection, access to sexual health services, and the vaccination of children highlight the sensitivity and difficulties doctors face in this area. Doctors need to know when a young person is competent and what this means in terms of their ability to consent and refuse health care, and what limits are placed on those with parental responsibility.

The purpose of this tool kit is not to provide definitive answers for every situation but to identify the key factors that need to be taken into account when such decisions are made and signpost other key documents. The tool kit consists of a series of Cards about specific areas relating to the examination and treatment of people in [England](#), [Wales](#), and [Northern Ireland](#) who are aged under 18 years, and in [Scotland](#) under 16 years. Separate Cards have been produced identifying factors to be considered when assessing competence and determining 'best interests', and sensitive areas including child protection and access to sexual health services. All Cards refer to useful guidance from bodies such as the General Medical Council (GMC), BMA and health departments, which should be used in conjunction with the Cards. In addition, the medical defence bodies and many of the royal colleges produce specific advice for their members: Card 15 lists contact details for organisations from whom further advice can be obtained.

About this tool kit

The tool kit is available on the BMA's website and individual Trusts, medical schools and individual health professionals may download and adapt it to suit their own requirements. There are no copyright restrictions on this tool kit – please feel free to make multiple copies.

The BMA would welcome feedback on the usefulness of the tool kit. If you have any comments please address them to:

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This is the first edition of the BMA's *Children and young people tool kit*. Information about developments since its publication may be obtained from the BMA's website or by contacting the BMA Medical Ethics Department.

CARD 1

Basic principles

Basic principles have been established regarding the manner in which the treatment of children and young people should be approached. These reflect standards of good practice, which are underpinned by domestic and international law.

The welfare of children and young people is the paramount consideration in decisions about their care. Children and young people can expect:

- to be kept as fully informed as they wish, and as is possible, about their care and treatment
- health professionals to act as their advocates
- to have their views and wishes sought and taken into account as part of promoting their welfare in the widest sense
- to be the individual who consents to treatment when they are competent to do so
- to be encouraged to take decisions in collaboration with other family members, especially parents, if this is feasible
- to be able to expect that information provided will remain confidential unless there are exceptional reasons that require confidentiality to be breached.

Doctors caring for children and young people have a number of ethical and legal obligations with which they should be familiar and are outlined in best practice guidance, statute and case law. For

Basic principles

example, the *Gillick* case, Children Acts 1989 and 2004, the Children (Scotland) Act 1995, Children (Northern Ireland) Order 1995, Age of Legal Capacity (Scotland) Act 1991, Mental Capacity Act 2005 (England & Wales), Family Law Reform Act 1969, Human Rights Act 1998 and the United Nations Convention on the Rights of the Child.

Key advice

- General Medical Council. *0-18 years: guidance for all doctors*. Available at www.gmc-uk.org
- BMA. *Consent, rights and choices in health care for children and young people*. More information available at www.bma.org.uk/ethics

CARD 2

Assessing competence

Can competence ever be presumed?

Yes. All people aged 16 and over are presumed in law to be competent to give their consent to medical treatment and to the release of information in England, Scotland, Wales and Northern Ireland (see Card 12 for more information on 16-17 year olds who lack mental capacity).

Can a young person be competent under the age of 16?

Yes, but this needs to be assessed in each case on a continual basis. Doctors should aim to involve all children and young people in decisions relating to their medical treatment. It is important to recognise when a young person is able to make a valid choice about a proposed medical intervention or disclosure of personal medical data and is therefore competent to make a personal decision. Doctors should not judge the ability of a particular child or young person solely on the basis of his or her age.

For a young person under the age of 16 to be competent, s/he should have:

- the ability to understand that there is a choice and that choices have consequences
- the ability to weigh the information and arrive at a decision
- a willingness to make a choice (including the choice that someone else should make the decision)

Assessing competence

- an understanding of the nature and purpose of the proposed intervention
- an understanding of the proposed intervention's risks and side effects
- an understanding of the alternatives to the proposed intervention, and the risks attached to them
- freedom from undue pressure.

Competent under 16 year olds are sometimes referred to as being *Gillick* competent. In [England](#), [Wales](#) and [Northern Ireland](#) children who are aged 12 or over are generally expected to have competence to give or withhold their consent *to the release of information*. In [Scotland](#), anyone aged 12 or over is legally presumed to have such competence (see Card 8 on children and young people's health information).

Who should assess competence?

GPs who have known the young patient for a long time are well placed to assess their development and maturity but because these change, it is unwise to rely on any assessment that is not contemporaneous. Health professionals who assess competence need to be skilled and experienced in interviewing young patients and eliciting their views without distortion. The treating doctor may be the most appropriate person, but other members of the health care team who have a close rapport with the patient may also have a valuable contribution to make.

How can competence be promoted?

When assessing a child's competence it is important to explain the issues in a way that is suitable for their age. A young patient may be competent to make some, but not all decisions, and clinical staff should promote an environment in which young patients are enabled to engage in decisions as much as they are able. The child or young person's ability to play a full part in decision-making can be enhanced by allowing time for discussion.

Key advice

- General Medical Council. *0-18 years: guidance for all doctors*. Available at www.gmc-uk.org
- BMA. *Consent, rights and choices in health care for children and young people*. More information available at www.bma.org.uk/ethics

CARD 3

Parental responsibility

Who can consent on behalf of a baby or child who lacks capacity?

Someone with parental responsibility, provided the decision is in the best interests of the child.

Do all parents have parental responsibility?

No. Not all parents have parental responsibility. Throughout the United Kingdom, a mother automatically acquires parental responsibility at birth. However, the acquisition of parental responsibility by a father varies according to where and when the child's birth was registered.

When does a father acquire parental responsibility?

- For births registered in [England, Wales](#) or [Northern Ireland](#). A father acquires parental responsibility if he is married to the mother at the time of the child's birth or subsequently. An unmarried father will acquire parental responsibility if he is recorded on the child's birth certificate (at registration or upon re-registration) from 1 December 2003 in England or Wales and from 15 April 2002 in Northern Ireland.
- For births registered in [Scotland](#). A father acquires parental responsibility if he is married to the mother at the time of the child's conception or subsequently. An unmarried father will acquire parental responsibility if he is recorded on the child's birth certificate (at registration or upon re-registration) from 4 May 2006.

Parental responsibility

- For births registered [outside the United Kingdom](#). The above rules for the UK country where the child resides apply.

Can other people have parental responsibility?

An unmarried father, whose child's birth was registered before the dates mentioned above, or afterwards if he is not recorded on the child's birth certificate, does not have parental responsibility even if he has lived with the mother for a long time. However, the father can acquire parental responsibility by way of a court registered parental responsibility agreement with the mother or by obtaining a parental responsibility order or a residence order from the courts. Married step-parents and registered civil partners can acquire parental responsibility in the same ways. Parental responsibility awarded by a court can only be removed by a court.

Other people can also acquire parental responsibility for a child:

- a guardian named in a will if no one with parental responsibility survives the person who wrote the will
- a guardian appointed by a court
- when a child is adopted, the adoptive parents
- a local authority (shared with anyone else with parental responsibility) while the child is subject to a care or supervision order. Foster parents rarely have parental responsibility
- for a child born under a surrogacy arrangement, parental responsibility will lie with the surrogate mother (and her husband if she married) until the intended parents either (a) obtain a parental

order from a court under the Human Fertilisation and Embryology Act 1990, or (b) adopt the child.

Parents are also entitled to authorise another person to take over particular responsibilities. For example, a parent may sign consent for another person to take the child for immunisation or to collect medication.

What if the parents are divorced?

Parents do not lose parental responsibility if they divorce – nor can a separated or divorced parent relinquish parental responsibility. This is true even if the parent without custody does not have contact with the child and does not make any financial contribution.

Until what age can parental responsibility be exercised?

In [England, Wales](#) and [Northern Ireland](#), parental responsibilities may be exercised until a young person reaches 18 years. In [Scotland](#), only the aspect of parental responsibilities concerned with the giving of 'guidance' endures until 18 years – guidance meaning the provision of advice. The rest is lost when the young person reaches 16 years, although some may be lost before this if the child attains legal capacity to act on his or her own behalf.

What is the role of parents who do not have parental responsibility?

It should be noted that parents who do not have parental responsibility may also play an essential role in determining best interests and may have a right,

under the Human Rights Act, to participate in treatment decisions.

What happens if there is a disagreement between people with parental responsibility?

Generally, the law requires doctors to have consent from only one person in order lawfully to provide treatment. In practice, however, parents sometimes disagree and doctors are reluctant to override a parent's strongly held views, particularly when it is not clear what is best for the child. Discussion aimed at reaching consensus should be attempted. If this fails, a decision must be made by the clinician in charge whether to go ahead despite the disagreement. The onus is then on the parent who refuses treatment to take steps to stop it. If the dispute is over an irreversible, controversial, elective procedure, for example male infant circumcision for religious purposes or immunisation when it is known one of the parents objects, doctors must not proceed without the authority of a court (see Card 6 on disputes – when to seek legal advice). In [Scotland](#), however, the Children Act imposes an obligation on any person exercising a parental responsibility or parental right to have regard to the views of any other person with the same rights and responsibilities.

What if the parents aren't communicating with each other?

There are occasions when parents do not communicate with each other but both want to be involved in their child's health care. For example, GPs are frequently asked to tell the parent with whom the child is not resident when

Parental responsibility

the other parent brings the child to the surgery. There is no requirement on GPs to agree to such requests, which could entail a lot of time and resources if the child presents frequently. It is clearly better if parents are able to communicate with each other about their child's health, although doctors may agree to contact the absent parent under certain circumstances, for example if there is a serious concern.

Where a procedure is controversial, however, for example non-therapeutic circumcision, if a child presents with only one parent, the doctor must make every effort to contact the other parent in order to seek consent.

Key advice

- BMA. *Parental responsibility*. Available at www.bma.org.uk/ethics

CARD 4

Consent and refusal

Who can consent to a child's or young person's treatment?

The following are legally entitled to give consent to medical treatment of a child or young person:

- a competent child or young person (see Card 2 on assessing competence)
- a parent or other person or agency with parental responsibility where the decision is in the best interests of the child (see Cards 3 and 5 on parental responsibility and best interests)
- a court
- an appointed proxy (in [Scotland](#) where the patient is over 16 and unable to make decisions for him or herself) (see Card 12 on mental capacity); or
- a person caring for a child, for example a grandparent or child minder, may do what is reasonable in the circumstances to safeguard or promote the child's welfare (see Card 3 on parental responsibility). In [Scotland](#), the primacy of any known wishes of the parents in these situations has statutory force. If a carer brings a child for treatment, steps should be taken to ascertain the parents' views, and if there is doubt about authority to proceed, doctors should seek legal advice.

Are there any procedures a young person over 16 years old is not presumed to be competent to consent to?

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

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

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

The same principles apply to advance decisions to refuse treatment. In UK jurisdictions where a young person's contemporaneous refusal of treatment may

not be determinative, it follows that advance decisions to refuse treatment made by young people cannot be legally binding on health professionals.

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

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

Can a person with parental responsibility refuse treatment?

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

In an emergency, where consent is unavailable, on what basis can a child or young person be treated?

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

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

Key advice

- BMA. *Consent, rights and choices in health care for children and young people* – chapters 2 and 3. More information available at www.bma.org.uk/ethics
- Department of Health. *Seeking consent: working with children*. Available at www.dh.gov.uk

CARD 5

Best interests

Who decides what is in a child's or young person's best interests?

Where a child lacks competence there is a presumption that the child's parents have the child's best interests at heart. This is not always the case, however, and doctors should be alert to situations in which parents' decisions appear to be contrary to their child's interests.

Where a young person is competent, the young person's views on what would be in his or her 'best interests' are of importance to the decision-making process, although they may not always be determinative.

What needs to be taken into account when assessing a child's or young person's best interests?

A best interests judgement is as objective a test as possible of what would be in the child's actual best interests, taking into account all relevant factors. It is customary to assume that a person's interests are usually best served by measures that offer the hope of prolonging life or preventing damage to health, but this is not always the case. A number of factors should be considered, including:

- the patient's own wishes, feelings and values (where these can be ascertained)
- the patient's ability to understand what is proposed and weigh up the alternatives

Best interests

- the patient's potential to participate more in the decision, if provided with additional support or explanations
- the patient's physical and emotional needs
- clinical judgment about the effectiveness of the proposed treatment, particularly in relation to other options
- where there is more than one option, which option is least restrictive of the patient's future choices
- the likelihood and extent of any degree of improvement in the patient's condition if treatment is provided
- risks and side effects of the treatment or non-treatment
- the views of parents and others who are close to the patient about what is likely to benefit the patient
- relevant information about the patient's religious or cultural background
- the views of other health care professionals involved in providing care to the child or young person, and of any other professionals who have an interest in their welfare.

What if there is disagreement over what is in a child's or young person's best interests?

Where there is disagreement over what is in the best interests of a child or young person, further discussion should take place and a second opinion should be offered, but it may be necessary to seek legal advice. In the interim only emergency treatment that is essential to preserve life or prevent serious deterioration should be provided (see Cards 3 and 6 on parental responsibility and disputes).

Best interests

Key advice

- General Medical Council. *0-18 years: guidance for all doctors* – sections 12 and 13. Available at www.gmc-uk.org

CARD 6

Disputes

When do disputes occur?

Ideally, medical decisions are made in partnership between the patient, the family, and the health team, with the parental role gradually fading as the child develops in maturity. Disputes arise, however, where there is a difference of opinion as to what is in a child's or young person's best interests. For example, there could be a disagreement between a competent young person and their parents or the courts; the parents disagree with each other; or the family may oppose the treatment plan suggested by the health team.

How should a dispute be approached?

Many disputes arise because of poor communication and all efforts should be made to avoid this. An independent second opinion may be helpful in resolving some disagreements but ultimately, some may have to be resolved by the courts. Health professionals must always focus on the overall best interests of the child or young person.

When should legal advice be sought?

Legal advice should be sought swiftly when:

- agreement over how to proceed cannot be reached (for example where consent is refused by the holders of parental responsibility)
- a competent young person refuses an intervention or invasive treatment that the health care team considers necessary

Disputes

- administering treatment against the wishes of a competent young person would require the use of restraint or force
- it is not clear whether the people with parental responsibility are acting in the best interests of the child
- the proposed care is beyond the scope of parental consent because it is controversial or non-therapeutic (for example sterilisation, organ donation and circumcision if parents disagree)
- the courts have stated that they need to review a particular decision
- the treatment requires detention outwith the provisions of mental health legislation
- the people with parental responsibility lack the competence to make the decision
- the child is a ward of court and the proposed step is important; or
- the proposed course of action might breach a person's human rights under the Human Rights Act 1998.

If agreement cannot be reached in a reasonable period of time, which will depend on the nature and likely course of the patient's condition, lawyers may advise that it is necessary to seek a court order. Parents, and where appropriate the patient, should be informed and told how to seek legal representation.

How can involving the courts help?

Going to court can be distressing for those concerned and it is essential that ongoing support is provided for the child, the parents, other relatives and carers, and the health care team. There are great benefits, however, in a legal system that can

Disputes

give rulings very quickly when necessary. The law can provide a protective role for both patients and the health care team who treat them and where there is disagreement that cannot be resolved.

Can the courts insist on treatment?

In [England](#), [Wales](#), and [Northern Ireland](#) the courts have the power to give consent to treatment on behalf of competent and incompetent patients aged under 18. A court can override a child's refusal or parents' refusal of a particular treatment if there is evidence that it would be in the child or young person's best interests.

In [Scotland](#) the courts have the same powers to give consent to treatment on behalf of people aged under 16 when the child is not competent to give valid consent for himself or herself. It is unclear whether a Scottish court may override the decision of a child if the medical practitioner believes the child is competent, although it is thought that this is unlikely.

The courts cannot, however, require doctors to treat contrary to their professional judgment.

Key advice

- General Medical Council. *0-18 years: guidance for all doctors*. Available at www.gmc-uk.org
- BMA. *The law and ethics of male circumcision: guidance for doctors*. Available at www.bma.org.uk/ethics

CARD 7

Use of restraint to provide treatment

Can doctors restrain children or young people to provide treatment against their wishes?

Once a decision has been made that it is lawful and ethically acceptable to override a refusal of treatment (see Card 4 on consent and refusal), in principle there cannot be an absolute prohibition on the use of force to carry it out. However, doctors must look at the patient's overall interests, and whether imposing treatment is a proportionate interference given the expected benefits.

What factors should be taken into account when considering the use of restraint?

Doctors should consider if imposing treatment could damage the young person's current and future relationships with health care providers and undermine trust in the medical profession. It is important for young people to understand that restraint of any form in order to provide treatment is used only as a matter of last resort and not until other options for treatment have been explored. The child and the family must be offered continual support and information throughout the period of treatment.

If, after spending as much time as is practicable, it is impossible to persuade a child to cooperate with essential treatment, the clinician in charge of the patient's care may decide that restraint is appropriate.

Use of restraint to provide treatment

The following points are relevant to any action taken.

- Restraint should be used only when it is necessary to give essential treatment or to prevent a child from significantly injuring himself or herself or others.
- The effect should be to provide an overall benefit to the child and in some cases the harms associated with the use of restraint may outweigh the benefits expected from treatment.
- Restraint is an act of care and control, not punishment, and should be administered with due respect.
- Unless life prolonging or other crucial treatment is immediately necessary, legal advice should be sought when treatment involves restraint or detention to override the views of a competent young person, even if the law allows doctors to proceed on the basis of parental consent.
- All steps should be taken to anticipate the need for restraint and to prepare the child, his or her family, and staff.
- Wherever possible, the members of the health care team involved should have an established relationship with the child and should explain what is being done and why.
- Treatment plans should include safeguards to ensure that restraint is the minimum necessary, that it is for the minimum period necessary to achieve the clinical aim, and that both the child and the parents have been informed what will happen and why restraint is necessary.
- Restraint should usually be used only in the presence of other staff, who can act as assistants and witnesses.

- Any use of restraint should be recorded in the medical records. These issues are an appropriate subject for clinical audit.

Who is responsible for the decision to use restraint?

Members of the health team should be given an opportunity to express their views and to participate in decision-making, although ultimate responsibility rests with the clinician in charge of care. All staff require support, and must not be asked to be involved in restraining a child without proper training.

Can children and young people be detained to provide medical treatment?

Detaining children for the purpose of providing medical treatment raises serious legal issues. Legal advice is essential before children are detained outwith the provisions of mental health legislation, and court approval will be necessary. A court asked to rule on such an issue is required to have regard to the young person's rights under the Human Rights Act 1998, and whether, in the circumstances, detention is compatible with these. For example, the right not to be subjected to inhuman or degrading treatment (Article 3), the right to liberty and security (Article 5), and the right to a fair hearing (Article 6).

CARD 8

Children and young people's health information

When is a duty of confidentiality owed to a child or young person?

A duty of confidentiality is owed to all children and young people. The duty owed is the same as that owed to an adult.

When is a young person competent to consent to the disclosure of his/her personal information?

In [England](#), [Wales](#) and [Northern Ireland](#) children who are aged 12 or over are generally expected to have competence to give or withhold their consent to the release of information. In [Scotland](#), anyone aged 12 or over is legally presumed to have such competence.

Younger children may also be competent to make decisions regarding the control of their health information (see Card 2 on assessing competence). Health professionals should, unless there are convincing reasons to the contrary, for instance abuse is suspected, respect the child's wishes if they do not want parents or guardians to know about all or aspects of their health care (see Card 11 on child protection). However, every reasonable effort must be made to persuade the child to involve parents or guardians particularly for important or life-changing decisions.

Are there limits to confidentiality if a child lacks competence?

The duty of confidentiality owed to a child who lacks competence is the same as that owed to any other person. Occasionally, young people seek medical treatment, for example, contraception, but are judged to lack the competence to give consent. A child's confidentiality should be respected when information is shared on the understanding that the information will not be disclosed to parents or guardians, or indeed to any third party, save in the most exceptional circumstances, for example, where it puts the child at risk of significant harm or there is a suspicion that the child is being abused, in which case disclosure may take place in the 'public interest' without consent. Therefore, even where the health professional considers a child to be too immature to consent to the treatment requested, confidentiality should still be respected concerning the consultation, although parental involvement should be encouraged, unless there are very convincing reasons to the contrary.

GMC guidance states that where a child who lacks capacity refuses disclosure if the doctors 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' (GMC. *0-18 years: guidance for all doctors*, paragraph 51).

Where a health professional decides to disclose information to a third party against a child's wishes, the child should generally be told before the information is disclosed. The discussion with the child and the reasons for disclosure should be documented in the child's record.

Can someone with parental responsibility refuse disclosure of a child's or young person's personal information?

Anyone with parental responsibility can give or withhold consent to the release of information where the child lacks competence. Where an individual who has parental responsibility refuses to share relevant information with other health professionals or agencies and the health professional considers that it is not in the best interests of the child, (for example, it puts the child at risk of significant harm), disclosure may take place in the public interest without consent (see Cards 5 and 11 on best interests and child protection). Parents should usually be informed of the information and reasons in advance of a disclosure.

What if there are concerns a child or young person is at risk of abuse or neglect?

Where health professionals have concerns about a child or young person who may be at risk of abuse or neglect, it is essential that these concerns are acted upon and information is given promptly to an appropriate person or statutory body, in order to prevent further harm (see Card 11 on child protection).

Children and young people may try and elicit a promise of confidentiality from adults to whom they disclose abuse. Doctors must avoid making promises

of confidentiality that they cannot keep. Where doctors believe that, in the interests of the child or others, it is important that action is taken, they need to discuss disclosure with the child, and, if possible, the child should be given sufficient time to come to a considered decision. If the child cannot be persuaded to agree to voluntary disclosure, and there is an immediate need to disclose information to an outside agency, he or she should be told what action is to be taken, unless to do so would expose the child or others to increased risk of serious harm.

Who can access a child's or young person's health record?

Competent children and young people may apply for access to their own records, or may authorise others to do so on their behalf. It is not necessary for competent patients to give reasons as to why they wish to access their records.

Furthermore, anyone with parental responsibility has a statutory right to apply for access to their child's health records. If the child is capable of giving consent, access may only be given with his or her consent. It may be necessary to discuss parental access alone with children if there is a suspicion that they are under pressure to agree. (For example, the young person may not wish a parent to know about a request for contraceptive advice.) If a child lacks the competence to understand the nature of an application but access would be in his or her best interests, it should be granted. Parental access must not be given where it conflicts with the child's best interests and any information that a child revealed in the expectation that it would not be disclosed should not be released unless it is in the child's best interests to do so.

Where parents are separated, and both have parental responsibility, and one of them applies for access to the medical record, doctors are under no obligation to inform the other parent, although they may consider doing so if they believe it to be in the child's best interests. It is advisable to make a note of when and who accessed the record.

If a child lacks competency the GMC advises that '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'.

Key advice

- BMA. *Access to health records*. Available at www.bma.org.uk/ethics
- BMA. *Confidentiality and disclosure of health information tool kit*. Available at www.bma.org.uk/ethics
- GMC. *0-18 years: guidance for all doctors*. Available at www.gmc-uk.org
- Northern Ireland Department of Health, Social Services and Public Safety. *Code of Practice on Protecting the Confidentiality of Service User Information*. Available at www.dhsspsni.gov.uk
- Department of Health. *Confidentiality: NHS Code of Practice*. Available at www.dh.gov.uk
- Scottish Government Health Directorates. *NHS Code of Practice on Protecting Patient Confidentiality*. Available at www.ehealth.scot.nhs.uk

CARD 9

Unaccompanied minors

Can children or young people make appointments for themselves?

Health care staff should not prohibit children and young people making appointments and seeing a doctor without an accompanying adult. Although there are circumstances in which it is reasonable for doctors to want a parent present – because, for example, the child has a serious condition and needs help in complying with a treatment regime – a rule prohibiting young patients attending alone could lead to a complaint against the doctor and is also not good practice. Establishing a trusting relationship between the patient and doctor at this stage will do more to promote health than if doctors refuse to see young patients without involving parents. Both ethically and contractually, GPs, for example, are required to provide immediately necessary treatment and so they need to ascertain the kind of care patients are seeking. Although doctors are now less likely to try to ban unaccompanied minors, they may remain anxious about seeing young patients – especially in very sensitive or complex situations – without any input from an appropriate adult. The possible provision of family or parental support needs to be at least raised in the consultation even though patients may reject the notion for various reasons and their views then need to be respected.

Is there a minimum age for consultations?

There is no reason why a patient of any age, who is capable of communicating, should not be able to ask to see a doctor in private. Doctors too may want to ask to see a patient alone. If, for example, a doctor suspects that a child is experiencing any form of child abuse, neglect or bullying, it may be appropriate to talk to the child privately (see Card 11 on child protection).

What if a child or young person fails to collect test results?

Where possible health professionals should arrange in advance how competent children and young people will collect test results, and what should happen if they fail to collect them. If a prior arrangement has not been agreed, doctors should examine all reasonable options, including writing to or telephoning the patient, with due regard to confidentiality. If the young person lives with his or her parents and does not want the parents to know of the health interaction this should be borne in mind when examining the best way of contacting the patient.

Should a chaperone always be offered when a child or young person is unaccompanied?

A parent or carer often acts as a chaperone for children or young people, but in the case of unaccompanied children or young people, they may be unaccompanied because they do not wish a parent or carer to be present. In these cases consideration should be given to the GMC's guidance *0-18 years*, which states 'you should think carefully about the effect the presence of a

Unaccompanied minors

chaperone can have. Their presence can deter young people from being frank and from asking for help’.

If a doctor needs to perform an intimate examination, however, the GMC’s general advice is that wherever possible, a chaperone should be offered. If either the doctor or the patient does not wish the examination to proceed without a chaperone present, or if either is uncomfortable with the choice of chaperone, the doctor may offer to delay the examination to a later date when a chaperone (or an alternative chaperone) will be available, if this is compatible with the patient’s best interests. If the patient does not want a chaperone, the doctor should record that the offer was made and declined.

Key advice

- NHS Clinical Governance. *Guidance on the Role and Effective Use of Chaperones in Primary and Community Care.*
- GMC. *Maintaining Boundaries.* Available at www.gmc-uk.org
- GMC. *0-18 years: guidance for all doctors.* Available at www.gmc-uk.org

CARD 10

Sexual activity

Are there limits to what interventions a competent young person can consent to?

As with other medical interventions, a competent young person may give valid consent to abortion, contraception and treatment for a sexually transmitted infection, regardless of age or parental involvement, although every reasonable effort must be made to persuade the child to involve their parents or guardians. The courts have also confirmed that a parent's refusal to give consent for an abortion cannot override the consent of a competent young person. With respect to providing contraceptives, doctors should take into account whether the patient is likely to have sexual intercourse without contraception; assess whether the patient's physical or mental health or both are likely to suffer if the patient does not receive contraceptive advice or supplies; consider whether the patient's best interests would require the provision of contraceptive advice or methods or both without parental consent.

Sexual activity in someone under the age of 13 *will always* be a cause for concern (see later question). The need to share information without consent to protect the young person must be balanced against the need to provide a service that encourages young people to seek help when they need it. Where health professionals believe that children may be subject to coercion or exploitation, existing

Sexual activity

child protection guidelines must be followed. Health professionals with concerns should seek advice and help, anonymously if necessary, from colleagues with expertise in child protection, such as named and designated professionals (see Card 11 on child protection).

What if the young person lacks capacity?

If a young person lacks competence, somebody with parental responsibility can legally give consent for the provision of contraception and abortion (provided the legal requirements of abortion legislation are met). If a young person lacks competence to consent validly to the provision of contraceptives (for the purpose of providing contraception) and termination of pregnancy, this raises the question over the ability of the young person to consent to sexual intercourse. In cases of doubt or difficulty, doctors should seek legal advice. If there are concerns that a child is being sexually abused, doctors should act in accordance with child protection guidelines.

Does a doctor need to inform the police or social services of all underage sexual activity?

No, only when there are concerns that the young person is being abused. The GMC's *0-18 years* guidance states that doctors 'should usually share information about sexual activity involving children under 13, who are considered in law to be unable to consent'. Doctors 'should discuss a decision not to disclose with a named or designated doctor for child protection and record [your] the decision and the reasons for it' (GMC. *0-18 years: guidance for all doctors*, paragraph 67). While reporting to social

services or the police should always be considered where the individual is very young, the obligation of health professionals is to act in the best interests of the patient and this requires flexibility. Where a health professional decides to disclose information to a third party against a child's wishes, the child should generally be told before disclosing the information. The discussion with the patient and the reasons for disclosure should also be documented in the patient's record.

Does a doctor need to inform the parents of a young person?

In most cases no. If children under 16 are competent to understand what is involved in the proposed treatment, the health professional should, unless there are convincing reasons to the contrary, for instance abuse is suspected, respect the patient's wishes if they do not want their parents or guardians to know. However, every reasonable effort must be made to persuade the child to involve their parents or guardians, and explore the reasons if the patient is unwilling to do so, particularly for important or life-changing decisions.

Occasionally, young people seek medical treatment, for example contraception but are judged to lack the capacity to give consent. An explicit request by a patient that information should not be disclosed to parents or guardians, or indeed to any third party must be respected save in the most exceptional circumstances, for example where the health, safety or welfare of the patient or another individual would be at risk. Therefore, even where the health professional considers that a child is too immature

Sexual activity

to consent to the treatment requested, confidentiality should still be respected concerning the consultation, unless there are very convincing reasons to the contrary.

Is it legal to provide contraception, sexual and reproductive health care without parental involvement?

Many of these above principles are supported by statute. For example, the Sexual Offences Act 2003 provides a legal framework aimed at protecting children from sexual abuse. Under the Act, young people under the age of 16 still have the right to confidential advice on contraception, sexual and reproductive health. The bulk of the Act applies to England and Wales, with a small number of provisions applicable in Scotland and Northern Ireland. Furthermore, the Sexual Offences (Northern Ireland) Order 2008 lowered the age of consent to sexual activity in Northern Ireland from 17 to 16; and in addition, it established that the provision of sexual health services to individuals under the age of 16 will not constitute an offence.

What if a doctor disapproves of young people being sexually active?

Doctors must not allow any personal views held about a patient to prejudice their assessment of the patient's clinical needs or delay or restrict the patient's access to care. Doctors should not impose their beliefs on patients. Where doctors exercise a conscientious objection, within the limits set by the GMC, doctors should be aware that children and young people in particular may have difficulties making alternative arrangements and

Sexual activity

must, therefore, make sure that arrangements are made for another suitably qualified colleague to take over as quickly as possible (GMC. *0-18 years*, paragraph 72).

What if a GP doesn't provide contraceptive services?

GPs who do not provide contraceptive services must advise young people seeking those services of colleagues whom they could consult. It is acceptable for another GP to offer contraceptive advice and treatment to a competent young person in such circumstances. It must, however, be explained to the patient that it is in her medical interests for her GP to be informed if contraception has been prescribed and of any medical condition discovered, which requires investigation or treatment. This is particularly important if the patient is at the same time under the active clinical care of her own GP or that of another doctor. Providing that young people trust that their confidentiality will be respected by their GP and the Primary Care Team, they are unlikely to refuse a request that information be passed to their usual doctor.

Can sterilisation be performed on children and young people?

Sterilisation is occasionally requested for young women with serious learning difficulties. Although considerably rarer, it may also be suggested as an option for a young man with learning difficulties. Sterilisation for contraceptive purposes should not normally be proposed for young people aged under 18 given that there are other options available. In the exceptional circumstances in which there is

Sexual activity

agreement that sterilisation is the best option for a young person, doctors should seek legal advice in order to obtain a court declaration.

Key advice

- Department of Health. *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*. Available at www.dh.gov.uk/assetRoot/04/08/69/14/04086914.pdf
- GMC. *0-18 years: guidance for all doctors*. Available at www.gmc-uk.org

CARD 11

Child protection

Where doctors have concerns about a child or young person who may be at risk of abuse or neglect, it is essential that these concerns are acted upon, in accordance with local and national guidelines. The best interests of the child or children involved must guide decision-making at all times. 'Child abuse and neglect' is a generic term that includes all maltreatment of children including serious physical and sexual assaults, serious psychological harm, as well as cases where the standard of care does not adequately support the child's health or development.

The National Institute for Health and Clinical Excellence (NICE) has published guidance on the alerting features in children and young people (under 18 years) of – physical, sexual and emotional abuse; neglect; and fabricated or induced illness – details in key advice box below. The guidance highlights the alerting features, according to the level of concern, with recommendations to either 'consider' or 'suspect' maltreatment.

This tool kit Card only offers a very brief summary of the principles that doctors take into account when they have concerns about a child. The BMA has published a specific tool kit – *Child protection: a tool kit for doctors* – to which doctors are strongly advised to refer.

Being alert to a child's welfare

- In child protection cases, a doctor's primary responsibility is to the wellbeing of the child or children concerned. Where a child is at risk of significant harm, the interests of the child override those of parents or carers. Never delay taking emergency action.
- All doctors working with children, parents and other adults in contact with children should be able to recognise, and know how to act upon, signs that a child may be at risk of abuse or neglect, both in a home environment and in residential and other institutions.
- All doctors working directly with children should ensure that safeguarding and promoting their welfare forms an integral part of all stages of the care they offer. Where doctors have patients who are parents or carers, they must also consider the potential impact of domestic violence, drug and alcohol misuse, and health conditions in those adults on the children in their care.

Including children, young people and parents

- Efforts should be made to include children and young people in decisions that closely affect them. The views and wishes of children should therefore be listened to and respected according to their competence and the level of their understanding. In some cases translation, interpreting and signing services suitable for young people may be needed.
- Wherever possible, the involvement and support of those who have parental responsibility for, or regular care of, a child should be encouraged, in so far as this is in keeping with promoting the

Child protection

best interests of the child or children concerned. Older children and young people may have their own views about parental involvement.

Assessment and record keeping

- All doctors working with children, parents and other adults in contact with children must be familiar with relevant local child protection procedures, and must know how to deal promptly and professionally with any child protection concerns raised during their practice.
- When concerns about deliberate harm to or neglect of children or young people have been raised, doctors must keep clear, accurate, comprehensive and contemporaneous notes. This must include a future care plan and identify the individual with lead responsibility.
- As full a picture as possible of the circumstances of a child at risk must be drawn up.
- Where a child presents at hospital, inquiries must be made about any previous admissions.
- Where a child is admitted to hospital, a named consultant must be given overall responsibility for the child protection aspects of the case.
- Any child admitted to hospital about whom there are concerns about deliberate harm or neglect must receive a thorough examination within 24 hours unless it would compromise the child's care or wellbeing.

Discharge

- Where a child at risk is to be discharged from hospital, a documented plan for the future care of the child must be drawn up.

Child protection

- A child at risk must not be discharged from hospital without being registered at an identified GP.
- Any doctor seeing a child who raises concerns must ensure follow-on care. In particular, children must not be discharged from hospital without a full examination.
- All professionals must be clear about their own responsibilities, and which professional has overall responsibility for the child protection aspects of a child's care.

Confidentiality

- Health professionals should not make promises to the child about confidentiality that they may not be able to keep, but as in the case of any patient, trust is best maintained if disclosure is not made without prior discussion between the health professional and the child, unless to do so would expose the child or others to an increased risk of serious harm. Where disclosure is not considered to be in the child's best interests it is recommended that the health professional discusses the matter with an experienced colleague.
- Where there is any doubt as to whether disclosure is in the child's best interests, it is recommended that the health professional discusses the matter, without revealing the identity of the child, with an experienced colleague, the Caldicott guardian, their professional body or defence body. Health professionals must ensure that their concerns, and the actions they have taken, or intend to take, including any discussion with the child,

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colleagues or professionals in other agencies, are clearly recorded in the child's medical record.

Key advice

- BMA. *Child protection tool kit*. Available at www.bma.org.uk/ethics
- DCSF. *Working together to safeguard children*. Available at www.everychildmatters.gov.uk/workingtogether
- RCGP. *Safeguarding children and young people: a tool kit for general practice*. Available at www.rcgp.org.uk
- Department of Health. *What to do if you're worried a child is being abused*. Available at www.everychildmatters.gov.uk
- RCPCH. *Safeguarding Children and Young People: Roles and Competences for Health Care Staff and Child protection companion*. Available at www.rcpch.ac.uk
- BMA. *Female genital mutilation*. Available at www.bma.org.uk/ethics
- GMC. *0-18 years: guidance for all doctors*. Available at www.gmc-uk.org
- National Institute for Health and Clinical Excellence. *When to suspect child maltreatment. NICE clinical guideline 89*. Available at www.nice.org.uk

CARD 12

16-17 year olds who lack mental capacity

There may be occasions when a 16-17 year old, who would usually be presumed to be competent to make decisions, may lack capacity or may become incapacitated. In these circumstances doctors are advised to look at more detailed guidance on mental capacity and they may need to seek expert advice.

On what basis can decisions be made for 16-17 year olds who lack capacity?

In [England](#) and [Wales](#) most of the Mental Capacity Act 2005 applies to 16-17 year olds who lack capacity because of an impairment of, or a disturbance in the functioning of, the mind or brain. At the heart of the Act lies the principle that any decision or action taken must be in the best interests of the 16-17 year old who lacks capacity.

There are some provisions in the Act that do not apply to 16-17 year olds, namely:

- they cannot make a Lasting Power of Attorney (LPA)
- they cannot make an advance decision to refuse medical treatment
- the Court of Protection cannot make a statutory will.

In [Scotland](#), the Adults with Incapacity (Scotland) Act 2000 sets out the framework for regulating

intervention in the affairs of adults (people over 16) who have impaired capacity. It allows people over the age of 16 who have capacity to appoint a welfare attorney to make health and personal welfare decisions once capacity is lost. The Court of Session may also appoint a deputy to make these decisions.

In [Northern Ireland](#), the GMC advises that 'treatment can be provided in the young person's best interests if a parent cannot be contacted, although' doctors 'should seek legal advice about applying for court approval for significant (other than emergency) interventions' (GMC. *0-18 years*, paragraph 28).

There are plans to introduce new legislation relating to both mental health and mental capacity in [Northern Ireland](#). Details of any changes will be posted on the BMA website www.bma.org.uk

Key advice

England and Wales

- BMA. *Mental Capacity Act tool kit*. Available at www.bma.org.uk/ethics
- DCA. *Mental Capacity Act 2005: Code of Practice* – chapter 12. Available at www.publicguardian.gov.uk

Scotland

- BMA. *Medical Treatment For Adults With Incapacity: Guidance On Medico-Legal Issues in Scotland*. Available at www.bma.org.uk/ethics

CARD 13

Compulsory treatment for a mental disorder

When should mental health legislation be used?

In most cases treatment and support for a young person's mental disorder is provided with consent. In some circumstances, however, mental health legislation can provide a legal structure for compulsory psychiatric care and treatment for a young person's mental disorder. Compulsory treatment cannot be used to provide treatment for physical illness unrelated to the mental disorder. Although for some patients severe mental illness is associated with a corollary lack of capacity, mental disorder does not automatically diminish patient's legal capacity.

Doctors who believe that the legislation may apply to one of their young patients but who are unfamiliar with the legislation should seek expert advice.

What legislation is applicable in England and Wales?

The Mental Health Act 2007 applies to all children and young adults under 18. The Act contains some new provisions and specific safeguards for under 18s. Amongst other things:

- 16 and 17 year olds with capacity cannot have their consent or refusal to informal admission to hospital, or registered establishment for

Compulsory treatment for a mental disorder

treatment of a mental disorder, overridden by those with parental responsibility

- at least one of the people involved in the assessment on admission and treatment under the Act should be a clinician specialising in Child and Adolescent Mental Health Services (CAMHS). Where this is not possible, a CAMHS clinician should be consulted as soon as possible
- ECT cannot be given without approval of a second opinion appointed doctor (SOAD) even if the child/young person consents to it, unless it is an emergency
- children/young people detained under the Act must be referred after one year (as opposed to three for adults) for a tribunal hearing.

What legislation is applicable in Scotland?

Where a patient is detained, the Mental Health (Care and Treatment) (Scotland) Act 2003 procedures must be followed. The Act contains some provisions and specific safeguards for under 18s. Namely, none of the regulated treatments for mental disorder may be provided to an incapacitated patient who is 16 or 17 unless either the doctor in charge of care has a qualification, or special experience, in child and adolescent psychiatry or that doctor has sought and obtained an opinion in writing from a doctor who does. In addition, the practitioner appointed by the Mental Welfare Commission must have a qualification, or special experience, in child and adolescent psychiatry or another specialism appropriate to the treatment of the patient.

What legislation is applicable in Northern Ireland?

The Mental Health (Northern Ireland) Order 1986 applies to all children and young adults under 18. There are no specific safeguards for under 18s.

There are plans to introduce new legislation relating to both mental health and mental capacity in Northern Ireland. Details of any changes will be posted on the BMA website www.bma.org.uk/ethics

Key advice

England and Wales

- Department of Health. *Code of Practice Mental Health Act 1983* – chapter 36. Available at www.dh.gov.uk

Scotland

- BMA. *Medical Treatment For Adults With Incapacity: Guidance On Medico-Legal Issues in Scotland*. Available at www.bma.org.uk/ethics

CARD 14

Research and innovative treatment

Can children and young people be involved in research and innovative treatment?

Children and babies should be eligible for inclusion in research and innovative therapy, with appropriate safeguards. To fail to do research would lead to stagnation of current practice and the continuation of medical management by using untried or unproven remedies on the basis of belief rather than best evidence. The need for pharmaceutical products specifically designed for use by children has long been recognised. These need to be developed with the involvement of children and young people once initial studies involving adults have proved the safety and efficacy of the product. There must be no financial reward to the child or parent (expenses are permitted) and all projects must be carefully scrutinised by a research ethics committee.

Who can consent to their involvement in research and innovative treatment?

Families need support and independent advice about their options. The final decision about participation rests with patients (when competent) and with parents. Children and their parents must be given clear and appropriate information, with candid explanations of the purposes, risks, and expected benefits of the research. If competent, the child must give unpressured and informed consent. Depending on the nature of the research, and the

research ethics committee's view, parental consent may also be required, even if the child is competent.

What if the parents consent but the child refuses?

When the procedures are more intrusive than those required for ordinary clinical care, a child's (verbal or non-verbal) refusal is good reason not to proceed even if parental consent has been obtained, unless it would be in a child's best interests.

What if one parent consents but another refuses?

Legally, the consent of one person with parental responsibility should suffice if the intervention is not contrary to the child's interests, and there are obvious circumstances when the consent of one parent has to be sufficient because, for example, the child is in contact with only one parent. Nevertheless, the reasons for one parent refusing would need to be taken very seriously.

Can children and young people be involved in emergency care trials?

Yes, children can take part in emergency care trials, when there would be no time to seek initial consent before administering the medicine, if certain criteria are met. In 2008, the Medicines for Human Use (Clinical Trials) and Blood Safety and Quality Amendment was passed. As well as amending the Blood Safety and Quality Regulations 2005, this amended the regulations to enable children to be involved in emergency trials in certain circumstances. The MHRA has published an explanatory memorandum (see key advice).

Key advice

- Medical Research Council. *Medical research involving children*. Available at www.mrc.ac.uk
- Royal College of Paediatrics and Child Health. *Safeguarding informed parental involvement in clinical research involving new-born babies and infants*. Available at www.rcpch.ac.uk
- MHRA. *Explanatory memorandum to the medicines for human use (clinical trials) and blood safety and quality (amendment) Regulations 2008. no. 941*.

CARD 15

Useful names and addresses

British Medical Association

Medical Ethics Department, BMA House,
Tavistock Square, London WC1H 9JP.

Tel: 020 7383 6286

Fax: 020 7383 6233

Web: www.bma.org.uk/ethics

Department of Health

Wellington House,
133-55 Waterloo Road, London SE1 8UG.

Tel: 020 7972 2000

Web: www.doh.gov.uk

Faculty of Pharmaceutical Medicine

1 St Andrew's Place, Regent's Park,
London NW1 4LB.

Tel: 020 7224 0343

Fax: 020 7224 5381

Web: www.fpm.org.uk

General Medical Council

Regents Place, 350 Euston Road,
London, NW1 3JN.

Tel: 020 7189 5404

Fax: 020 7189 5401

Web: www.gmc-uk.org

Health Professions Council

Park House, 184 Kennington Park Road,

London SE11 4BU.

Tel: 020 7582 0866

Fax: 020 7820 9684

Web: www.hpc-uk.org

Medical and Dental Defence Union of Scotland

Mackintosh House, 120 Blythswood Street,

Glasgow G2 4EA.

Tel: 0141 221 5858

Fax: 0141 228 1208

Web: www.mddus.com

Medical Defence Union

230 Blackfriars Road, London SE1 8PG.

Tel: 020 7202 1500

Fax: 020 7202 1666

Web: www.the-mdu.com

Medical Foundation for AIDS and Sexual Health

BMA House, Tavistock Square, London WC1H 9JP.

Tel: 020 7383 6345

Fax: 020 7388 2544

Web: www.medfash.org.uk

Medical Protection Society

33 Cavendish Square, London W1G 0PS.

Tel: 0845 605 4000

Fax: 020 7399 1301

Web: www.mps.org.uk

Northern Ireland Department of Health, Social Services and Public Safety

Castle Buildings, Stormont, Belfast BT4 3SJ.

Tel: 028 90520500

Web: www.dhsspsni.gov.uk

NSPCC

Helpline: 0808 800 5000

Email: help@nspcc.org.uk

Web: www.nspcc.org.uk

Nursing and Midwifery Council

23 Portland Place, London W1B 1PZ.

Tel: 020 7637 7181

Fax: 020 7436 2924

Web: www.nmc-uk.org

Office of the Public Guardian and the Court of Protection (England and Wales)

Archway Tower, 2 Junction Road,
London N19 5SZ.

Tel: 0845 330 2900

Fax: 020 7664 7705

Web: www.publicguardian.gov.uk

Office of the Public Guardian (Scotland)

Hadrian House, Callendar Business Park,
Callender, Road, Falkirk FK1 1XR.

Tel: 01324 678300

Fax: 01234 67830

Web: www.publicguardian-scotland.gov.uk

Royal College of General Practitioners

14 Princes Gate, Hyde Park, London SW7 1PU.

Tel: 020 7581 3232

Fax: 020 7225 3047

Web: www.rcgp.org.uk

Royal College of Nursing

20 Cavendish Square, London W1M 0AB.

Tel: 020 7409 3333

Web: www.rcn.org.uk

**Royal College of Obstetricians and
Gynaecologists**

27 Sussex Place, London NW1 4RG.

Tel: 020 7772 6200

Fax: 020 7723 0575

Web: www.rcog.org.uk

Royal College of Paediatrics and Child Health

50 Hallam Street, London W1N 6DE.

Tel: 020 7307 5600

Fax: 020 7307 5601

Web: www.rcpch.ac.uk

Royal College of Physicians

11 St Andrew's Place, London NW1 4LE.

Tel: 020 7935 1174

Fax: 020 7487 5218

Web: www.rcplondon.ac.uk

**Royal College of Physicians and Surgeons
of Glasgow**

232-42 St Vincent Street, Glasgow G2 5RJ.

Tel: 0141 221 6072

Fax: 0141 221 1804

Web: www.rcpsglasg.ac.uk

Royal College of Physicians of Edinburgh

9 Queen Street, Edinburgh EH2 1JQ.

Tel: 0131 225 7324

Fax: 0131 220 3939

Web: www.rcpe.ac.uk

Royal College of Psychiatrists

17 Belgrave Square, London SW1X 8PG.

Tel: 020 7235 2351

Fax: 020 7245 1231

Web: www.rcpsych.ac.uk

Royal College of Surgeons of Edinburgh

Nicolson Street, Edinburgh EH8 9DW.

Tel: 0131 527 1600

Fax: 0131 557 6406

Web: www.rcsed.ac.uk

Royal College of Surgeons of England

35-43 Lincoln's Inn Fields, London WC2A 3PN.

Tel: 020 7405 3474

Fax: 020 7831 9438

Web: www.rcseng.ac.uk

Scottish Government Health Directorate

St Andrew's House, Regent Road,

Edinburgh EH1 3DG.

Tel: 0131 556 8400

Fax: 0131 244 8240

Web: www.sehd.scot.nhs.uk/

For further information about these guidelines, BMA members may contact:

0300 123 123 3 or

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Department of Medical Ethics, BMA House
Tavistock Square, London WC1H 9JP.
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Fax: 020 7383 6233
Email: ethics@bma.org.uk

Non-members may contact:

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Public Affairs Department, BMA House
Tavistock Square, London WC1H 9JP.
Tel: 020 7387 4499
Fax: 020 7383 6400
Email: info.public@bma.org.uk

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