

Ethics Toolkit

Children and young
people under 16



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About this toolkit

Questions about children and young people aged under 16 are a significant area of ethical enquiry for the British Medical Association (BMA) with doctors facing ever more complex dilemmas.

The purpose of this toolkit is not to provide definitive answers for every situation but to identify the key factors that need to be considered when such decisions are made, and signpost to other key documents. All sections 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 guidance. In addition, the medical defence bodies and many of the royal colleges produce specific advice for their members. For healthcare professionals who need guidance on the treatment of 16 and 17 year-olds, the BMA has published guidance for England, Wales, and Northern Ireland, and separate guidance for Scotland.

The toolkit is available on the BMA's website. Individual healthcare professionals, trusts, health boards, and medical schools may download it and make copies.

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

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Introduction and basic principles

Questions about children and young people aged under 16 make up a significant area of ethical enquiry for the BMA. High-profile cases around disagreements as to what is in a child's or young person's best interests, child protection, access to sexual health services, and non-therapeutic male circumcision highlight the sensitivity and difficulties doctors face in this area. Doctors need to know when a child or young person under 16 is competent and what this means in terms of their ability to consent and refuse healthcare, and what limits are placed on those with parental responsibility.

This guidance has sections about specific areas relating to the examination and treatment of children and young people in England, Wales, Northern Ireland, and Scotland under the age of 16. For healthcare professionals who need guidance on the treatment of 16 and 17 year-olds, the BMA has published guidance for England, Wales, and Northern Ireland, and separate guidance for Scotland (see key resources).

Basic principles have been established regarding the way 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. Doctors should take this into consideration when deciding what treatments are clinically indicated. Children and young people can expect:

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

Doctors caring for children and young people under the age of 16 have a number of ethical and legal obligations with which they should be familiar and that are outlined in best practice guidance, statute, and case law. For 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, Family Law Reform Act 1969.



Key resources

BMA – [Treatment of 16 and 17-year-olds – England, Wales, and Northern Ireland](#)

BMA – [Treatment of 16 and 17-year-olds – Scotland](#)

GMC – [0-18 years](#)



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Assessing competence

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

Yes, but this needs to be assessed in each case on an ongoing basis. Healthcare professionals 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 can make a valid choice about a proposed medical intervention, or disclosure of personal medical data, and is therefore competent to make their own decision. Healthcare professionals should not judge the ability of a particular child or young person, solely based on their age.

Competent young people under 16 are sometimes referred to as being 'Gillick competent'. For a child or young person under the age of 16 to be competent, they 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);
- 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; and
- freedom from undue pressure.

Gillick competence is specific to the child or young person and to the decision. The level of understanding required will depend on the gravity of the decision.

Who should assess competence?

Healthcare professionals who assess competence need to be skilled and experienced in discussions with young patients and eliciting their views. The treating doctor may be the most appropriate person, but other members of the healthcare team who have a close rapport with the patient may also have valuable contributions to make. The healthcare professional providing the treatment must be satisfied that the patient is competent before providing the treatment if they are relying on their consent.

How can competence be promoted?

When assessing a child or young person'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. In all cases, however, healthcare professionals should promote an environment in which young patients can 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 resources

GMC – [0-18 years](#)



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Parental responsibility

What is parental responsibility?

Parental responsibility is a legal term that identifies who has particular legal rights and roles for a child. This includes the right to consent to treatment on behalf of a child or young person under 16 who lacks competence, provided the decision is in their best interests (see section 5 on best interests), or if the child or young person is competent and that is their wish – (see section 4 on consent and refusal).

Do all parents have parental responsibility?

No. Not all parents have parental responsibility. In the UK, a mother automatically acquires parental responsibility at birth.

A father acquires parental responsibility if he is married to the mother at the time of the child or young person's birth (conception in Scotland) or subsequently. An unmarried father will acquire parental responsibility if he is recorded on the child or young person's birth certificate (at registration or upon re-registration).

For births registered outside the UK, the rules for the country where the child or young person resides apply.

Can other people have parental responsibility?

An unmarried father who is not recorded on the child or young person'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.

For a child or young person born under a surrogacy arrangement, parental responsibility will lie with the surrogate mother and, if she is married or in a civil partnership, her husband or partner, until the intended parents either obtain a parental order from a court under the Human Fertilisation and Embryology Act 1990 or adopt the child or young person.

Where the surrogate mother is not married or in a civil partnership, the intended mother or non-biological intended father in the surrogacy arrangement will have parental responsibility jointly with the surrogate mother provided:

- they were treated together in a UK clinic that is licensed by the Human Fertilisation and Embryology Authority (HFEA);
- they both signed the relevant form provided by the clinic, before the child or young person's conception; and
- they are both named on the birth certificate.

Other people can also acquire parental responsibility for a child or young person including:

- 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;
- the adoptive parents when a child or young person is adopted; and
- a local authority, shared with anyone else with parental responsibility, while the child or young person is subject to a care or supervision order (foster parents rarely have parental responsibility).



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Parents are also entitled to authorise another person to take over particular responsibilities. For example, a parent may consent for another person to take the child for a vaccination, 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 or young person and does not make any financial contribution.

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.

Are there any limits to what people with parental responsibility can consent to?

The moral authority behind parental responsibility depends on the entirely reasonable supposition that parents will act in the best interests of their children. If it appears, however, that parents are following a course of action which is contrary to their child's best interests, their decisions can be challenged. Where doctors believe that parental decisions are not in the best interests of the child or young person, it may be necessary to seek a view from the courts. In the interim, in terms of any treatment on which there is dispute, only that which is essential to preserve life or prevent serious deterioration should be provided.

Do doctors need consent from more than one parent to proceed with treatment?

Generally, the law requires doctors to have consent from only one person to lawfully provide treatment. For complex, or controversial, treatment decisions, if there is more than one person with parental responsibility, it would be good practice to enquire and document if the other parent(s) are aware of the proposed treatment, and if they would have any objections or concerns about it.

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

As stated above, generally, the law requires doctors to have consent from only one person to lawfully provide treatment. In the context of relying upon the consent of a person with parental responsibility, this means that it is possible in principle to rely upon the consent of one parent. In practice, however, parents sometimes disagree, and healthcare professionals are often reluctant to override a parent's strongly held views, particularly when it is not clear what is best for the child or young person. Discussions aimed at reaching a 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 (see section 7 on disputes). There are a small number of situations where the consent of both parents, or the authorisation of a court, is required (see section 13 on vaccination, and section 15 on non-therapeutic male circumcision).



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What if the parents are not 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 healthcare. For example, GPs are frequently asked to tell the parent with whom the child or young person is not resident when the other parent brings the child or young person to the surgery. There is no requirement for GPs to agree to such requests, which could entail a lot of time and resources if the child or young person presents frequently, 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, for example, non-therapeutic male circumcision, if a child presents with only one parent, the doctor must contact the other parent to seek consent (see section 15 on non-therapeutic male circumcision).



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Consent and refusal

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

The following are legally entitled to give consent to medical treatment of a child or young person under 16 in their best interests:

- a competent child or young person (see section 2 on assessing competence);
- a parent or other person or agency with parental responsibility where they are asked to do so by a competent child or young person;
- a parent or other person or agency with parental responsibility where the child or young person is not competent, and the decision is in their best interests (see sections 3 and 5 on parental responsibility and best interests);
- a person caring for a child, for example, a grandparent or childminder, who may do what is reasonable in the circumstances to safeguard or promote the child's welfare. 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; and
- a court.

If a competent young person under 16 can consent to treatment, does it also follow that they can refuse treatment?

No, not always. In England, Wales, and Northern Ireland, a competent refusal by a patient under 16 can be overruled by a court. Healthcare professionals faced with an informed refusal of a treatment they believe to be in the patient's best interests, for example, a refusal of lifesaving treatment or treatment that would prevent permanent injury, should take legal advice.

Whilst in the past, the courts in England and Wales have found that a person with parental responsibility can override a refusal by a competent young person, recent case law in England has given greater weight to a young person's views and suggests a growing trend towards increasing respect for autonomy. If a patient under 16 is competent, and refuses treatment, healthcare professionals should **not therefore** rely upon consent from a person with parental responsibility to override their decision, but should seek legal advice. Although decisions in the English High Court are not binding in Northern Ireland, it is also likely to be the case that a person with parental responsibility in Northern Ireland cannot override a refusal from a competent young person aged under 16, and it is therefore advisable to seek legal advice.

Before making an application to court, healthcare professionals must consider whether the harms associated with imposing treatment on a competent young person aged under 16 who refuses, outweigh the potential benefits, 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 young person. As much time as is practicable should be taken for discussion, and treatment delayed if that is possible without jeopardising its likely success.

In Scotland, there are indications that the position is different, and that a competent refusal by a child or young person cannot be overridden by any other person, or by the court, even if that treatment is necessary to save or prolong life. However, given the lack of case law, this matter is not beyond doubt and legal advice should be sought when such situations arise.

Can a young person under 16 in England, Wales, and Northern Ireland make a legally binding Lasting Power of Attorney (LPA) or Advance Statement to Refuse Treatment (ADRT)?

In England, Wales, and Northern Ireland, a child or young person cannot make an LPA or a binding ADRT. In the event that a young person under 16 were to document their views and wishes about treatment and were



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subsequently to lose their ability to take part in decisions, their documented wishes (although not binding) would be relevant to the determination of the young person's best interests and should be taken into account.

Can a young person under 16 in Scotland make a legally binding Power of Attorney or Advance Statement to Refuse Treatment?

In Scotland, a child under 16 cannot make a power of attorney. There is no formal provision for advance statements relating to physical health treatment, but it is likely that an advance statement made by a competent child under 16 to refuse physical treatment could not be overridden. This matter is not beyond doubt and legal advice should be sought when such situations arise. The provisions in

Sections 275 and 276 of the Mental Health (Care and Treatment) (Scotland) Act 2003 enable a competent young person aged under 16 to make an advance statement setting out how they would wish to be treated, or not to be treated, should their ability to make decisions about treatment for their mental disorder become significantly impaired as a result of their mental disorder (see section 16 on compulsory treatment for a mental health condition).

Can a person with parental responsibility refuse treatment?

Treatment may be provided, despite the refusal by those with parental responsibility, in three circumstances:

- in an emergency where treatment is considered to be clearly in the child's or young person's best interests;
- a competent young person consents to treatment; or
- the court approves treatment.

Where a child or young person needs 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. Legal advice should be sought in such circumstances.

In a non-emergency situation, where parents have refused treatment that doctors believe to be in a child or young person's best interests, they should seek legal advice.

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 their wishes and nobody with parental responsibility is available, it is legally and ethically appropriate for healthcare professionals to proceed with the 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 no time to refer the matter to court.

If such an emergency involves administering a treatment to which the child or young person 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, healthcare professionals are advised to take all essential steps to stabilise the patient. Legal advice may be needed once emergency action has been taken.



Key resources

GMC – [0-18 years](#)



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Best interests

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

Where a child or young person under 16 lacks competence, there is a presumption that their parents have their 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 or young person's best interests.

Where a young person is competent, the young person's views on what would be in their best interests are of importance to the decision-making process, although they may not always be determinative (see section 4 on consent and refusal).

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

A best interests judgement is as objective a test as possible of what would be in the child or young person's actual best interests, considering 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. The test is similar but not identical to the test for adults under the Mental Capacity Act in England and Wales. In the case of children and young people under the age of 16, the factors that should be considered include:

- the patient's wishes, feelings, beliefs, and values (where these can be ascertained, and placing appropriate weight on them given the age of the child or young person);
- the patient's ability to understand what is proposed and weigh up the alternatives;
- 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 judgement about the effectiveness of the proposed treatment, and particularly 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 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; and
- the views of other healthcare professionals involved in providing care to the child or young person, and of any other professionals who have an interest in their welfare.

What if there is disagreement over what is in a child 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 independent mediation, the views of a Clinical Ethics Committee/Clinical Ethics Advisory Group, and/or legal advice. In the interim, in terms of any treatment on which there is dispute only that which is essential to preserve life or prevent serious deterioration should be provided (see sections 3 and 7 on parental responsibility and disputes).



Key resources

GMC – [0-18 years](#)



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Unaccompanied minors

Can children or young people make appointments for themselves?

Healthcare staff should not prohibit children and young people from 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, for example because the child has a serious condition and needs help in complying with a treatment regime, a rule prohibiting young patients attending alone is not good practice and could lead to a complaint against the doctor. 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 their parents.

Some doctors may be 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 in these circumstances 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 competent to make a request 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 or young person is experiencing any form of child abuse, neglect, or bullying, it may be appropriate to talk to the child or young person privately (see section 10 on child protection).

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

Where possible, healthcare 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 their parents and does not want the parents to know of the health interaction, this should be borne in mind when considering the best way of contacting the patient.

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

The presence of a chaperone can sometimes deter young people from being frank and from asking for help, but as with adult patients, whether or not a chaperone is offered will depend on the nature of the consultation. GMC guidance (see key resources) states that when an intimate examination is being carried out, a chaperone should be offered wherever possible, and this person should usually be a healthcare professional.

When no chaperone is available, and 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, and the examination cannot be delayed, the doctor should record that the offer was made and declined.



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Further guidance on the use of chaperones can be found in the BMA's doctor-patient relationship toolkit.

Key resources

BMA – [Doctor-patient relationship toolkit](#)

GMC – [Intimate examinations and chaperones](#)

GMC – [0-18 years](#)



7

Dispute resolution

When do disputes occur?

Ideally, medical decisions are made in partnership between the patient, the family, and the healthcare team, with the parental role gradually reducing as the child develops in maturity. Disputes arise, however, where there is a difference of opinion as to what is in a child or young person's best interests. For example, there could be a disagreement between a competent young person and their parents, the parents may disagree with each other, or the family may oppose the treatment plan suggested by the healthcare team. See, for example, a [summary](#) of the case of *Yates & Gard v Great Ormond Street Hospital for Children NHS Foundation Trust & Anor* (2017). It is also possible for the healthcare team not to agree about the right course of action.

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, the view of a clinical ethics committee/Clinical Ethics Advisory Group, and/or independent mediation may help to resolve some disagreements, but ultimately some may have to be resolved by the courts. Healthcare 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 where the child or young person is not competent, and consent is refused by the holders of parental responsibility;
- a competent young person refuses an intervention or invasive treatment that the healthcare team considers necessary;
- 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 or young person;
- the proposed care is beyond the scope of parental consent because it is controversial and/or non-therapeutic (for example sterilisation, living organ donation, or where the parents disagree about vaccination or non-therapeutic male circumcision - see sections 13 and 15);
- the courts have stated that they need to review a particular decision;
- the treatment requires detention outside the provisions of mental health legislation;
- the people with parental responsibility lack the competence to make the decision;
- the child or young person 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, 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 child or young person, should be informed and told how to seek legal representation.



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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 or young person, the parents, other relatives and carers, and the healthcare team. There are great benefits, however, of a legal system that can give rulings very quickly when necessary. The law can provide a protective role for both patients and the healthcare team who treat them and where there is a 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 patients and patients who lack competence aged under 16. A court can override a child or young person's refusal or parental refusal of a particular treatment if there is evidence that it would be in the child or young person's best interests, even if the child or young person is competent to make the decision. See, for example, a [summary](#) of the case of *A NHS Trust v X (In the Matter of X (A Child) (No 2) (2021)*.

In Scotland, the courts have the same powers to give consent to treatment on behalf of a child or young person aged under 16 when they are not competent to give valid consent for themselves. However, it is unclear whether a Scottish court may override the decision of a child or young person under 16 if the medical practitioner believes them to be competent, although it is thought that this is unlikely. Legal advice should therefore always be sought.

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



Key resources

GMC – [0-18 years](#)



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Use of restraint when providing 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 (with court approval where required) (see section 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?

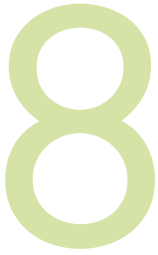
Doctors should consider if imposing treatment could damage the young person's current and future relationships with healthcare providers and undermine trust in the medical profession. It is important for young people to understand that restraint of any form to provide treatment is used only as a last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

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

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 or young person from significantly injuring themselves or others;
- the effect should be to provide an overall benefit to the child or young person 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 child or young person;
- all steps should be taken to anticipate the need for restraint and to prepare the child or young person, their family, and staff;
- wherever possible, the members of the healthcare team involved should have an established relationship with the child or young person 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 or young person and the parents have been informed of 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; and
- any use of restraint and the justification for it should be recorded in the medical records.





Who is responsible for the decision to use restraint?

Members of the healthcare team should be allowed to express their views and to participate in decision making, although ultimate responsibility rests with the clinician in charge of the patient's care. All staff require support and must not be asked to be involved in restraining a child or young person without proper training.

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

Detaining children and young people to provide medical treatment raises serious legal issues. Legal advice is essential before children, or young people are detained outside the provisions of mental health legislation, and court approval may be necessary.



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Confidentiality

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. As with adults, the duty of confidentiality is not absolute and confidential information can be disclosed when one of the following circumstances applies:

- consent (see section 4 on consent and refusal);
- a legal requirement to disclose or the disclosure has statutory authorisation which trumps the common law duty of confidentiality; or
- where there is an overriding public interest.

In addition to the specific circumstances outlined in this guidance that relate only to children and young people, the BMA's *Confidentiality and health records toolkit* provides more detail on the latter two points (see key resources).

When disclosing confidential information healthcare professionals must:

- disclose only the minimum relevant information necessary;
- ensure the disclosure is to the appropriate authority;
- document the disclosure and the reasons for the disclosure in the medical record;
- be prepared to justify their decisions to disclose (or not to disclose); and
- seek advice from the Caldicott Guardian, Data Protection Officer, or other appropriate senior person if there is uncertainty.

When is a young person competent to consent to the disclosure of their personal information?

In Scotland, anyone aged 12 or over is legally presumed to have such competence. In England, Wales, and Northern Ireland, it is also reasonable to presume that children who are aged 12 or over have the competence to give or withhold their consent to the release of information. Younger children may also be competent to make decisions regarding the control of their health information (see section 2 on assessing competence).

Healthcare professionals should, unless there are convincing reasons to the contrary (for example, where abuse is suspected) respect the child or young person's wishes if they do not want parents or guardians to know about all or some aspects of their healthcare (see section 10 on child protection, respectively). However, every reasonable effort must be made to persuade the child or young person to involve parents or guardians, particularly for important or life-changing decisions.

Are there limits to confidentiality if a child or young person lacks competence?

Occasionally, children or young people who lack competence seek or receive healthcare without their parents or guardians being present. They may lack the competence to give consent to treatment, and the disclosure of information (see sections 11 and 12 for example, on sexual activity). In these circumstances, confidentiality should usually be respected if they share information on the understanding that the information will not be disclosed to parents or guardians, or indeed to any third party. Parental involvement, however, should be encouraged, unless there are very convincing reasons to the contrary.



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There are, however, exceptions to this. For example, when not sharing the information puts the child or young person, or others, at risk of significant harm (see for example, section 10 on child protection). GMC guidance on 0-18 years also states: 'You should usually try to persuade the child to involve a parent in such circumstances. If they refuse and you consider it is necessary in the child's best interests for the information to be shared (for example, to enable a parent to make an important decision, or to provide proper care for the child), you can disclose information to parents or appropriate authorities' (paragraph 51).

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

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

Anyone with parental responsibility can give or withhold consent to the release of information where the child or young person lacks competence. Where an individual who has parental responsibility refuses to share relevant information with other healthcare professionals or agencies, and the healthcare professional considers that it is not in the best interests of the child or young person, for example if it puts the child or young person at risk of significant harm, disclosure may take place in the public interest without consent (see sections 5 and 10 on best interests and child protection). Parents should usually be informed of the disclosure, the reasons for it, and the information that will be provided in advance of disclosure.

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

Where healthcare professionals have concerns about a child or young person who may be at risk of abuse or neglect, these concerns must be acted upon, and information given promptly to an appropriate person or statutory body to prevent further harm (see section 10 on child protection).

Children and young people may try to 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 it is important that action is taken, they need to discuss disclosure with the child or young person and, if possible, the child or young person should be given sufficient time to come to a considered decision. If the child or young person cannot be persuaded to agree to voluntary disclosure, and there is an immediate need to disclose information to an outside agency, they should be told what action is to be taken unless doing so would expose them or others to increased risk of serious harm.

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

Competent children and young people may apply for access to their records or may authorise others to do so on their behalf. Competent patients do not need to give reasons as to why they wish to access their records. If a child or young person lacks competence, the GMC in paragraph 53 of its guidance on 0-18 years 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.'

Anyone with parental responsibility may usually exercise their right to apply for access to the child or young person's health records. If the child or young



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person is capable of giving consent, access may only be given with their consent. It may be necessary to discuss parental access alone with the child or young person if there is a suspicion that they are under pressure to agree. For example, a young person may not wish a parent to know about a request for contraceptive advice. If a child or young person lacks the competence to understand the nature of an application, but access would be in their best interests, it should be granted. Parental access must not be given where it conflicts with the child or young person's best interests.

Where parents are separated, and both have parental responsibility, and one of them exercises their right to access 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 or young person's best interests. It is advisable to make a note of when, and by whom the record is accessed.



Key resources

BMA – [Access to health records](#)

BMA – [Confidentiality and health records](#)

GMC – [0-18 years](#)

GMC – [Protecting children and young people](#)



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Child protection

Where doctors have concerns about a child or young person who may be at risk of abuse or neglect, these concerns must be acted upon following local and national guidelines (see key resources). The best interests of the children or young people involved must always guide decision making. Paragraph 1 of the GMC's guidance on protecting children and young people outlines the following key principles for protecting children and young people:

- a. All children and young people have a right to be protected from abuse and neglect – all doctors have a duty to act on any concerns they have about the safety or welfare of a child or young person.
- b. All doctors must consider the needs and well-being of children and young people – this includes doctors who treat adult patients.
- c. Children and young people are individuals with rights – doctors must not unfairly discriminate against a child or young person for any reason.
- d. Children and young people have a right to be involved in their own care – this includes the right to receive information that is appropriate to their maturity and understanding, the right to be heard and the right to be involved in major decisions about them in line with their developing capacity (see the advice on assessing capacity in appendix 1 to this guidance).
- e. Decisions made about children and young people must be made in their best interests – the factors to be considered when assessing best interests are set out in appendix 2.
- f. Children, young people and their families have a right to receive confidential medical care and advice – but this must not prevent doctors from sharing information if this is necessary to protect children and young people from abuse or neglect.
- g. Decisions about child protection are best made with others – consulting with colleagues and other agencies that have appropriate expertise will protect and promote the best interests of children and young people.
- h. Doctors must be competent and work within their competence to deal with child protection issues – doctors must keep up to date with best practice through training that is appropriate to their role. Doctors must get advice from a named or designated professional or a lead clinician or, if they are not available, an experienced colleague if they are not sure how to meet their responsibilities to children and young people'.





Key resources

GMC – [Protecting children and young people](#)

GMC – [0-18 years](#)

DFE – [Working together to safeguard children Statutory guidance on inter-agency working to safeguard and promote the welfare of children](#)

DFE – [Child sexual exploitation Definition and a guide for practitioners](#)

RCPCH – [Safeguarding guidance for children and young people under 18 accessing early medical abortion services](#)

DFE – [What to do if you're worried a child is being abused: advice for practitioners](#)

DHNI – [Co-operating to Safeguard Children and Young People in Northern Ireland](#)

NICE – [Child maltreatment: when to suspect maltreatment in under 18s. NICE clinical guideline 89](#)

RCPCH – [Child protection and safeguarding toolkit](#)

RCPCH intercollegiate document – [Safeguarding Children and Young People: Roles and Competences for Health Care Staff](#)

Scottish Government – [National Guidance for Child Protection in Scotland](#)

Welsh Government – [Safeguarding guidance](#)



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Sexual activity

Can a young person consent to treatment associated with sexual activity?

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 young person 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 contraceptive advice and/or treatment, doctors should take into account:

- whether the patient is likely to have sexual intercourse without contraception;
- whether the patient's physical and/or mental health is likely to suffer if the patient does not receive contraceptive advice or supplies; and
- whether the patient's best interests would require the provision of contraceptive advice or methods or both without parental consent.

Sexual activity by 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 healthcare professionals believe that a child or young person may be subject to coercion or exploitation, existing child protection guidelines must be followed. Healthcare 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 section 10 on child protection).

What if the young person lacks competence?

If a young person lacks competence, and it is in their best interests, a person 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 to the provision of contraceptives for contraception and the termination of pregnancy, however, this raises a question about the ability of the young person to consent to sexual intercourse. In cases of doubt, or where the provision of contraception will involve restraint or an invasive procedure, for example insertion of an intra-uterine device (IUD), doctors should seek legal advice. If there are concerns that a child or young person is being sexually abused, doctors should follow 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 (see section 12 on some exceptions in Northern Ireland). The GMC states in its guidance on 0-18s years: 'You should usually share information about sexual activity involving children under 13, who are considered in law to be unable to consent. You should discuss a decision not to disclose with a named or designated doctor for child protection and record your decision and the reasons for it' (paragraph 60).

While reporting to social services or the police should always be considered when the individual is very young, healthcare professionals are obliged to act in the best interests of the patient, and this requires flexibility. Where



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a healthcare professional decides to disclose information to a third party against a child or young person's wishes, they 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 of all underage sexual activity?

No. All children and young people are entitled to have their confidentiality respected, unless there are very convincing reasons to the contrary, for example if abuse is suspected. However, every reasonable effort must be made to persuade the child or young person 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.

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

Yes. Many of the principles set out above are supported by statute. For example, the Sexual Offences Act 2003 provides a legal framework aimed at protecting children and young people from sexual abuse. Under the Act, children, and young people under the age of 16, still have the right to confidential advice on contraception, sexual, and reproductive health. Most 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. 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. The GMC states in its guidance on 0-18 years: 'If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see another doctor. You should make sure that information about alternative services is readily available to all patients. Children and young people in particular may have difficulty in making alternative arrangements themselves, so you must make sure that arrangements are made for another suitably qualified colleague to take over your role as quickly as possible' (paragraph 65).

Can sterilisation be performed on children and young people?

Sterilisation is occasionally requested for young women with serious learning difficulties. Although 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 under 18, given that there are other options available. In exceptional circumstances where there is agreement that sterilisation is the best option for a young person, doctors should seek legal advice to obtain a court declaration.



Key resources

GMC – [0-18 years](#)

RCPCH – [Safeguarding guidance for children and young people under 18 accessing early medical abortion services](#)



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Sexual activity – additional obligations in Northern Ireland

What is different about the law in Northern Ireland?

Section 5 of the Criminal Law (Northern Ireland) Act 1967 places a duty, unique to Northern Ireland, on everyone to report to the police information they may have about the commission of a relevant offence (one with a maximum sentence of five years or more). There are few exceptions to the law, for example 'medical confidentiality' is not, in and of itself, understood to be an exception.

If the legal age of consent is 16, does this mean I have to report all underage sexual activity even where the activity is entirely mutually agreed and non-exploitative?

No, you do not have to automatically report all underage sexual activity. The Sexual Offences (Northern Ireland) Order 2008 makes some exceptions to the duty to report. Doctors are not under a duty to report sexual activity involving a young person aged 13 to 15 where the other party is under 18. Where doctors are unsure of their duties and obligations, they should seek advice from social services and/or the child protection team.

Does the law affect my ability to provide contraceptive or sexual health advice to a young person under the age of 16?

No. Doctors can provide treatment to an under-16-year-old, without having to report the child or young person's sexual activity to the police, where both individuals are aged between 13 and 18 and the treatment provided is to:

- protect a child or young person from sexually transmitted infection;
- protect the physical safety of a child or young person;
- prevent a child or young person from becoming pregnant; or
- promote the child or young person's emotional wellbeing by giving advice.

Where doctors are unsure of their duties and obligations, they should seek advice from social services and/or the child protection team.



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Vaccination

Who can consent to vaccination?

A competent child or young person aged under 16, can consent to vaccination, and a person with parental responsibility cannot override that consent. If a competent child or young person refuses vaccination, that refusal should be accepted. For infants and young children not competent to give or withhold consent, consent can be given by a person with parental responsibility (see section 3 on parental responsibility).

What if parents with parental responsibility disagree?

In England and Wales, the UK Health Security Agency's Immunisation against infectious disease (known as the [Green Book](#)), advises that vaccination should not be carried out unless both people with parental responsibility can agree to vaccination, or there is specific court approval that the vaccination is in the best interests of the child (see sections 5 and 7 on best interests and disputes). This is likely to be the same in Scotland and Northern Ireland.

Who should be present at the vaccination?

A competent child or young person can attend for vaccination on their own. For infants or children who are not competent, the person with parental responsibility does not need to be present at the time of the vaccination; they may be brought for vaccination by a person without parental responsibility, for example a grandparent or childminder. There is no requirement for such arrangements to be made in writing. However, the healthcare professional needs to be satisfied that the person with parental responsibility has consented in advance to the vaccination and that they have asked the other person to take the child to the appointment, to consider any further information given by the healthcare professional, and to confirm agreement to vaccination.



Key resources

UK Health Security Agency – [Immunisation against infectious diseases](#)



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Female genital mutilation

What is female genital mutilation (FGM)?

FGM is a collective term used for a range of practices involving the removal or alteration of parts of healthy female genitalia for non-therapeutic reasons. Different degrees of mutilation are practised by a variety of cultural groups in the UK. FGM has immediate risks, including severe pain, haemorrhage, tetanus and other infections, septicaemia, or even death. In the longer term, girls and women may experience problems with their sexual, reproductive, and general physical and psychological health. The risk of FGM may also give rise to legitimate grounds for an application for refugee or asylum status.

Are there any considerations additional to the usual child protection measures?

FGM is illegal in England, Wales, and Northern Ireland under the Female Genital Mutilation Act 2003 (as amended by the Serious Crime Act 2015) and in Scotland under the Prohibition of Female Genital Mutilation Act 2005 (as amended by the Serious Crime Act 2015). If a child or young person is identified as being at risk of FGM, urgent safeguarding action must be taken. There is additional legislation and guidance specifically relating to FGM that doctors should be aware of – see key resources below. For example, there is a statutory duty to notify the police of FGM in England and Wales, if a young woman or girl who is aged under 18:

- informs a healthcare professional that FGM has been carried out on her; or
- a healthcare professional observes physical signs appearing to show FGM.



Key resources

UK-wide:

GMC – [Protecting children and young people](#)

Health Education England – [FGM e-learning programme \(available in all four nations, including for medical students\)](#)

RCGP – [Female Genital Mutilation](#)

RCOG – [Female Genital Mutilation and](#)

RCOG – [Female Genital Mutilation and its Management \(Green-top Guideline No. 53\)](#)

RCPCH – [Female Genital Mutilation Resources](#)

England and Wales: HM Government – [Multi-agency statutory guidance on female genital mutilation](#)

Northern Ireland: Department of Health – [Multi-agency practice guidelines: female genital mutilation](#)

Scotland: Scottish Government – [Violence against women and girls](#)



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Non–therapeutic male circumcision (NTMC) of babies and young children who lack competence

What is non-therapeutic male circumcision?

Male circumcision is the removal of part or all of the foreskin (prepuce) that covers the penile glans. If it is undertaken for any reason other than current physical clinical need, it is termed non-therapeutic (or sometimes 'ritual') circumcision.

Why is it requested?

Some people ask for NTMC for their children as they believe it is a defining feature of their identity and/or faith. According to the Jewish tradition, boys born to Jewish parents should be circumcised at 8 days old. Circumcision is also recommended for boys born to Muslim parents; according to Islamic tradition this should take place either within 4 weeks or as young boys. Others ask for NTMC to incorporate a child into a practising community, and some want their sons to be like their fathers. It should not be assumed, however, that because a child is born into a practising community, the parents will automatically seek NTMC and are supportive of the practice.

Is NTMC lawful?

Although there is no statute covering NTMC, there is now a body of case law which confirms that NTMC is lawful if:

- it is in the child's best interests;
- there is valid consent from both parents (or, in cases of dispute, it is authorised by a court); and
- it is performed competently.

The General Medical Council (GMC) in its guidance on 0-18 years says at paragraph 34:

'Both the GMC and the law permit doctors to undertake procedures that do not offer immediate or obvious therapeutic benefits for children or young people, so long as they are in their best interests ... and performed with consent.'

In 2021 a case decided in the High Court of England and Wales, of [Re P, \(Circumcision: Child in Care\)](#) where there was disagreement between the parents and the local authority about whether P should be circumcised, Mr Justice Cobb held – based on the facts of the case – that circumcision should be delayed. He regarded the case as a 'finely balanced decision' but that his decision had:

'... to some extent, been influenced by the fact that presently neither parent chooses to see P, and neither parent has (contrary to their offer to do so) provided P with age-appropriate books and/or learning materials about Islam' (paragraph 34).

In his conclusions, however, Mr Justice Cobb made clear that:

'Had there been no interim care order in place, these two parents acting in agreement, and exercising their shared parental responsibility, would have



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been able to provide consent for P's circumcision for either therapeutic or non-therapeutic reasons.' (paragraph 29).

Setting out the general principles derived from previous cases, Mr Justice Cobb quoted Mr Justice Munby in the case of [Re B and G \(Children\)\(No 2\)](#) stating:

'While it can never be reasonable parenting to inflict any form of FGM [female genital mutilation] on a child, the position is different with male circumcision; 'Society and the law, including family law, are prepared to tolerate non-therapeutic male circumcision performed for religious or even for purely cultural or conventional reasons, while no longer being willing to tolerate FGM in any of its forms' (paragraph 27(i))

Mr Justice Munby had also said in that case: 'although both involve significant harm, there is a very clear distinction in family law between FGM and male circumcision'.

How are best interests determined in relation to NTMC?

Doctors should only undertake NTMC where they are satisfied that it is in the best interests of the child. Parental request alone does not constitute sufficient grounds for performing NTMC on a child unable to express his own view. Parents seeking NTMC for their sons should be asked to explain and justify their request for circumcision, in terms of the individual factors in relation to that child's best interests. They need to explain why the benefits of NTMC outweigh the risks of the procedure for their child, considering both the child's health interests and their social and cultural circumstances. For example, where a child is living in a culture in which circumcision is perceived to be required for all males, the increased acceptance into a family or society that circumcision can confer, is considered to be a strong social or cultural benefit. Some religions require circumcision to be undertaken within a certain time limit, and so a decision to delay circumcision may also be harmful. Equally, however, the harm of a person not having the opportunity to choose not to be circumcised or choose not to follow the traditions of his parents must also be taken into account, together with the damage that can be done to the individual's relationship with his parents and the medical profession, if he feels harmed by an irreversible non-therapeutic procedure.

In addition to asking parents to explain and justify their request for circumcision, doctors should discuss with parents the irreversibility of the procedure and ask what the implications might be for a child of being, or not being, circumcised, and whether circumcision can be deferred until the child can make his own decision.

Where a child is able to express a view about NTMC even if he does not have the competence to give consent – his views on what would be in his best interests are of importance to the decision-making process. The BMA cannot envisage a situation in which it is ethically acceptable to circumcise a child who refuses the procedure, irrespective of the parents' wishes.

What factors should be considered in the best interests assessment?

In *Re P*, the judge emphasised that the welfare of the child, both in the immediate and long-term, is the paramount consideration and set out a number of 'important guiding principles' that the court should consider when making decisions in disputed cases. These provide a helpful framework for doctors making best interests assessments in individual cases. The factors that were deemed to be important included:



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- the medical risks and benefits of such a procedure;
- that the circumcision procedure is irreversible;
- the religious upbringing of the child;
- the religious views and wishes of both parents;
- the views of the primary carers of the child (if not the parents); and
- the particular environment in which the child is going to be raised.

The GMC, at paragraph 35 of its 0-18 years guidance, states:

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

As with all best interests assessments, there are no set formulae to follow when weighing different interests; it is a matter of professional judgement. As with any other aspect of care, healthcare professionals must be able to justify their decisions and should record the basis on which their decisions are made in the medical record.

Whose consent is required for NTMC of children who cannot consent for themselves?

The BMA and GMC have long recommended that consent should be sought from both parents for NTMC. Although parents who have parental responsibility are usually allowed to take medical decisions for their children alone, NTMC has been described by the courts as an ‘important and irreversible’ decision that should not be taken against the wishes of a parent. It follows that where a child has two parents with parental responsibility, doctors considering circumcising a child must satisfy themselves that both have the necessary parental authority and have given valid consent. If a child presents with only one parent, it is essential that efforts are made to determine whether there is a second person with parental responsibility and, if so, to contact that person for consent.

What if the parents disagree?

If parents disagree about having their child circumcised, the parent seeking circumcision could seek a court order authorising the procedure, which would make it lawful, although doctors are advised to consider carefully whether circumcising against the wishes of one parent would be in the child’s best interests. In its guidance on personal beliefs and medical practice at paragraph 20, the GMC gives the following guidance on consent for circumcision:

‘If the patient is a child, you must proceed on the basis of the best interests of the child and with consent. Assessing best interests will include the child’s and/or the parents’ cultural, religious or other beliefs and values. You should get the child’s consent if they have the maturity and understanding to give it. If not, you should get consent from all those with parental responsibility. If you cannot get consent for a procedure, for example, because the parents cannot agree and disputes cannot be resolved informally, you should:

- inform the child’s parents that you cannot provide the service unless you have authorisation from the court
- advise the child’s parents to seek legal advice on applying to the court.’

Whilst the courts have the power to give consent to circumcision on behalf of a child it cannot require doctors to perform NTMC contrary to their professional judgement.



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Does NTMC require written consent?

In the case of NTMC, it is advisable to obtain written consent. Doctors should ask parents to confirm their consent in writing by signing a consent form. This is simply a document showing that a discussion has taken place, and consent has been provided and does not itself mean that consent is valid.

What if I have a moral objection to NTMC?

If a doctor declines a request to perform NTMC solely on the basis of their moral beliefs about the practice, irrespective of an assessment of a child's best interests, they should explain this to the parents and follow the GMC's guidance on conscientious objection. The GMC's guidance on personal beliefs and medical practice at paragraphs 12 and 13 states:

'Patients have a right to information about their condition and the options open to them. If you have a conscientious objection to a treatment or procedure that may be clinically appropriate for the patient, you must do the following.

- a. Tell the patient that you do not provide the particular treatment or procedure, being careful not to cause distress. You may wish to mention the reason for your objection, but you must be careful not to imply any judgement of the patient.
- b. Tell the patient that they have a right to discuss their condition and the options for treatment (including the option that you object to) with another practitioner who does not hold the same objection as you and can advise them about the treatment or procedure you object to.
- c. Make sure that the patient has enough information to arrange to see another doctor who does not hold the same objection as you.

If it's not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made – without delay – for another suitably qualified colleague to advise, treat or refer the patient.'

Although the BMA recognises the importance of frankness and openness with patients, this does not extend to doctors offering unsolicited opinions about their own moral views. Although all doctors have private moral views, they should not share them unless explicitly asked by patients to do so. In particular, doctors should avoid making pejorative or judgemental comments about patients' or parents' values or behaviour. Doctors must avoid language or actions that imply discrimination. NHS guidance makes clear that such behaviour in a healthcare setting could be construed as harassment.

Who can carry out NTMC?

There is no legal requirement to be a doctor to perform NTMC and it is sometimes carried out by special practitioners within religious groups who are not medically qualified. We urge parents, who are considering having their child circumcised, to ensure that the practitioner who carries out the circumcision has undergone relevant training and has proven experience and competence in the practice. As with other areas of clinical practice, doctors may have professional obligations to notify authorities if they become aware of medical or non-medical practitioners falling below the expected standards of care when performing NTMC.

All doctors who perform NTMC, wherever and in whatever capacity, are obliged to adhere to professional standards, including having the necessary skills and experience to perform the procedure. Doctors who carry out NTMC must also be registered in England with the Care Quality Commission (CQC), in Wales with Healthcare Inspectorate Wales (HIW), and in Scotland with Healthcare Improvement Scotland (HIS). In Northern Ireland, there is no requirement to be registered with The Regulation and Quality Improvement



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Authority (RQIA) to carry out circumcision.

The BMA is aware of reports of individual doctors who perform NTMC being harassed for their involvement in the provision of NTMC. The BMA respects the right to peaceful protest and to democratic processes to challenge accepted norms. However, the BMA abhors the harassment of individual doctors through intimidating and threatening behaviour on the basis of their involvement in the provision of NTMC.



Key resources

British Association of Paediatric Surgeons – [Circumcision \(child\) parent leaflet](#)

British Association of Paediatric Surgeons – [Religious circumcision](#)

GMC – [0-18 years](#)

GMC – [Personal beliefs and medical practice](#)



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Compulsory treatment for a mental health condition

When should mental health legislation be used?

In most cases, treatment and support for a young person's mental health condition 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 health condition, irrespective of whether or not they are competent. Compulsory treatment cannot be used to provide treatment for a physical illness unrelated to the mental health condition. Although for some patients a severe mental illness is associated with a corollary lack of competence, a mental health condition does not automatically diminish a young person's legal competence. Doctors who believe that the legislation may apply to one of their young patient but who are unfamiliar with the legislation should seek expert advice.

What legislation is applicable in England and Wales?

The Mental Health Act 1983 (as amended by the Mental Health Act 2007) covers all children and young people under 16. The Act contains some provisions and specific safeguards for under-16s. Amongst other things:

- the Code of Practice to the Mental Health Act 1983 states that it would be inadvisable for practitioners to rely on the consent of a person with parental responsibility to treat a competent child or young person who has refused the treatment. In such situations the court should be asked to provide consent to the treatment.
- where the child or young person lacks competence, and has refused treatment, the Code of Practice suggests that court authorisation may also be required in some circumstances. However, in a recent high court judgment of [An NHS Trust v Mother & Ors \[2024\] EWHC 2207 \(Fam\)](#) the judge held that this is 'erroneous', and legal advice should therefore be sought.
- 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;
- electro-convulsive therapy (ECT) cannot be given without approval of a second opinion appointed doctor even if the child or young person consents to it unless it is an emergency; and
- children and young people detained under the Act must be referred after one year (as opposed to three for adults) for a tribunal hearing.

New legislation is anticipated following an independent review of the Mental Health Act. Details of any changes will be posted on the [BMA website](#).

What legislation is applicable in Scotland?

The Mental Health (Care and Treatment) (Scotland) Act 2003 (as amended by the Mental Health (Scotland) Act 2015) covers all children and young people under 16. Any functions under the Act in relation to a young person with mental disorder should be discharged in the way that best secures the welfare of the young person. In particular, it is necessary to take into account:

- the wishes and feelings of the young person and the views of any carers;
- the carer's needs and circumstances which are relevant to the discharge of any function;
- the importance of providing any carer with information as might assist them to care for the patient;



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- where the young person is or has been subject to compulsory powers, the importance of providing appropriate services to that young person; and
- the importance of the function being discharged in the manner that appears to involve the minimum restriction on the freedom of the young person as is necessary in the circumstances.

Wherever possible, it is best practice to admit a young person to a unit specialising in child and adolescent psychiatry, and for the Responsible Medical Officer (RMO) responsible for their care to be a child and young person specialist. In addition, specified conditions must be satisfied before the following treatments may be given to a child or young person under the age of 16 who are informal patients:

- Electro Convulsive Therapy (ECT);
- Transcranial Magnetic Stimulation (TMS); and
- Vagus Nerve Stimulation (VNS).

In addition, the provisions in Sections 275 and 276 of the Mental Health (Care and Treatment) (Scotland) Act 2003 also enable a competent young person aged under 16 to make an advance statement setting out how they would wish to be treated, or not to be treated, should their ability to make decisions about treatment for their mental disorder become significantly impaired as a result of their mental disorder. Whilst it is not legally binding, a healthcare professional giving medical treatment must have regard to the wishes specified in it, and record if a decision is made that conflicts with those wishes.

What legislation is applicable in Northern Ireland?

The Mental Health (Northern Ireland) Order 1986 covers all children and young people under 16. Additional safeguards in relation to those under 16 were subsequently introduced and are contained in Part 3A of the Order. In particular, where a person responsible for the treatment or care (or both) of a patient under 16 their primary consideration, when making decisions about the patient's treatment or care, must be their best interests. The person so far as reasonably practicable must:

- encourage and help the child or young person to participate, or improve their ability to participate, as fully as possible in any decision about their treatment or care; and
- ensure that the child or young person is provided in an appropriate way with information and advice about the treatment or care; and
- have special regard to the past and present wishes and feelings (and, in particular, any relevant written statement made by the child or young person and their beliefs and values).

There is also a requirement to consult the relevant people about what would be in the child or young person's best interests including:

- every person who has parental responsibility;
- the nearest relative;
- the independent advocate;
- any other person named by the child or young person as someone to be consulted on the matter in question or on matters of that kind; and
- anyone engaged in caring for the child or young person or interested in their welfare.





Key resources

England and Wales: Department of Health – [Code of Practice Mental Health Act 1983 \(2015\) – primarily chapter 19](#)

Scotland: Department of Health – [Mental Health \(care and treatment\) \(Scotland\) Act 2003: Code of Practice Volume 1](#)

Northern Ireland: Regulation and Quality Improvement Authority – [Guidelines on the use of the Mental Health \(Northern Ireland\) Order 1986 e05\)](#)



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Research and innovative treatment

Can children and young people under 16 be involved in research and innovative treatment?

Children and babies should be eligible for inclusion in research and innovative therapy, with appropriate safeguards. Failing to do research would lead to stagnation of current practice and the continuation of medical management by using untried or unproven remedies, based on belief, rather than best evidence. The need for pharmaceutical products specifically designed for use by children and young people 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 young person or parent (expenses are permitted) and all projects must be carefully scrutinised by a Research Ethics Committee (REC).

Who can consent to children and young people under 16 being involved in research and innovative treatment not involving a Clinical Trial of an Investigational Medicinal Product (CTIMP)?

There is no statute, or regulations in the UK which govern a child or young person's right to consent to take part in research not involving a CTIMP. As with other treatment decisions, the final decision about participation therefore rests with the child or young person (when competent) and those with parental responsibility, when they are not competent, provided it is in their best interests.

Children and young people and their parents need support and independent advice about their options. The child or young person and their parents, where appropriate, must be given clear and appropriate information, with candid explanations of the purposes, risks and expected benefits of the research.

Even if the child or young person is not competent to make a decision, their *assent* should be sought if possible. If competent, the child or young person must give unpressured and informed consent. Depending on the nature of the research, and the REC's view, parental consent may also be required, even if the child or young person is competent.

Who can consent to children and young people under the age of 16 taking part in a Clinical Trial of an Investigational Medicinal Product (CTIMP)?

The Medicines for Human Use (Clinical Trials) Regulations which apply throughout the UK prohibit children and young people under the age of 16 from giving consent to take part in a CTIMP. However, children and young people should be involved in the decision-making process whenever possible, and healthcare professionals should ensure that they receive information about the trial, which is understandable to them. Those who are able to give consent on behalf of children and young people under 16 in the UK are:

- a parent or someone with parental responsibility (agreement of only one parent is required);
- a personal legal representative – in other words, a person not connected with the conduct of the trial who is suitable to act as the legal representative by virtue of their relationship with the child/young person and is available and willing to do so. A legal representative should only



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ever be approached if someone with parental responsibility cannot be contacted prior to the proposed inclusion of the child/young person, by reason of the urgent nature of the treatment provided as part of the trial; and

- if a personal legal representative is not available, a professional legal representative – in other words, a doctor responsible for the medical treatment of the child/young person if they are independent of the study, or a person nominated by the healthcare provider.

Parents or legal representatives must:

- understand that they are giving consent on behalf of the child/young person;
- understand the objectives, risks and inconveniences of the trial and the conditions under which it is to be conducted;
- have been informed of the right to withdraw the child/young person from the trial at any time; and
- have a contact point where further information about the trial can be obtained.

What if the parents' consent but the child or young person who lacks competence refuses?

It would rarely be appropriate to proceed with non-therapeutic research in a child who is expressing their opposition to participation.

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

What if one parent consents but the other refuses where the child or young person lacks competence?

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

Can children and young people aged under 16 be involved in emergency care trials?

Yes. Children, and young people under 16 can take part in emergency care trials when there would be no time to seek initial consent before administering the medicine, or intervention 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 and young people to be involved in emergency trials in certain circumstances.



Key resources

HRA – [Research involving children](#)

MRC and ESRC – [Involving children in medical research](#)





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