

Clinical ethics: consent for vaccination in children

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The prospect of vaccinating children and young people against COVID-19 raises questions that apply more widely to vaccination in children. When can children or adolescents consent, on their own, for vaccination? What should happen if children and their parents disagree about the desirability of a vaccine? When, if ever, should vaccination proceed despite a child's dissent or apparent refusal? A range of ethical dilemmas may arise (box 1). In this article, we will address general ethical issues relating to consent for vaccination, highlighting their relevance to COVID-19. We will not address the wider ethical questions of whether or when children should be vaccinated against COVID-19.

PARENTAL CONSENT

In general, parents play a key role in making decisions about medical treatment and procedures in their children. Except in an emergency, informed consent is always sought from a caregiver with parental responsibility prior to significant medical interventions. For childhood vaccinations in the UK, consent from parents is currently routinely required, although some groups have argued that mandatory vaccination would promote children's best interests. If parents decline immunisations after being counselled about the evidence for vaccine safety and efficacy, their decision would usually be respected. Rarely vaccination may proceed against parental wishes; for example, for a child in care, or a child at particularly high risk from a specific infection, although this would usually require a Best Interests decision by a court.

As with other medical procedures, consent from a single adult with parental responsibility is sufficient for vaccination to proceed. However, if it is known that

Box 1 Ethical dilemmas relating to vaccine consent for children and young people

- ▶ A. Two parents disagree about vaccination for a young child (one supports, the other is opposed).
- ▶ B. Both parents support vaccination, but a 3-year-old child cries vigorously and tries to escape when vaccination is attempted.
- ▶ C. A 12-year-old requests a vaccine in the absence of parental permission (eg, in a school vaccination programme).
- ▶ D. Parents decline vaccination, but an adolescent requests vaccination.
- ▶ E. Parents support vaccination, but an adolescent refuses.

the parents have opposing views (case A, Box 1), health professionals should encourage them to reach consensus. In cases of persistent parental disagreement, one parent may apply to the court for a 'specific issue order'. In that situation, the courts have generally taken the view that it would be in the child's best interests to receive vaccines that are on the current immunisation schedule and authorised immunisation. In a recent case, the court declined to rule on COVID-19 vaccination (since it was not at the time approved for children), but the judge noted: "it is very difficult to foresee a situation in which a vaccination against COVID-19 approved for use in children would not be endorsed by the court as being in a child's best interests".¹

CHILD ASSENT

Many childhood immunisations are given prior to a child having sufficient maturity to make an informed decision for themselves. However, it is widely accepted that it is important to involve children in medical decisions as much as practicable. For primary school-age children, their agreement would typically be sought even though they are not able to consent. 'Assent' is a concept used more often in relation to research; it refers to the agreement of a child or young person who is

not legally able to give informed consent. Ideally, the child should be provided with age-appropriate information or explanation. Assent might be verbalised or simply inferred from sitting still for the injection.

CHILD DISSENT

In a pre-school child or infant, behavioural or verbal evidence of not wanting immunisation is common, developmentally appropriate and may be unavoidable (case B). Comfort holding or gentle firm restraint is commonly used by parents or health professionals in these settings.² Such restraint may be ethically justified if it is unavoidable and the procedure is in the child's best interests. However, efforts should be made to use other techniques (analgesia, distraction, play therapy, age-appropriate explanation etc) before resorting to restraint, and parents should be involved in the discussion about how best to gain their child's cooperation. If a child is particularly distressed at the prospect of immunisation, it may be best to defer, seek the support of caregivers and try again on another occasion.

For non-urgent interventions in older children, restraint is an option of last resort. In some children, for example, those with developmental problems, resistance to immunisation may persist despite all reasonable attempts. It may not be in the child's best interests to proceed. Where other options have been exhausted, paediatricians should weigh up whether the risks of sedation (in an appropriate, monitored clinical environment) outweigh the risks of non-immunisation.

ADOLESCENT REFUSAL

For an adolescent over the age of 16, or younger than 16 but with the maturity and capacity to understand the nature of the decision (ie, Gillick competent),³ and who declines immunisation (case E), health professionals should make efforts to correct any misunderstandings. Reluctant teenagers may be able to be persuaded or encouraged. Needle fear and phobia can often be effectively managed using behavioural and psychological techniques. However, persistent refusal should usually be respected, even if parents have given their permission and even if the paediatrician believes that it would be in the young person's best interests to be immunised. While courts have occasionally authorised life-saving treatment (eg, blood transfusions) against the objections of competent teenagers, there are no precedents for this occurring for immunisation.

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Box 2 Potential checklist for determining Gillick competence for immunisation^{3 5}

- ▶ Does the young person have sufficient maturity to make this sort of decision?
- ▶ Are they sufficiently free from undue influences on their decision-making (eg, social media, peer pressure, family pressure, fear)?
- ▶ Do they understand the reasons why immunisation is being offered?
- ▶ Do they understand and are they able to weigh up the risks and benefits of immunisation?
- ▶ Do they understand their options in this situation?

ADOLESCENT CONSENT

A different dilemma may arise where an adolescent presents for vaccination either in the absence of information about their parents' wishes (case C) or despite their parents declining immunisation (case D).

Current UK programmes for school-based human papilloma virus (HPV) vaccination in children 12–13 years old often include a requirement for parental written consent. Lack of parental authorisation is the the most common barrier to young people receiving these vaccinations.⁴ However, ethically and legally, those adolescents (<16 years) who are Gillick competent can consent on their own. This has been incorporated into some HPV vaccination programmes, although it appears that it is rarely enacted.⁴ In such a setting, if it is not possible to obtain parental consent, professionals should assess whether the young person is Gillick

competent and understands the risks and benefits of vaccination (box 2).³ If they do, immunisation can ethically (and should usually) proceed.

COVID-19 AND CONSENT

There are no in-principle differences between COVID-19 vaccines and other vaccines.

When COVID-19 vaccination becomes available for young people under 16, the same principles should apply as for other routine immunisations in childhood/adolescence. Vaccine hesitancy, either among young people or their parents, may reduce the uptake of a COVID-19 vaccine. Some of these issues may make the expansion of vaccine programmes to young people more complicated and resource intensive than vaccination in adults. As with the HPV vaccination, lack of parental consent is likely to be the main barrier to adolescents receiving the vaccination, and self-consent by Gillick competent adolescents (or those over the age of 16) should be supported.

(A version of this paper with additional references can be found on PhilArchive: <https://philarchive.org/archive/WILCEC-3>).

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Acknowledgements The authors are very grateful for extremely helpful feedback from Mr Robert Wheeler, Dr Steven Turner and Dr Maggie Wearmouth.

Contributors DW conceived of the article and wrote the first draft. AKSM performed a literature search and edited the manuscript. Both approved of the final version.

Funding This research was funded in whole, or in part, by the Wellcome Trust [203132/Z/16/Z] and by the Arts and Humanities Research Council (AHRC) as part

of the UK Research and Innovation rapid response to COVID-19 [AH/V013947/1].

Disclaimer The funders had no role in the preparation of this manuscript or the decision to submit for publication.

Competing interests None declared.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; internally peer reviewed.

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To cite Wilkinson D, McBride AKS. *Arch Dis Child* 2022;**107**:3–4.

Published Online First 27 September 2021

Arch Dis Child 2022;**107**:3–4.

doi:10.1136/archdischild-2021-322981

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