judicious control of hypertension in elderly people affords great potential for improved health and increased longevity.

J M S PEARCE

Honorary consultant neurologist

Anlaby,
Hull HU10 7BG

- 1 Bennett DA, Wilson RS, Gilley DW, Fox JH. Clinical diagnosis of Binswanger's disease. *J Neurol Neurosurg Psychiatry* 1990;53:961-5.
- 2 Toole JF. *Cerebrovascular disorders*. 4th ed. New York: Raven Press, 1990:352.
- 3 Sulkava R, Erkinjuntti T. Vascular dementia due to cardiac arrhythmias and systemic hypotension. *Acta Neurol Scand* 1987;76:123-8.
- 4 Burke WJ, Coronado PG, Schmitt CA, Gillespie KM, Chung HD. Blood pressure regulation in

- Alzheimer's disease. *J Auton Nerv Syst* 1994;48:65-71.
- 5 Guo Z, Viitanen M, Fratiglioni L, Winblad B. Low blood pressure and dementia in elderly people: the Kungsholmen project. *BMJ* 1996;312:805-8.
 - 6 Prince MJ, Bird AS, Blizard RA, Mann AH. Is the cognitive function of older patients affected by antihypertensive treatment? Results from 54 months of the Medical Research Council's treatment trial of hypertension in older adults. *BMJ* 1996;312:801-5.
 - 7 Elias MF, Wolf PA, D'Agostino RB, Cobb J, White LR. Untreated blood pressure is inversely related to cognitive functioning: the Framingham study. *Am J Epidemiol* 1993;138:353-61.
 - 8 Farnett L, Mulrow CD, Linn WD, Lucey CR, Tuley MR. The J-curve phenomenon and the treatment of hypertension: is there a point beyond which the treatment of hypertension is dangerous? *JAMA* 1991;265:489-95.
 - 9 MRC Working Party. Medical Research Council trial of treatment of hypertension in older adults: principal results. *BMJ* 1992;304:405-12.
 - 10 Stamler J, Stamler R, Neaton JD. Blood pressure, systolic and diastolic, and cardiovascular risks: US population data. *Arch Intern Med* 1993;153:598-615.
 - 11 Pearce JMS. Vascular dementia. In: Russell RR, ed. *Cerebrovascular disease*. 2nd ed. Edinburgh: Churchill Livingstone, 1984:356-67.

Making decisions with children

A child's rights to share in health decisions can no longer be ignored

See p 798

Most health care professionals support the ideal of shared decision making with adult patients. Decisions affecting children and young people are more complex, involving parents as a third party. Children want to be part of the decision making process,^{1,2} but protective attitudes of paediatricians, and our generally overcautious assessment of children's ability to understand and reason in an environment of traditional adult superiority, have probably contributed to a tendency to overlook the rights of children to express their views. Case law, mostly derived from unusual or extreme cases, has compounded the problems, leading to the present confused and unsatisfactory position regarding children's rights.

The United Nations Convention on the Rights of the Child falls short of recognising children's rights to autonomy; it limits the decision making process to "giving due weight to the views of the child according to age and maturity."³ The strength of such "participation" rights depends on information given and is consistent with limited or no choice for the child. The Gillick ruling allowed children under 16 years to consent provided that they were competent as assessed by their doctor.⁴ However, this was undermined by the Donaldson ruling that parents could overrule a competent child who refused treatment.⁵ That ruling also gave doctors criminal or civil liability for second guessing how the judiciary would assess a child's competence. The Children Act 1989 failed to make any commitment to children's rights to autonomy, limiting itself to stating that children's views should be heard. The government and health professionals have failed to uphold even these limited rights.²

The recently published report from the Institute of Public Policy Research, "Health Care Choices: Making Decisions with Children," recommends a code of practice.⁶ This embodies fundamental principles of children's rights to receive clear and detailed information; to express views; to grant or withhold consent to any aspect of proposed management or research plan, provided that the children are considered to be competent by a doctor acting in good faith and subject to the supervisory role of the courts. The assessment of competence would be based on the child's functional ability, not on age or outcome of the decision. All children of school age should be presumed competent. Otherwise competence would be defined as when a child understands the type, purpose, and broad nature and effect of treatment, and possesses the capacity to choose whether to accept or not. Parental consent would continue to be valid if it was not against the ascertained wishes of the child. A competent child's refusal of a management plan would be respected,

and the basis of an assessment of incompetence would be documented.

How might the code affect clinical practice? It would operate in all health care decisions, most of which are minor and mundane. At present, few children are asked if they agree to be weighed and measured, or to have a blood test, or to being given a drug, or to having an operation, or to be involved in a research study: this number would be expected to increase considerably. A reorientation of many of the country's health professionals would be necessary. More time would need to be spent with patients, but perhaps not as much as expected because explanations need not in most cases be duplicated for parents, as is often the case at the moment. Would there be many differences of opinion between children and parents? This is not the experience of doctors who presently adhere to similar principles. Would research suffer as a result of reduced recruitment? Probably not. Better, more appropriately thought out and honestly presented research may result.

But what of the major decisions in health care? The assumption of competence in relatively young children would be controversial. Even with a relatively specific definition of competence, assessment would continue to prove difficult. Doctors and parents would need educating. Assessment procedures would need refining and updating. Recourse to the courts would probably not be more frequent than at present. In the few cases, the courts' main function would be to confirm competence or otherwise, and it would be necessary to overrule a competent child's refusal to follow a management plan only if serious irreparable harm were the likely outcome.

The report presents a compelling challenge to all health professionals and deserves serious consideration. The recommended code, further refined by discussion involving young people as well as professionals and later established by act of parliament, would represent an important milestone in adult acceptance of children's basic rights.

GEORGE RYLAND
Consultant paediatrician

Children's Hospital,
Ladywood Middleway,
Birmingham B16 8ET

- 1 Alderson P. *Children's consent to surgery*. Buckingham: Open University Press, 1993.
- 2 Rylance G, Bowen C, Rylance J. Measles and rubella immunisation: information and consent in children. *BMJ* 1995;311:923-4.
- 3 United Nations. *Convention on the Rights of the Child* 1989. Geneva: UN, 1989.
- 4 Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (1985) 2 BMLR 11.
- 5 R (a minor) (Wardship: Medical Treatment), Re [1991] 4 All ER 177 (1991) 7 BMLR 147.
- 6 Alderson P, Montgomery J. *Health care choices: making decisions with children*. London: Institute for Public Policy Research, 1996.