

Introduction

Pediatric assent is an important ethical construct, yet there is little agreement on what precisely it means, including the ethical justifications on which it is grounded.

In the pediatric ethics literature, the concept of assent ranges between two extremes (Sabatello 2018). One extreme counts a child’s mere acquiescence to a treatment as sufficient, while the other characterizes assent as a full analogue to informed consent in adults who have decision-making capacity, but without a corresponding legal recognition of the child’s right to refuse or authorize treatment.

The AAP’s characterization of assent can be seen as a middle position between these two extremes. First articulated in 1995 (AAP 1995), and updated in 2016 (AAP 2016; Katz and Webb 2016), the AAP definition of assent identifies a process for providing developmentally appropriate information to a child and soliciting their preference about treatment. It includes the following components:

- 1. Helping the patient achieve a developmentally appropriate awareness of the nature of their condition.
- 2. Telling the patient what they can expect with tests and treatment(s).
- 3. Making a clinical assessment of the patient’s understanding of the situation and the factors influencing how they are responding (including whether there is inappropriate pressure to accept testing or therapy).
- 4. Soliciting an expression of the patient’s willingness to accept the proposed care.

This view of assent does not require full understanding, but clearly involves criteria that surpass mere acquiescence.

Aims and Objectives

The primary goal of this study is to assess the range of ways that pediatric assent is specified in the clinical ethics literature, as well as what different conceptions intimate about its moral value.

This systematic review will summarize the normative claims about pediatric assent in recent literature. Analysis will map divergent constructs and various moral justifications

Methods

Relevant MESH terms were defined and nine databases identified in consultation with an information sciences expert. Inclusion and exclusion criteria centered on the use of pediatric assent as a normative construct and in the context of clinical care (as opposed to research). Article screening at both the title/abstract and full text review stages was conducted by two independent reviewers using the COVIDENCE software, with conflicts resolved by a third expert reviewer. Of the 7,446 initial search results (including duplicates), 29 articles were ultimately included in the analysis.

The articles included in the study were reviewed independently by two authors for any content that provided:

- 1. The author’s operational definition of assent;
- 2. Discussion about the temporal nature of assent (e.g. assent as a process);
- 3. Discussion of the concept of “understanding” and its role in the assent process; and
- 4. Ethical justifications for soliciting pediatric assent.

Results

The primary finding reported here concerns how ethical justifications for assent are underspecified. While largely mirroring the compendium of both instrumental and intrinsic reasons stipulated by the AAP, authors often invoked, but did not elaborate, broad notions like “respect” or drew on the questionably relevant concept of autonomy. Among the articles reviewed, however, the moral justification for soliciting pediatric assent were often absent, or only superficially described. In 6 articles, there was no explicit ethical justification for pediatric assent articulated at all.

In articles which did specify a moral reason for soliciting pediatric assent, authors often seamlessly blended together both instrumental reasons (good because it achieves something else; e.g. promoting health) and intrinsic reasons (good in and of itself; e.g. respect). Instrumental reasons were explicated in 10 of the articles, including such things as improving patient relationships and fostering trust, promoting the developing autonomy of the child, encouraging treatment compliance, and protecting the child from harm.

Additionally, many articles invoked the notion of the “rights” of children, but in these cases, the term appeared to be used in a general sense, rather than referring to specific concept of socio-political entitlements that need to be protected.

Conclusions

This study was intended to assist in clarifying the normative parameters of pediatric assent and the moral obligations of clinicians to include children in treatment decisions. The moral justification for pediatric assent currently contributes to wide variation in the practice of including children in their own care, and undermines the ability of physicians to adequately and ethically use assent processes to involve children in their own care.

Additional work is needed to elaborate the moral justifications for pediatric assent. For example, it is common to attempt to justify child assent in the notion of autonomy. However, insofar as assent applies specifically to non-autonomous persons, this is not necessarily the case and such assumptions place the notion of pediatric assent on a very unstable foundation (Navin and Wasserman 2019).

Future work in pediatric ethics should aim at further development of the ethical justifications of pediatric assent.

References

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