

## Review

# Ethical Considerations in Consent for Pediatric Population

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### Abstract

Informed consent in pediatric healthcare presents a distinct set of ethical challenges, largely shaped by the evolving capacity of children to participate in decisions about their own care. Unlike adults, children are not presumed to have full legal autonomy, which places decision-making authority in the hands of parents or legal guardians. However, ethical practice requires more than legal compliance. It involves recognizing the child as an individual with emerging rights, preferences, and an ability to understand their medical situation to varying degrees, depending on age and maturity. Assent has emerged as a key concept in addressing this gap, serving as a process that respects the child's voice without displacing parental responsibility. The role of parents in medical decisions is complex and influenced by cultural beliefs, values, and social structures. In some contexts, parental authority is shaped by communal norms rather than individualistic ideals, making it essential for healthcare providers to understand and adapt to varying expectations. Conflicts may arise when parental choices are at odds with clinical recommendations or when children express dissent. In such cases, ethical guidance and legal frameworks must work together to protect the child's welfare while respecting family integrity. Cultural and contextual factors further influence how consent and assent are understood and practiced. In settings where health literacy is limited or where traditional belief systems shape medical decisions, clinicians must engage with families thoughtfully, using culturally sensitive approaches that build trust and promote informed participation. Assent and consent are not fixed procedures but relational processes that evolve with each encounter. Recognizing the diverse ways in which families understand health, authority, and childhood can lead to more ethical and effective pediatric care, grounded in respect, communication, and shared decision-making.

**Keywords:** *pediatric consent, child assent, parental authority, medical ethics, cultural context*

## Introduction

Informed consent stands as a cornerstone of ethical medical practice, ensuring that individuals voluntarily engage in decisions about their healthcare with adequate understanding and without coercion. However, in pediatric populations, the concept becomes more complex due to the evolving cognitive and emotional maturity of children and adolescents. Unlike competent adults, children often lack the legal and developmental capacity to provide fully autonomous consent, necessitating parental or guardian involvement in healthcare decisions. This unique situation gives rise to a range of ethical dilemmas surrounding autonomy, protection, and best interests.

Children are not a homogeneous group; their ability to understand medical information and make informed choices develops progressively with age and experience. Consequently, ethical frameworks advocate for the involvement of children in the decision-making process through the concept of assent. Assent refers to a child's affirmative agreement to medical interventions, acknowledging their developing agency while still deferring ultimate responsibility to adult caregivers (1). Ethical considerations thus revolve around determining when and how children should be involved in consent processes, balancing their growing autonomy with the duty to protect their well-being.

The role of parents or legal guardians is critical in pediatric consent, as they are generally entrusted to act in the best interests of the child. Nonetheless, parental decisions may sometimes conflict with medical recommendations or the expressed wishes of the child, leading to ethical tension. For example, in cases involving life-sustaining treatment or participation in research, disagreements may arise between healthcare providers and parents about what constitutes an appropriate course of action. Such situations highlight the ethical challenge of respecting family values and parental authority while ensuring the child's rights and health are not compromised (2).

Moreover, the cultural and social context in which consent occurs significantly influences how ethical principles are interpreted and applied. Attitudes toward children's autonomy, parental authority, and the role of the community can vary widely across different societies and healthcare systems. In some cultures, collective decision-making predominates over individual choice, potentially complicating standard models of informed consent (3). Ethical practice in pediatric care must therefore be sensitive to these cultural dimensions while upholding universal human rights principles.

Legal frameworks also differ across jurisdictions, further complicating the ethical landscape. Some countries recognize the "mature minor doctrine," allowing adolescents deemed sufficiently capable of consent independently to certain medical procedures. Others adopt rigid age-based thresholds that do not always align with an individual child's actual capacity for understanding and choice (4).

## Review

Ethical challenges in pediatric consent are deeply rooted in the evolving nature of a child's autonomy and the responsibilities of caregivers and healthcare providers. Unlike adults, children often cannot provide legally valid informed consent, prompting reliance on parental permission and the child's assent. However, determining the appropriate level of a child's involvement in medical decisions is ethically nuanced. As children mature, their capacity for understanding health information and expressing preferences increases, which necessitates a flexible, developmentally appropriate approach to consent. This involves recognizing their emerging autonomy while also safeguarding their best interests, particularly in high-stakes or complex medical decisions (5).

Parental authority plays a central role in pediatric healthcare decisions, but it is not absolute. Ethical tensions arise when parental choices appear to contradict the medical team's assessment of the child's best interests. In such cases, clinicians may face the dilemma of respecting family values versus intervening to prevent harm. This is especially significant in life-sustaining treatments, where

disagreements about prognosis or acceptable quality of life can complicate consent discussions. Legal systems often act as arbiters in such disputes, but ethical reasoning remains essential to guide clinicians toward decisions that are compassionate, culturally sensitive, and child-focused (6).

### ***Evolving Autonomy and Decision-Making Capacity***

Research has shown that many children, particularly adolescents, can understand medical information relevant to their condition and express preferences that reflect consistent values (7). Informed assent, therefore, becomes a vital ethical practice that respects the child's emerging sense of self. While not legally binding, assent acknowledges the child's voice, giving them a participatory role without displacing the legal authority of parents or guardians. The goal is not simply to inform but to engage in a dialogue where the child's concerns, fears, and preferences are heard and considered.

The concept of evolving capacity has been reinforced in various international frameworks, including the United Nations Convention on the Rights of the Child (UNCRC), which promotes the right of children to express views freely in matters affecting them, with weight given in accordance with their age and maturity (8). This principle does not eliminate adult responsibility, but it shifts the ethical duty toward actively involving children in their care. It also raises questions about how to measure capacity fairly, without imposing adult-centric standards that undervalue young people's perspectives.

Within clinical settings, assessing capacity often relies on a combination of developmental psychology and physician judgment. Studies suggest that adolescents as young as 12 or 13 may demonstrate reasoning abilities comparable to adults, especially in low-stakes decisions with clear outcomes (9). However, when risks increase or consequences become irreversible, clinicians may require a higher threshold of understanding. The variability in individual maturity levels makes standardized protocols difficult, reinforcing the need for a tailored, empathetic approach to capacity

assessment. This complexity is particularly evident in chronic conditions, where adolescents gradually become more involved in managing their treatment. The repeated exposure to medical discussions can enhance their ability to participate actively in decision-making, fostering a more robust sense of agency over time.

The evolving autonomy of children also intersects with the broader moral aim of fostering responsibility and independence. Supporting a child's growing participation in healthcare decisions is not merely an ethical requirement but also a developmental opportunity. It provides a structured environment where young patients can learn to weigh risks, ask questions, and consider future consequences. These interactions with clinicians and caregivers become foundational for future encounters with the healthcare system, especially as they transition into adulthood. Respect for emerging autonomy, therefore, is not only a matter of ethical integrity but also an investment in long-term health literacy and self-efficacy (10).

### ***Parental Consent and the Role of Child Assent***

Legal systems generally give parents the authority to make medical decisions until the child reaches the age of majority. Within this structure, parents serve as surrogate decision-makers, weighing risks, benefits, and future implications of treatment. However, the ethical legitimacy of their choices depends not only on technical understanding but also on how well those decisions align with the child's evolving preferences and emotional needs. Parents may occasionally prioritize religious beliefs, cultural expectations, or deeply held personal values when authorizing or refusing care. When such values diverge from accepted medical standards, conflicts can arise between healthcare teams and families, often placing the child's voice at the margins of the conversation (11).

Including children in medical discussions through assent helps bridge this gap. Assent is not about granting full decision-making power to the child, but rather inviting them to be heard, respected, and informed. It means clinicians explain the nature of the illness, the proposed intervention, and what the

child might experience, in language suited to their developmental stage. When children express discomfort, resistance, or disagreement, those responses carry ethical weight. While their dissent may not override parental consent, it signals emotional distress that clinicians have a duty to address with sensitivity. Some healthcare providers may delay or modify treatment plans in response to a child's dissent when the intervention is elective or not urgently required (12).

This dual framework requires clinicians to operate with ethical flexibility. It also demands attentiveness to family dynamics. Not all parents are equipped to understand the gravity of medical decisions, especially when anxiety or grief clouds judgment. In such contexts, the healthcare provider's role extends beyond informing to guiding. Encouraging parents to consider the child's preferences does not diminish their authority; it enriches the decision-making process by anchoring it in mutual respect and understanding. In situations involving older children or adolescents, parental authority may become more collaborative, as both parties weigh in on the course of treatment (13).

Ethical frameworks increasingly support this inclusive model. Professional guidelines from pediatric associations emphasize the importance of assent, especially in research settings. Respecting a child's developing voice, even when not legally required, aligns with broader commitments to patient-centered care. By engaging children in their own care and helping parents navigate this engagement, clinicians foster ethical clarity in moments that are often emotionally charged and morally complex (14, 15).

### ***Cultural and Contextual Factors in Pediatric Consent***

Pediatric consent does not unfold in a vacuum. It is shaped by deeply rooted cultural norms, religious beliefs, legal systems, and socioeconomic conditions. What may be considered ethically appropriate or legally valid in one country might be perceived very differently in another. The role of family, community, and authority figures varies across cultural contexts, and these variations

influence how decisions about children's health are made and interpreted. In many societies, the notion of individual autonomy carries less moral weight than collective responsibility, and children are often viewed not as independent decision-makers but as members of tightly integrated familial or social units (16).

In Western healthcare systems, informed consent has evolved around the principle of individual rights, placing a strong emphasis on personal autonomy, disclosure, and voluntary agreement. Yet, these principles may not align neatly with the values of non-Western communities. For example, in cultures where elders hold decision-making power, or where medical decisions are seen as a shared family duty, expecting a parent to act as the sole consenting authority may oversimplify complex family hierarchies. Similarly, involving the child through assent may be viewed as unnecessary or even inappropriate, depending on local customs or beliefs about childhood and authority (3).

Socioeconomic conditions add further layers to the ethical dimensions of pediatric consent. In low-resource settings, consent processes may be compromised by limited access to information, low literacy rates, or dependence on overburdened healthcare systems. The pressure to accept treatment without fully understanding the implications can lead to consent that is legally obtained but ethically questionable. In these environments, healthcare workers may also face challenges in providing culturally tailored explanations or securing time for meaningful dialogue. When language barriers exist or when families have had limited prior interaction with formal medical institutions, trust becomes fragile. Building that trust requires more than simply presenting facts; it calls for cultural competence, patience, and the ability to navigate local expectations (17).

Religious beliefs further complicate the ethical terrain. Families may refuse medical interventions based on spiritual convictions, creating tension between respecting cultural identity and ensuring a child's right to health. These situations often require ethics consultations or legal intervention when

refusal of care is perceived to cause significant harm. Still, dismissing these beliefs outright risks alienating families and weakening the therapeutic alliance. A more nuanced response involves dialogue that acknowledges the spiritual dimensions of care while exploring acceptable compromises. This may include integrating community or religious leaders into discussions to foster trust and encourage cooperation with medical teams (18). Differences in medical norms can lead to misunderstandings or conflict between clinicians and families. Parents from cultures with limited exposure to pediatric research, for instance, may hesitate to enroll their child in a clinical trial, even when the risks are minimal and the benefits substantial. To ethically engage these communities, consent procedures must account for cultural attitudes toward medicine, authority, and child development. This does not mean abandoning the ethical principles of autonomy and protection but adapting how those principles are communicated and applied in diverse cultural landscapes.

### **Conclusion**

Pediatric consent involves a careful balance between protecting the child's welfare and respecting their evolving autonomy. Ethical practices must adapt to developmental stages, family dynamics, and cultural diversity. Involving children meaningfully while guiding parents ethically strengthens trust and care outcomes. Ongoing dialogue, context-sensitive approaches, and legal clarity remain essential.

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All data is available within the manuscript.

### ***Author contribution***

All authors contributed to conceptualizing, data drafting, collection and final writing of the manuscript.

### **References**

1. Alderson P. Choosing for children: parents' consent to surgery: Routledge; 2023.
2. Diekema D. Parental refusals of medical treatment: the harm principle as threshold for state intervention. *Theoretical medicine and bioethics*. 2004;25(4):243-64.
3. Gatrad AR, Sheikh A. Medical ethics and Islam: principles and practice. *Archives of Disease in Childhood*. 2001;84(1):72-5.
4. Buchanan AE, Brock DW. Deciding for others: the ethics of surrogate decision making. 1989.
5. Ross LF. Children, families, and health care decision making: Oxford University Press; 1998.
6. McDougall RJ, Notini L. Overriding parents' medical decisions for their children: a systematic review of normative literature. *Journal of medical ethics*. 2014;40(7):448-52.
7. Miller VA, Drotar D, Kodish E. Children's competence for assent and consent: a review of empirical findings. *Ethics & behavior*. 2004;14(3):255-95.
8. Assembly UG. Convention on the Rights of the Child. United nations, treaty series. 1989;1577(3):1-23.
9. Weithorn LA, Campbell SB. The competency of children and adolescents to make informed treatment decisions. *Child development*. 1982:1589-98.
10. Alderson P, Montgomery J. Health care choices: making decisions with children: Institute for Public Policy Research; 1996.
11. Schoeman F. Parental discretion and children's rights: background and implications for medical decision-making. *The Journal of medicine and philosophy*. 1985;10(1):45-62.

12. Leikin SL. Minors' assent or dissent to medical treatment. *The Journal of pediatrics*. 1983;102(2):169-76.
13. Katz AL, Webb SA, Bioethics Co, Macauley RC, Mercurio MR, Moon MR, et al. Informed consent in decision-making in pediatric practice. *Pediatrics*. 2016;138(2):e20161485.
14. Joseph PD, Craig JC, Caldwell PH. Clinical trials in children. *British journal of clinical pharmacology*. 2015;79(3):357-69.
15. Caldwell PH, Murphy SB, Butow PN, Craig JC. Clinical trials in children. *The Lancet*. 2004;364(9436):803-11.
16. Sibley A, Sheehan M, Pollard AJ. Assent is not consent. *Journal of medical ethics*. 2012;38(1):3-.
17. Molyneux CS, Wassenaar DR, Peshu N, Marsh K. 'Even if they ask you to stand by a tree all day, you will have to do it (laughter)...!': community voices on the notion and practice of informed consent for biomedical research in developing countries. *Social science & medicine*. 2005;61(2):443-54.
18. Bhutta ZA. Beyond informed consent. *Bulletin of the World Health Organization*. 2004;82:771-7.