

---

# Child Assent and Parental Permission for Clinical Research — Some Considerations

by Christian Simon

---

*The success of our future efforts to understand and improve the ethics of pediatric informed consent may depend, in large measure, on our willingness and ability to conceive of child assent and parental permission as joint, mutually affective processes. Given current trends, our empirical efforts may need to unfold at the interface of assent and parental permission, rather than exclusively or even primarily in one domain or the other. This shift will permit researchers to identify those areas in which the two mechanisms function in concert — in the best interests of patients, parents, and clinicians — and those in which they do not. Targeting these problematic areas for intervention and improvement may result in a more effective consent process for clinical research involving minors.*

**H**ow best to inform and protect children who are eligible to participate in clinical research is an important, timely, and difficult issue. Key in this regard are recent efforts aimed at granting children, particularly older, more mature children, greater say in discussions and decisions about clinical trials for which they are eligible.

These efforts include guidelines developed by the bioethics committee of the American Academy of Pediatrics (AAP 1995); the World Medical Association's 1996 *Declaration of Helsinki* (Robinson 2000); and the former Department of Health, Education, and Welfare's regulations in the *Federal Register* on the Protection of Human Subjects (1973).

An increasing number of institutional review boards (IRBs) have adopted these policies and guidelines (Mammel and Kaplan 1995). Despite considerable variability among states concerning standards of disclosure in the clinical setting (Denham and Nelson 2002), IRBs in pediatric care institutions are following the mandate that parental permission be augmented with "assent."

This joint process grants greater say to children without unfairly diminishing the concerns and decision-making rights of parents.

Lively debate has surrounded this development. How much information about study risks should be shared with a ten-year-old, or how much autonomy to turn down a potentially beneficial research

---

*[How can] the goal of granting children greater say be integrated with the goal of informing parents and respecting their decision-making input?*

---

study should be granted to a fourteen-year-old, for example, remains a thorny issue despite a host of well-intentioned policies and guidelines.

Also challenging and important is the question of how, in everyday clinical practice, the goal of granting children greater say can best be integrated

with the goal of informing parents and respecting their decision-making input. Various factors potentially complicate this process. Children and adults typically have different information needs and wants. Their ability to comprehend abstract concepts such as randomization and other study-design elements is demonstrably different (Susman, Dorn, and Fletcher 1992 and Erb, Schulman, and Sugarman 2002). Successfully developing child assent and parental permission as a joint consenting mechanism may also require additional time and effort on the part of clinician/investigators. Children and their parents may need

---

*The doctrine of informed consent has only limited direct application in the pediatric setting.*

---

to be approached separately, in stages, and with a trained eye on potential problems and intra-family differences that might hinder the communication and understanding of key research-related information.

### **A Balance of Purposes**

The term "informed consent" is widely used to designate a decision-making process by which patients decide *for themselves* whether or not to enroll in a clinical trial. Informed consent is typically the situation in adult care when competency issues are not at work. For this reason, the term is viewed as having strict applicability in pediatric settings in only limited instances, such as the gaining of consent from a sixteen-year-old for the performance of a pelvic exam, or from a fifteen-year-old for a proposed long-term antibiotics treatment plan for severe acne (AAP 1995). More commonly, however, the formal decision to participate in clinical research is *not* made by pediatric patients themselves but by their parents or legal guardians along a continuum occupied at one end by parental permission and at the other by the patient/child's assent.

This distinction has led regulatory bodies and scholars to argue that the doctrine of informed consent has only limited direct application in the pediatric setting, and that "parental permission" and "assent" are preferable concepts for characterizing the decision-making process surrounding pediatric clinical trials (AAP 1995, Robinson 2002, Erb, Schulman and Sugarman 2002, and Bartholome 1996).

---

*Parental permission and child "assent" are preferable concepts for characterizing the decision-making process surrounding pediatric clinical trials.*

---

This distinction becomes ambiguous, however, when the concept of "informed consent" is more fully defined to refer not just to decision-making processes, but also to the disclosure and understanding of key information about treatment options (AAP 1995, Mammel and Kaplan 1995, Bartholome 1996, and Leiken 1983b). Information disclosure and understanding are key ethical and pragmatic prerequisites that govern fully informed decision making in both pediatrics and adult clinical settings (Denham and Nelson 2002). They are obvious prerequisites regardless of whether parents are in the process of deciding a course of action for themselves or their child. Losing sight of this similarity may put us at risk of minimizing the up-front activities that are essential to good, fully informed decision making, such as effective communication and understanding.

It is worth noting, therefore, that "informed consent" is a useful concept in the pediatric setting — and refers to more than those limited situations in which consent is actually sought from minors. The term conveys more effectively than "parental permission" or "assent" that decision making is one of three critical components of human subjects protection in the context of pediatric research. These are (1) the disclosure of key research-related

information; (2) understanding information; and (3) parental permission and (increasingly) the child's expression of preference.

It is in the third requirement that the similarity between adult and pediatric informed consent drops away and reveals the main justification for a process of assent: proxy decision making may not, by itself, uphold the rights and best interests of a patient capable of expressing a personal preference about their treatment options (AAP 1995, Bartholome 1996, and Bujorian 1988).

Driving much of the debate around assent is the question of how centrally this expression of preference should figure in the overall consent process for pediatric research. Evidence indicates, on the one hand, that children may be better equipped

---

*Evidence indicates that children may be better equipped to participate in clinical information sharing and decision making than was once thought.*

---

to participate in clinical information sharing and decision making than was once thought. Children cope remarkably well with the shock of a serious diagnosis, and may be better adjusted psychologically to their disease and its treatment if they are actively included in treatment-related deliberations (Slavin et al. 1982, Truog et al. 2002).

Empirical data also show that it may be unfeasible and even deleterious to include children, particularly those under ten years of age, in treatment-related decisions (Susman, Dorn, and Fletcher 2002, Leikin 1983b, and Ondrusek et al. 1998). Children may prefer not to become involved in decisions about their treatment options on the grounds that they are in pain or don't feel well, or that they fear having to reveal sensitive information about themselves (Mammel and Kaplan 1995). They may fail, even in adolescence, to grasp the abstract ideas and concepts that require

understanding if their support for a particular treatment option is to be even partially informed (Susman, Dorn, and Fletcher 1992). Also, children of all ages may be motivated by short-term gains, fear, coercion, and a desire to please their parents or clinical caregivers in expressing their support for a specific treatment option.

Many scholars suggest, as a result, that neither proxy decision making nor the patient's expression of preference ought to function solely by themselves, particularly in situations where children are mature enough to understand their diagnoses and treatment options (Ondrusek et al. 1998, Leikin 1983 and 1993b, and Olechnowicz et al. 2002). While there exist situations in which one mechanism should be preferred or exercised over the other (AAP 1995, Bartholome 1996, Leikin 1983a and 1993, and Kodish, Murray, and Shurin 1994), most stakeholders agree that the two ought to be developed in concert. Pediatric patients need to be informed and empowered, but this need should not impose unfairly or deleteriously on their interests, wants, and capabilities — or those of their parents.

### **Grounding a Balance of Purposes**

Given this ideal, it is unclear from current ethics literature what a balance of purposes would entail at the level of actual, everyday patient-parent-physician encounters around issues of clinical research. Can the process of assent simply be grafted onto the process of gaining parental permission in a fashion suggested, for example, by current pediatric consent documents that require an assenting signature in addition to written permission from the patient's parents or legal guardians? What of the clinician-investigator's approach? Should he or she take special steps, for example, by meeting privately with patients to discuss their options and assess their preferences without undue distraction or influence from the child's parents? Should a similar approach be taken with parents? Or would focus on the family as a whole, through a series of discussions that include both patient and parent, result in a better, ultimately more equitable, consenting experience?

A brief revisit to the three requirements introduced earlier provides some indication of the importance of these and other questions. Extended to assent, these requirements broadly involve a disclosure of information to parents and patients, an understanding of this information by the parents and patients, and parental decision by proxy and the patient's expression of preference.

### ***Disclosing Key Information***

For the process of assent and parental permission to occur, it is critical that adequate and understandable information be provided to both the pediatric patient and his or her parents. Researchers have suggested a spectrum of details that are critical to this process, including information about treatment options and alternatives to research, research purposes and procedures, anticipated risks and benefits, and voluntary participation (Sugarman, Kaalund, and Kodish 1997). Researchers also frequently emphasize the importance of communicating the differences between research and regular or "standard" treatment, and the need to minimize therapeutic misconception (Sugarman, Kaalund, and Kodish 1997, Appelbaum, Roth, and Lidz 1982, Appelbaum et al. 1987, and Kodish 2001).

Some of the effectiveness of this disclosure process hinges on "good" or "quality" communication, and the provision of "opportunities" for parents and children to ask questions and voice their concerns (Susman, Dorn, and Fletcher 1992, Sugarman, Kaalund, and Kodish 1997, and Sutherland et al. 1989). In urgent need of empirical attention, however, is the question of how the inclusion of adults and minors may shift or change communication-based priorities and behaviors in ways that potentially diminish the disclosure process or such outcomes as patient/parent understanding, trust, and satisfaction.

The relevant literature offers, to my knowledge, only one example of a study that has taken on this question. Conducted in the context of the informed consent process for Phase III pediatric leukemia trials, this study found that the dynamics of informed consent communication were significantly different when young patients (with a mean age of fourteen) were included in discussions

about treatment options, compared to discussions in which the patient was not present (Olechnowicz et al 2002).

For example, clinician-investigators (who were audiotaped) framed mortality issues and numerical information about chances of survival *less often* when the patient was present, compared to discussions in which the patient was absent. Likewise, parents asked significantly *fewer* questions when the patient was present during discussions of treatment options, compared to the number of questions parents asked during patient-absent discussions. One implication of this finding, the authors suggest, is that parental participation may be negatively affected in situations in which the patient is present and commands a clinician's attention, as opposed to situations in which the patient is absent and parents have the full attention of their child's clinician.

Human communication is a complex process, subject to differences in age, developmental maturity, and information needs and preferences; social and educational status; and, other "externally" imposed factors. More subtle cues are also important, such as frequency of eye contact, choice of vocabulary and tone, physical gestures, and other verbal and nonverbal behaviors.

---

***Would focus on the family as a whole, through a series of discussions that include both child and parent, result in a better, ultimately more equitable consenting experience?***

---

Clearly, these factors may need further consideration given the unanticipated consequences in the simultaneous disclosure of key information to both parents and patients. Even though it may be the intuitive, logical choice of most clinicians, putting the sole focus of the disclosure process on the family as a whole may prove more complex and limiting than expected. Assessment of alterna-

tive processes, such as a series of discussions that combine family-focused informed consent meetings with some meetings that are parent focused and some that are patient focused.

### *Ensuring understanding*

How thoroughly individuals understand key research-related information is critical to the effectiveness of informed consent. Empirical work in this area has been done to gauge the understanding of parents of pediatric patients, and, more

---

*Patients and parents may facilitate one another's understanding of key information.*

---

recently, to gauge the understanding of pediatric patients themselves. Little or no work has been done to gauge the understanding of both parents and patients involved in a shared pediatric-based consent process.

Several reasons create a demand for this research of which the most important may be that understanding can be diminished as a result of disclosure processes that fail to account for variations in information-processing capabilities between children and adults, interpersonal tensions or conflict, and the various challenges confronting a clinician-investigator engaged in sharing information with both parents and patients.

It is also possible that parents and patients may facilitate one another's understanding of certain key information. In the study conducted by Olechnowicz et al. (2002), for example, young patients displayed a willingness to talk and learn about serious side effects of chemotherapy, including brain damage, infertility, and life expectancy. They asked questions that, when answered in the presence of their parents, enlightened both the children and their parents. Parental question-asking in the presence of their children may play a similar role. Although it remains to be seen whether such dynamics have a measurable effect on informed consent understanding, if they do, they offer an

important reason to hold informed consent discussions that include both parents and patients, rather than separating them to accommodate discreet, age-tailored discussions.

### *Parental decision (by proxy) and the patient's expression of preference*

Driving much of our thinking on informed consent in medicine is the concern that individuals may be unduly influenced by their clinicians' views, values, or recommendations when asked to make decisions that ought to be, from an ethical standpoint, relatively autonomous and independent. Underlying this concern is the fact that decision making in the clinical setting, as much as in any other setting, is fundamentally a "social act" (Leikin 1983a). Individuals are asked to announce their choice of treatment to someone, usually a physician, whose authority, prestige, and clinical know-how is usually greater, or perceived to be greater, than their own.

Stepped-up efforts to afford pediatric patients greater say in research-related decisions adds another dimension to this social act. For the patient's assent to be meaningful, consideration

---

*Evidence indicates that children may be better equipped to participate in clinical information sharing and decision making than was once thought.*

---

must be given to the potential for unduly influencing pediatric patients. This potential may be tied on the one hand to the nature of the pediatric *doctor-patient* relationship, as perceptions of authority and compliance may be more acutely experienced by young patients whose clinical authority figures are also adults.

Undue influence is also a concern in light of the emphasis placed on the *parent-child* relationship by policies and guidelines that advocate a balance of purposes in pediatric informed con-

sent. Parents may react in any number of ways to this development, including with alarm and discomfort. A clinician-investigator's attempts to solicit their child's preferences, for example, may prompt parental comments that, intentionally or unintentionally, have an unwanted coercive effect. This effect may be particularly pronounced and deleterious in situations in which parents and their children disagree openly about the merits or drawbacks of enrolling in a clinical trial. Such disagreement may be hard to resolve, even where legal measures support the right of children to make their own decisions.

Although the doctor-patient relationship has benefited from longstanding scientific and public scrutiny, the parent-child relationship remains, in the context of pediatric care and decision making, relatively inaccessible and enigmatic. As a result, current assent regulations are being formulated without a clear understanding of the problems that may ensue from their formulation alongside a tradition of parental autonomy and proxy decision making.

### Conclusion

Older children and adolescents are increasingly looked on as potentially autonomous individuals, who are generally more capable of learning, comprehending, and making informed choices than was once thought. Current healthcare policies and practices reflect this shift in perspective, actively encouraging information sharing and participation in decision-making processes among older children and adolescents. The development of assenting procedures alongside parental permission for clinical trial involvement represents one key advance in this respect.

Embedded in this development is the idea that the family as an intergenerational whole, rather than one generational segment of the family, is the ideal locus for information-sharing and decision making about pediatric clinical trials. We lack the data, however, to know whether this assumption is valid. In fact, what little data have been produced suggest the potential for considerable friction between the processes of assent and

parental permission. Successfully integrating the two will likely depend on our ability to forge an effective partnership among patients, parents, and providers, a triad potentially as formidable in its complexity as the classic patient-provider dyad, but one still woefully understudied.

### References

- American Academy of Pediatrics Committee on Bioethics (AAP). 1995. "Informed Consent, Parental Permission, and Assent in Pediatric Practice." *Pediatrics* 95:314-317
- Appelbaum, P.S., L. H. Roth, and C. Lidz. 1982. "The Therapeutic Misconception: Informed Consent in Psychiatric Research." *International Journal of Law and Psychiatry* 5:319-329.
- Appelbaum, P.S., L. H. Roth, C. Lidz, P. Benson, and W. Winslade. 1987. "False Hopes and Best Data: Consent to Research and the Therapeutic Misconception." *Hastings Center Report* 17:20-24.
- Avery, M. E. 2000. "Ethics in Pediatric Research." *Pediatric Research* 47:542-543.
- Bartholome, William G. 1996. "Ethical Issues in Pediatric Research." In H. Y. Vanderpool, editor. *The Ethics of Research Involving Human Subjects: Facing the 21st Century*. Frederick, MD: University Publishing Group, pp. 339-370.
- Bujorian, G. A. 1988. "Clinical Trials: Patient Issues in the Decision-Making Process." *Oncology Nursing Forum* 15:779-783.
- Denham, E. J., and R. M. Nelson. 2002. "Self-Determination Is not an Appropriate Model for Understanding Parental Permission and Child Assent." *Anesthesia and Analgesia* 94:1049-1051.
- Department of Health, Education and Welfare (DHEW). 1973. Protection of Human Subjects: Policies and Procedures. *Federal Register* 38 FR 27882.
- Erb T. O., S. R. Schulman, and J. Sugarman. 2002. "Permission and Assent for Clinical Research in Pediatric Anesthesia." *Pediatric Anesthesia* 94:1155-1160.
- Kodish, E. 2001. "Phase I Cancer Trials: Therapeutic Research?" *Hastings Center Report* 31:4-5.
- Kodish, E., T. H. Murray, and S. Shurin. 1994. "Cancer Risk Research: What Should We Tell Subjects?" *Clinical Research* 42:396-402.
- Leikin, S. 1983a. "An Ethical Issue in Biomedical Research: The Involvement of Minors in Informed and Third Party Consent." *Clinical Research* 31:34-40.
- . 1983b. "Minors' Assent or Dissent to Medical Treatment." *Journal of Pediatrics* 102:169-176.
- . 1993. "The Role of Adolescents in Decisions Concerning Their Cancer Therapy." *Cancer* 71:3342-

- 3346.
- Mammel, K. A., and D. W. Kaplan. 1995. "Research Consent by Adolescent Minors and Institutional Review Boards." *Journal of Adolescent Health* 17: 323-330.
- Olechnowicz, J. Q., Michelle Eder, Christian Simon, Stephen Zyzanski, and Eric Kodish. 2002. "Assent Observed: Children's Involvement in Leukemia Treatment and Research Decisions." *Pediatrics* 109: 806-814.
- Ondrusek, N., R. Abramovitch, P. Pencharz, and G. Koren. 1998. "Empirical Examination of the Ability of Children to Consent to Clinical Research." *Journal of Medical Ethics* 24:158-165.
- Robinson, William. 2000. Ethical Issues in Pediatric Research. *Journal of Clinical Ethics* 11:145-156.
- Slavin, L., J. O'Malley, G. Koocher, and D. Foster. 1982. Communication of the Cancer Diagnosis to Pediatric Patients: Impact on Long-Term Adjustment. *American Journal of Psychiatry* 139:179-183.
- Sugarman, J., V. Kaalund, E. Kodish, et al. 1997. "Ethical Issues in Umbilical Cord Blood Banking." Working Group on Ethical Issues in Umbilical Cord Blood Banking. *JAMA* 278:938-943.
- Susman, E. J., L. D. Dorn, and J. C. Fletcher. 1992. Participation in Biomedical Research: The Consent Process As Viewed by Children, Adolescents, Young Adults, and Physicians." *Journal of Pediatrics* 547-552.
- Sutherland, H. J., H. A. Llewellyn-Thomas, G. A. Lockwood, D. L. Tritchler, and J. E. Till. 1989. "Cancer Patients: Their Desire for Information and Participation in Treatment Decisions. *J R Soc Med* 82:260-263.
- Truog, R. D., J. Burns, S. Shurin, and E. Emanuel. 2002. "Ethical Considerations in Pediatric Oncology." In P. A. Pizzo and D. G. Poplack, editors. *Principles and Practices of Pediatric Oncology*. Philadelphia: Lippincott, Williams, and Wilkins, pp. 1409-1427.