

Children refusing general anaesthesia: to postpone or proceed?

The competency of a child to give or withhold consent for surgery is a frequent problem encountered in anaesthetic practice. Children of all ages should be involved in the decision-making process regarding their care (General Medical Council, 2007).

Anaesthetic induction can be one of the most stressful experiences for a child during the perioperative period (Watson and Visram, 2003). A not infrequent anaesthetic dilemma is how to manage the 'non-cooperative' younger child who is not Gillick competent, where the child's and parent's wishes conflict.

A recent example of such a dilemma was a 5-year-old child who agreed to surgery but did 'not want to go to sleep', i.e. refused consent for general anaesthesia. The child wanted 'only the part to be operated upon to go to sleep' but not the rest of the body. The parents wished to proceed with general anaesthesia without the anaesthetist explaining this to the child. They were worried that their child would refuse the surgery after realizing that general anaesthesia was required. Similar dilemmas occur when a child appears to be cooperative on the ward but then refuses to cooperate in the anaesthetic room. Parents occasionally wish the anaesthetist to proceed anyway ('just get on with it') as they believe this to be in the child's best interest.

In such situations what are the options for the anaesthetist?

Proceed with general anaesthesia

The first option would be to go ahead with anaesthesia without the child's consent in keeping with the parents' wishes while using techniques to distract the child. One needs to consider the following issues before proceeding with this option:

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1. What are the implications of proceeding in the absence of consent by the child?
2. Are these young children competent to refuse?

Going ahead with a procedure without the consent of a child has some serious implications.

Studies (McCann and Kain, 2001) have showed that immediate negative behaviour response develops in a relatively large number of young children following surgery (60% at 2 weeks). However, the magnitude of these changes is usually limited and the long-term maladaptive behavioural response develops in only a small minority (Kain et al, 1996). Children who are anxious during induction of anaesthesia are more likely to develop postoperative negative behavioural changes (Kain et al, 1999), e.g. postoperative pain, sleep disturbances, parent-child conflict and separation anxiety. The child may develop 'hospital' or 'anaesthetic' phobia in the future (Watson and Visram, 2003).

An individual under the age of 16 years can give consent if they are considered Gillick competent. However, if the child refuses consent, parental consent overrides that of the child. Thus by a catch 22, a child whose competency is in doubt is deemed rational if he/she accepts a doctor's proposal but incompetent if he/she rejects it (Shaw, 2001).

Postpone surgery

It is likely that a young child is actually expressing a fear about going to sleep, e.g. waking up in the middle, not waking up at the end or being incontinent when asleep.

If the child has previously appeared cooperative but then becomes completely uncooperative in the anaesthetic room, a short period of time can be spent exploring these areas and attempting to allay the particular fears. If time permits, a pre-medication can be offered to help the child feel less frightened. Unless the child settles fairly quickly and agrees to cooperate with anaesthetic induction (by whichever route), postponing surgery to another date should

be considered to allow more time for discussion of the particular fears, get further input from staff members and consider an anxiolytic pre-medication next time.

Offer regional or local anaesthesia

If the child does not want to go to sleep, offering regional anaesthesia, if feasible, may theoretically provide an option in some children. It is unlikely to be successful as a sole technique in a young child. If the child becomes distressed at any point during the surgery, sedation or general anaesthesia would then become necessary.

Conclusions

The authors believe that particularly anxious children should be flagged up at the pre-assessment clinic and be given honest information to prepare them. They suggest that children of all ages refusing anaesthesia or refusing to cooperate in the anaesthetic room should have their procedure postponed to allow time to explore their particular fears, offer reassurance where appropriate and discuss whether a pre-medication would be helpful. Rather than seeing postponement as a failure, it helps to gain the child's confidence, makes him/her feel in control and prepares the child for the next time. **BJHM**

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