Rights of Children in Pediatric Settings: A Survey of Attitudes

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ABSTRACT. This study compares the attitudes of parents and health care professionals toward the bill of rights for children in pediatric settings of the National Association of Children’s Hospitals and Related Institutions (NACHRI) and a locally developed ombudsman committee bill of rights. Parents (N = 64), attending physicians (N = 33), resident physicians (N = 17), nurses (N = 27), nonmedical professionals (N = 35), administrators (N = 18), and clerical workers (N = 17) were surveyed. Each person rated statements derived from the bills from “strongly agree” to “strongly disagree.” Analyses of variance indicated a high level of agreement overall for both bills by all groups; however, the local bill was significantly preferred. There were significant differences in agreement between the groups for the local bill and the two bills combined (an overall measure of attitudes about children’s rights in pediatric settings). Attending physicians tended to agree significantly less than other groups. On the 32 individual items, attending or resident physicians were significantly lower in agreement than most other groups on 11 items, and nurses were lowest on one other. Disagreement was strongest on items concerning abortion or contraception, the child’s right to privacy, the right to consent to care, and the right to have an immediate response from the physician in understandable language. Pediatrics 60:715-720, 1977, CHILDREN’S RIGHTS, PROFESSIONALS’ ATTITUDES.

Throughout most of history the rights of children have been either denied, ignored, or subordinated to their economic or filial duties. In Roman law, “fathers had absolute power over their children, including the right to decide on matters of life or death and slavery or freedom.” Under English common law, fathers exercised the utmost authority over their legitimate minor children. While having a duty to support and protect them, this obligation was not legally enforceable.

In the present century, awareness has increased that children have special needs and must be extended certain rights if they are to be afforded an opportunity for optimal development. Several manifestations of this trend are apparent. Increasingly, the courts are being used to resolve conflicts between the rights of children and the rights, responsibilities, and actions of their parents. This is best noted in the development of child abuse legislation throughout the United States. Second, various state and national commissions have recognized that no single group or agency effectively advocates for the needs and rights of children. Such organizations have urged the development of child advocacy commissions to defend the needs and rights of children, both individually and collectively. Finally, there has been a proliferation of bills of rights for children developed by national commissions and study groups. These bills serve as statements of principle recognizing the developmental needs of children. Bills of rights have been developed for children in general as well as for groups of special, handicapped children.

There has been speculation that asserting and implementing the rights of children will be met with varying degrees of acceptance and resistance. Because of the implications that the assertion of children’s rights may have for public policy, a wide disparity in attitudes is highly likely: “We believe that every American child has the right to a mentally healthy life of well-being and effectiveness. If we are to fulfill this right, we must face squarely the social crises of our times and commit ourselves to radical social change [italics added].”

Attitudes toward the rights of children may
also differ among groups of parents, health, and mental health workers. While professionals devote themselves to improving the well-being of children, many may be threatened by and resistive to the changes implied by these rights. Parents may not welcome statements of children’s rights that seem to infringe on their own rights and prerogatives; on the other hand, such statements may indeed be welcomed by parents whose children have special needs, as have the parents of mentally retarded children.

Only one study has been located that directly examines the attitudes of different groups toward the rights of children. Wrightsman et al. developed a conceptualization of children’s rights as well as a scale for measuring attitudes toward them. These authors believe that all children’s rights can be categorized into one of two “orientations.” The nurturance orientation stresses the child’s right to the supposedly beneficial environments, experiences, and opportunities that should be freely provided by society. The self-determina-

### TABLE I

**MEAN SCORES FOR ITEMS YIELDING SIGNIFICANT DIFFERENCES AMONG GROUPS**

<table>
<thead>
<tr>
<th>Item (Abbreviated)</th>
<th>$F^*$</th>
<th>Mean Scores†</th>
<th>Low Groups‡</th>
<th>High Groups‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Patients and parents have the right to...&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Timely access to competent health care$§</td>
<td>3.14</td>
<td></td>
<td></td>
<td>A(2.4)</td>
</tr>
<tr>
<td>2. Names &amp; positions of everyone giving direct service$¶</td>
<td>3.62#</td>
<td>A(2.1)</td>
<td>P(2.9)</td>
<td>Ad(2.8)</td>
</tr>
<tr>
<td>6. Medical consultation, evaluation, &amp; referral ¶</td>
<td>2.59**††</td>
<td>...</td>
<td>...</td>
<td></td>
</tr>
<tr>
<td>12. Be informed of extended delays &amp; waits ¶</td>
<td>6.44‡‡</td>
<td>A(2.2)</td>
<td>R(2.3)</td>
<td>P(2.9)</td>
</tr>
<tr>
<td>14. Have an explanation of goals &amp; effects of a teaching hospital ¶</td>
<td>2.43**††</td>
<td>...</td>
<td>...</td>
<td></td>
</tr>
<tr>
<td>16. Know approximate cost of care in advance ¶</td>
<td>2.66**</td>
<td>R(2.0)</td>
<td>C(2.9)</td>
<td></td>
</tr>
<tr>
<td>22. Be informed of significant alternatives in treatment ¶</td>
<td>3.2#</td>
<td>A(2.7)</td>
<td>P(3.0)</td>
<td>Ad(3.0)</td>
</tr>
<tr>
<td>23. Privacy, to know why observers are present, &amp; to request their removal$¶</td>
<td>3.45#</td>
<td>A(1.9)</td>
<td>NM(2.7)</td>
<td></td>
</tr>
<tr>
<td>28. Physical &amp; verbal privacy in medical care$¶</td>
<td>3.68#</td>
<td>A(2.3)</td>
<td>P(2.9)</td>
<td>NM(2.9)</td>
</tr>
<tr>
<td>30. Confidentiality of written communications ¶</td>
<td>2.18**</td>
<td>N(2.3)</td>
<td>P(2.8)</td>
<td>NM(3.0)</td>
</tr>
<tr>
<td>31. Immediate response from attending physician in clear language$¶</td>
<td>4.55‡‡</td>
<td>A(1.9)</td>
<td>P(2.8)</td>
<td>NM(2.6)</td>
</tr>
<tr>
<td>32. Know when physicians are available &amp; what care is needed during &amp; after hospitalization ¶</td>
<td>3.62#</td>
<td>A(2.5)</td>
<td>NM(3.0)</td>
<td></td>
</tr>
</tbody>
</table>

*df = 6,204.
†Newman-Keuls test, $P < .05$.
‡P = parents; A = attending physicians; R = residents; N = nurses; Ad = administrators; C = clerical staff; NM = nonmedical professionals.
§From the NACHRI bill.
¶From the local bill.
#P < .005.
**P < .05.
††Newman-Keuls test yielded no specific group differences.
‡‡P < .001.
tion orientation stresses the child’s right to exercise control over different facets of his or her life and to make decisions about what he or she wants. Using a 300-item attitude questionnaire, they surveyed the attitudes of schoolteachers, college undergraduates, and high school juniors and seniors toward the rights of children ages 10 to 14 in five different areas (health and safety, care, education and information, economic, and legal-political-judicial). Group differences were found, with the high school students holding less favorable attitudes toward the nurturance rights of children and more favorable attitudes toward the self-determination rights of children. Females were more likely to endorse the nurturance rights than males.

Neither the study of Wrightsman et al. nor any other attempted to survey the attitudes toward any particular bill of rights or to survey the attitudes of parents and professional groups who would be influenced by the adoption of such a bill. For this reason the present study examines and compares (1) the attitudes of parents and health care professionals toward the rights of children in health care areas, as outlined in the National Association of Children’s Hospitals and Related Institutions (NACHRI) pediatric bill of rights; and (2) the attitudes of the same individuals toward a bill of rights developed by the ombudsman committee at Children’s Memorial Hospital. This bill was developed with an awareness of local conditions and needs. The bills differed in two major respects: the NACHRI bill proposes certain rights be granted to children regardless of age, while the local bill does not stipulate ages; the NACHRI bill proposes that children be granted rights to receive abortions, contraceptive devices, and treatment of venereal diseases in confidence, while the local bill is silent on these issues. (Summaries of the statements of rights from both bills are included in Tables I and II.)

### METHOD

#### Subjects

Staff members or volunteers delivered attitude questionnaires to hospital employees, and a total of 147 questionnaires were returned from the following groups: full-time attending physicians (N = 33; 63% return rate); resident physicians (N = 17; 49%); nurses (N = 27; 67%); nonmedical professionals, including social workers, psychologists, occupational and recreational therapists (N = 35; 78%); administrators (N = 18; 60%); and clerical workers (N = 17; 56%).

Questionnaires were also administered to parents who attended outpatient clinics or visited children who were inpatients on three days during spring 1976. These parents were informed that completion of the questionnaire was entirely voluntary. The questionnaires were administered to English-speaking parents only. Completed questionnaires were returned by 64 parents, which included virtually all parents who were approached to participate.

#### Instruments

The attitude questionnaire that was administered consisted of 32 items. Sixteen of the items were selected from the nine articles of the NACHRI bill of rights. The remaining items were drawn from the locally developed pediatric bill of rights. The items substantially reproduced the major elements of both bills. Each item was

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**TABLE II**

<table>
<thead>
<tr>
<th>Items*</th>
<th>Rate of Disagreement† (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>From among total sample</td>
<td></td>
</tr>
<tr>
<td>3. Right to receive information concerning contraception in a confidential relationship, regardless of age</td>
<td>17</td>
</tr>
<tr>
<td>5. Right to receive contraceptive devices in a confidential relationship, regardless of age</td>
<td>23</td>
</tr>
<tr>
<td>11. Right to receive confidential abortion &amp; pregnancy counseling, &amp; treatment producing abortion, regardless of age</td>
<td>24</td>
</tr>
<tr>
<td>From among one or more subgroups</td>
<td></td>
</tr>
<tr>
<td>19. Right of patient to consent to medical care, regardless of age</td>
<td>18 (physicians)</td>
</tr>
<tr>
<td>23. Right of patient to privacy &amp; to have observers removed from immediate examining area, regardless of age</td>
<td>22 (physicians)</td>
</tr>
<tr>
<td>31. Right to immediate response in language the patient understands, regardless of age</td>
<td>16 (physicians)</td>
</tr>
</tbody>
</table>

*All items are from the NACHRI bill.

† All items are from the NACHRI bill.
rated on a six-point scale, with the scale points ranging from "strongly disagree (−3)" to "strongly agree (+3)." The questionnaire required approximately 20 minutes to complete.

RESULTS

The data were analyzed, first, to determine which of the two bills of rights was preferred by the respondents in the study; second, to compare the attitudes of the different groups of respondents with one another on each of the bills; finally, to compare the attitudes of the seven groups of respondents on each individual item.

Comparison of the Two Bills

Attitudes toward the two bills of rights were compared by means of a 2 × 7 analysis of variance, with main effects for type of bill (NACHRI vs. local) and group membership (parents, attending physicians, residents, nurses, administrators, clerical staff, and nonmedical professionals). Significant main effects were found for type of bill ($F = 44.35; df, 1,408; P < .001$) and for group membership ($F = 3.43; df, 1,408; P < .001$). Overall, the locally developed bill of rights was favored more than the NACHRI bill.

The mean score for the 16 items of the local bill of rights was 2.76 (N = 211), and for the NACHRI bill, 2.44 (N = 211). Since a score of 3 indicates that the individual "strongly agrees" with the item and 2 indicates that the rater "agrees somewhat," there was a high level of agreement with both bills.

The interaction effect in the analysis of variance was not significant, indicating the groups did not differ in their preferences for one bill vs. the other.

Comparison Among Groups

There were no significant differences among the groups in their attitudes toward the NACHRI bill of rights. However, there were significant group differences on the local bill of rights ($F = 4.45; df, 6,204; P < .0003$) and on the two bills combined ($F = 2.42; df, 6,204; P < .03$). The combined bills served as a general measure of attitudes toward the rights of children in pediatric settings.

To determine which groups differed from one another on the local and combined bills of rights, post hoc comparisons were made by the Newman-Keuls method. For both the combined and local bills the level of agreement was relatively high among all groups, but the attending physicians were the least likely to agree with the proposed rights. With the combined bills, agreement with the proposed rights was significantly lower ($P < .05$) for attending physicians ($\bar{x} = 2.4$) than for parents ($\bar{x} = 2.6$), nonmedical professionals ($\bar{x} = 2.6$), and clerical staff ($\bar{x} = 2.7$); the latter three groups did not differ from one another. For the local bill the rate of agreement was again significantly lower ($P < .05$) for attending physicians ($\bar{x} = 2.6$) than for parents ($\bar{x} = 2.8$), nonmedical professionals ($\bar{x} = 2.8$), clerical staff ($\bar{x} = 2.9$), or administrators ($\bar{x} = 2.8$). No other groups differed significantly from one another in either comparison.

Item Analysis

Group differences on each of the 32 items were examined by analysis of variance. Significant differences were obtained on 12 of the 32 items. These items are presented in summary form in Table I, along with means for groups that differed significantly from one another on a Newman-Keuls test. Attending or resident physicians were significantly lower than other groups on 11 of 12 items, but the level of agreement for physicians was still fairly high.

The proposed rights with which physicians were least likely to agree varied widely in content. They included the patient’s and parents’ right to timely access to competent health care; their right to the names and positions of everyone giving direct service; their right to be informed of extended delays and waits; their right to know the approximate cost of care in advance; their right to be informed of significant treatment alternatives; their right to privacy and to request the removal of observers; their right to immediate and clear responses from the attending physician; and their right to know when physicians are available and what care is needed both during and after hospitalization.

In addition, nurses were the least likely to agree that patients have a right to confidentiality in written communications.

While a majority of raters tended to agree with each of the proposed rights, it is still possible that a sizeable minority of individuals could actually disagree with a proposed right and possibly work against its implementation. Because of this possibility, the percentage of disagreement for each item was calculated for the total sample and for each group of raters. An individual was said to disagree with an item if he acknowledged any amount of disagreement, from "slightly" to "strongly" disagreeing. While at least one person disagreed with almost every item, a "sizeable" level of disagreement was arbitrarily set at 15%.

Table II summarizes these findings. At least
15% of the total sample disagreed with the three items that asserted the child's right to information concerning contraception and abortion or to receiving either contraceptive devices or an abortion in confidence. On these items, each of the seven subgroups of raters also registered at least 15% disagreement with the proposed right. In contrast, the combined groups of respondents showed no more than 10% disagreement with any other item, including one item describing the child's right to confidential information and treatment for venereal disease, regardless of age (7% disagreement overall), and another item granting the right to treatment for pregnancy (8% disagreement), regardless of age.

In addition, physicians registered more than 15% disagreement on three additional items. These included the right of the child to consent to his own care, regardless of age, if the individual was of sufficient intelligence (18%); the right to privacy and to ask that observers be removed from the immediate area (22%); and the right to have an immediate response from the physician in understandable language (16%). No other group indicated more than 15% disagreement with any other item.

**DISCUSSION**

The mean level of agreement with all items tended to be high, whether the proposed rights were drawn from the national bill of rights or the local bill. However, the local bill of rights elicited significantly higher levels of agreement overall.

There are at least two possible reasons for this. First, the NACHRI bill of rights included several items pertaining to the child’s right to counseling and treatment for abortion, as well as the provision of contraceptive devices. The locally developed bill of rights contained no references to abortion or contraceptive devices. In this study approximately 20% of individuals from all classes of raters tended to disagree that these rights should be extended to children. Since these matters tend to be heatedly debated in our society at this time, opposition to these proposed rights for children perhaps is to be expected. Possibly inclusion of rights in these areas could make an entire proposed bill of rights somewhat less palatable.

Second, the NACHRI bill is uncompromising in asserting that these rights are to be extended to everyone, regardless of age, while the local bill extended rights in most cases to “a patient and parent.” It is likely that some people will object to certain rights for children under age 12 acting apart from their parents, whereas they would not object to the same rights extended to individual adolescents. While this is a possible objection to all of the rights proposed in the NACHRI bill, it is particularly true for items granting the child the right to greater “self-determination.” This objection may have played a role in the physicians’ tendency to disagree with the child’s right to consent to medical care, since the possibility that a child may object to receiving possible lifesaving, or even life-prolonging, treatment is particularly distressful to medical personnel. The effect that age qualifications may have on attitudes toward children’s rights in pediatric settings requires further explorations.

Significant group differences were found on the combined questionnaires, the local questionnaire, and over one third of the individual items. While their overall attitudes were favorable, on most items the attending physicians tended to have the least favorable attitudes toward the rights of children in pediatric settings. Possibly this tendency arises because the physicians are more likely to be inconvenienced and restricted in their activities than any other group if these rights are adopted and actively advocated. Implementing these rights could alter their freedom of choosing the type of treatment their patients receive if patients were granted the right to be informed of alternatives in treatment and to refuse treatment. Other rights could prove inconvenient or disruptive if patients were to be informed of all delays, collect names of everyone giving direct service, and have an immediate response to questions. Other proposed rights could prove deleterious to medical training or practice if medical students could not observe procedures because a child or his parents objected, or if a patient could demand and receive a referral to a specialty clinic when the physician did not believe it was warranted.

Also of note is the fact that several of the proposed rights received almost no opposition. These included the patient’s right to have his parents and himself receive information needed for informed consent; the right to respectful care; the right to know which physician is responsible for his care; and the right to ask questions about his care. Significantly, these are rights that either are nurturant in intent or do not depart from currently routine hospital procedure.

In fact, in view of the far-reaching implications of some of the proposed rights, it is surprising that the level of agreement with most of them is so high. The pattern of responses, however, suggests that the greatest opposition will come if proposed bills of rights advocate free access to contraceptive devices and abortion, and to a lesser degree as...
the proposed rights cause changes in current hospital procedures and medical practice.

REFERENCES

ACKNOWLEDGMENT
We wish to acknowledge the assistance in data collection of Ms. Alice Saar, Ms. Nancy Wachs, hospital ombudsman, and the ombudsman volunteer staff.

NATHALIE MASSE MEMORIAL COMMITTEE

Dr. Nathalie Masse, who died in 1975, was director of teaching at the International Children's Centre for 18 years. She made major contributions to the improvement of child health and welfare. At the request and with the help of many of Dr. Masse's friends, a Memorial Committee to perpetuate her memory has been established. This committee has decided to create an international prize and a research fellowship.

The prize award of 10,000 francs, to be known as the International Nathalie Masse Prize, will be awarded for the first time in 1979. Subsequently, it will be offered at two-year intervals. It will reward an original work relating to children, resulting from research done by an institution, or an individual under 40 years of age, in order to promote young professional workers and investigators. The award winner will be chosen without regard to nationality by an international jury.

The fellowship research grant, to be known as the Nathalie Masse Research Grant, will be awarded for the first time in 1978, and subsequently every two years. Intended for young research workers, its aim is to assist them in studies which are directed toward social and preventive pediatrics.

The regulations concerning the grant and the application forms may be obtained by writing to Nathalie Masse Memorial Committee, International Children's Centre, Château de Longchamp, Bois de Boulogne, 75016, Paris.
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Pediatrics 1977;60;715

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