The Mental Health Act 2001 (MHA) seeks to curtail and define the circumstances under which an adult's decision-making rights might be removed, such circumstances generally relating to mental illness, severe dementia or significant intellectual disability, or situations involving acquired brain injury (ABI) or fluency-related inability to communicate decisions. The Act specifically excludes instances of social deviancy, intoxication or addiction as justification for the curtailment of an individual's rights.

When a person does not have capacity to consent, a number of alternatives may be considered, including application of 'power of attorney', making the person a 'ward of court', the use of the 'best interests' principle or 'substituted judgements', or the introduction of guardianship, as envisaged in the Law Reform Commission (LRC) paper on vulnerable adults and the Mental Capacity and Guardianship Bill (2007). Both focus on a promotion of capacity unless proven otherwise by a person with legal difficulties which arise where an adult is considered to be incompetent. While doctors and decision-makers may be appointed personal guardians under the Bill, and may avail of the insight and recommendations of family members and carers when deciding what might be in a patient's best interests, it is essential that pharmacists clearly understand that family members are generally not entitled to make decisions on behalf of patients.

Pharmacists may have difficulty in assessing a patient's capacity and the Bill seeks to protect practitioners from charges of negligence in the event that, having taken all due caution, they impose healthcare decisions on a patient who is afterwards deemed to have been competent. In addition the Minister for Health and Children will have the power to set up a working group to produce guidelines for medical professionals in relation to capacity to make healthcare decisions. Pharmacists would also certainly benefit from such guidelines.

Pharmacists in many branches of the profession face potential dilemmas with respect to the capacity of children and vulnerable adults. It is not unusual to find oneself dispensing to a 15-year-old without 'parental consent', and in the full knowledge that the teenager with whom you are engaged in a trusting healthcare-practitioner-patient relationship does not wish for the aforementioned parents to be informed of the medication being taken. Vulnerable adults, such as those with intellectual disabilities, present with a range of abilities - some of which may well provide adequate capacity to decide to take, for example, oral contraceptives and who are as entitled as any patient to privacy regarding such decisions. Some people may have poor sight, sub-optimal hearing, literacy difficulties or physical disabilities. Some healthcare practitioners may require a reminder that none of these disabilities necessarily means there is a diminution of the person's capacity to make decisions.

I particularly remember one patient that regularly presented prescriptions while in an intoxicated state. If asked to judge whether he had capacity to make decisions at that point in time, my conclusion would have been 'negative'. To have refused him would risk, amongst other things, a charge of both cultural bias and a misuse of the 'position of power' a pharmacist holds in the medicines 'supply' process. In reality he was vulnerable. The circumstances and reasons why people misuse medicines remains a mystery to most practitioners, not least the issue of parasuicide, yet skills in the identification of those vulnerable to suicidal tendencies are not core to pharmacists' training.

Key points for pharmacists to consider include that fundamental beliefs about capacity are challenged and understood, that family members or carers are not generally entitled to make healthcare-related decisions for patients, that declining physical strength does not necessarily correlate with declining capacity to make healthcare-related decisions for oneself, and that there is something unsettling about those situations where pharmacists dispense medication to patients of 'uncertain' capacity. However, the
greatest dilemmas arise for pharmacists when we do not even meet the patients to whom we are responsible, thus denying the opportunity to professionally judge factors related to capacity at the point of dispensing. The range of potential ‘carers’ through whom pharmacists deliver patient care include family members, neighbours, HSE or privately employed ‘home-help’ and employees of nursing homes and other care facilities. While there may be occasions when sedation is appropriate, and consented to by the patient, pharmacists do not want to unwittingly collude in scenarios where a competent patient is given medication without his/her knowledge.

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References —
2. Re MB (Caesarean Section) 1997: 2 FLR 426; 38 BMLR 175.

Other reading —
Mental Health Act (2001).

PLEA: Association welcomes Irish Pharmacists interested in Ethics

The Pharmacy Law and Ethics Association was set up in England in 1998 and its objectives include the stimulation of debate on what constitutes ethical and responsible professional practice, and why, and to promote understanding at undergraduate level and beyond of the ethical basis for professional judgement.

Such objectives could be validly pursued in Ireland and, to this end, a branch of PLEA merits establishment. Pharmacists with a particular interest or qualification in Ethics and/or Law may join PLEA (gordon.appelbe@btopenworld.com).

A local branch could then develop.

PLEA founder members Joy Wingfield and Gordon Appelbe, and current editor of the PLEA newsletter, Alan Nathan, are very encouraging of this objective.