

Children and the Law:

Dispensing prescriptions to minors



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A friend's only daughter has just reached the age of 16. I asked how she would react if the family GP gave her daughter a prescription without her knowledge. Suffice to say that her initial reaction was one of 'indignity' that her GP would dare to do so and her presumption was that I was referring to oral contraceptives. This 'parental' reaction occurred despite decades of experience working in a pharmacy and a reputation for an entirely professional approach to dealing with teenagers when fulfilling her workplace responsibilities.

'Gillick Competency' is a term generally referenced when considering whether someone under 18 may be capable of making independent decisions about healthcare interventions. Its origins lie in a case brought by Mrs Victoria Gillick, who challenged health service guidance that would have allowed her daughters aged under 16 to receive contraceptive advice without her knowledge. It addresses whether doctors should be entitled to give advice or treatment to under 16-year-olds without parental consent, and its philosophy proposes that the right of a younger child to independently consent is considered to be proportionate to his/her competence, rather than just a matter of age. 'Gillick Competency' seeks to frame an objective assessment of an individual's competence to understand and evaluate the advantages and disadvantages of a proposed treatment, including the risks and potential alternative courses of action "so the consent, if given, can be properly and fairly described as true consent".

The associated 'Fraser guidelines', as proposed by Lord Fraser in his judgement of the Gillick case in the House of Lords (1985), relate specifically to contraception, the preference that parents be involved in related decisions and the risks of unprotected sex. However, these guidelines also tend to be more widely used to help assess whether a child has the maturity to make his/her own decisions and to understand the implications of consenting to or refusing treatment options.

"...a doctor could proceed to give advice and treatment provided he is satisfied in the following criteria:

- 1) that the girl (although under the age of 16 years of age) will understand his advice;
- 2) that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice;
- 3) that she is very likely to continue having sexual intercourse with or without contraceptive treatment;

4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer;

5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent."

Of particular relevance to my friend with the 16-year-old daughter, Lord Scarman's comments in his judgement of the Gillick case included specific reference to the passing of authority from parents to children, as maturity, rather than a specific age, is reached:

"Parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."

Notwithstanding that the Courts appear to be moving towards a position whereby it may be accepted that some form of assessment of patient's capacity to consent is required,¹ it is important to clarify that 'Gillick Competence' does not apply in Ireland. The Non-Fatal Offences Against the Person Act (1997) allows children of 16 years of age to consent to medical treatment without permission from their parents, yet it does not provide any guidance on whether there is a right to refuse medical treatment. (Shannon 2007). (While the general issues related to refusal of healthcare interventions do merit review in the context of pharmacy practice, they are considered beyond the scope of this particular article.) However, the general view is that children under 16 do not have power to consent to medical treatment and in most such circumstances parental consent should, if at all possible, be obtained.²

The Law Reform Commission consultation paper, *Children and the Law: medical treatment*, "provisionally recommends that, in the context of healthcare provision, the law should respect the evolving capacity of individuals under the age of 17, with the aim of promoting access to necessary medical treatment", thereby seeking, effectively, to promote the adoption of an Irish version of Gillick. It also highlights deficiencies related to the treatment of minors in other pieces of legislation, e.g. the comparatively reduced protection of such minors under the Mental Health Act 2001. Given current national debate regarding the desirability of constitutional amendment of matters related to children's rights, the LRC consultation process is particularly timely and to be welcomed.

However, if capacity (to make decisions) is an evolving process, pharmacists dispensing medicines require to satisfy themselves as to the competency of minors in the context of the patient-pharmacist healthcare relationship and the corresponding responsibilities of a pharmacist to a patient in such a relationship. The LRC consultation paper places the focus on the decision that a medical practitioner will make in deciding to, for example, write a prescription. It does not appear to consider the related decision-making that occurs with a pharmacist when the patient seeks to have a prescription dispensed. Under the LRC proposals, the doctor should seek to obtain parental consent with the agreement of the child and record his or her attempts to obtain such consent. It is not clear how a pharmacist would be made aware of the basis on which the GP considers an under-18 competent and, where required, whether the parents have been notified. This could raise the spectre of a pharmacist being obliged to repeat the process of inquiry with the minor – in order to meet the pharmacist's independent responsibilities to the patient during the dispensing process. Such repetition of inquiry might not be in the patient's best interests.

Issues that may arise for pharmacists, especially those practising in primary care, include:

- Clarification of the nature of the pharmacist's professional responsibility to the 'child', including expectations of health promotion and health education during the process.

- Privacy, confidentiality and data protection rights of the child: once the healthcare practitioner/patient relationship has been engaged, the pharmacist is duty-bound to maintain the trusting relationship on which the professional relationship is founded, including those situations where professional resilience may be required to resist requests from parents, guardians, carers (e.g. the HSE) or other healthcare professionals to disclose information regarding the dispensing of prescriptions to minors.

- Issuance of MED-1 tax receipts, wherein the pharmacist facilitates authentication of financial governance on behalf of the Comptroller and Auditor General, by signing to validate annual receipts of expenditure on prescription medicines, but may inadvertently violate the privacy of a minor where records of the minor's prescription history are included on the family's MED-1 receipt, without specific authorisation to share such personal information.

Many scenarios may cause difficulty for pharmacists dispensing prescriptions. Oral contraceptives or the morning-after-pill are the examples commonly highlighted. However, depression, psychiatric illness and related treatments are also areas of sensitivity where young people may seek treatment on condition that privacy is respected, and STDs (sexually transmitted diseases) inevitably attract peer pressure to not disclose. Indeed the provision of a 'private area', to provide an environment in which sensitive matters can be discussed without fear of being overheard, will inevitably form part of pharmacy's professional management of such scenarios. For some young people, impetigo and similar contagious diseases cause acute distress, while lice, scabies and similar infestations would certainly be regarded as personal information and 'not for disclosure'. Treatment for addictions, including but not restricted to smoking cessation or methadone maintenance (where family addictions may discourage an individual from seeking maintenance therapy), also merit consideration in this context. It must not be forgotten, either, that many of the above scenarios have the potential to provide indicators of underlying social problems, thereby further increasing the need for ethical guidance to practitioners.

Legislative change is required in order to clarify the issues surrounding the consent by

minors to medical treatment, and the LRC consultation process seeks to address this. However, the consultation paper as currently presented suggests that a pharmacist's responsibilities in the process by which a patient acquires medicines are not altogether apparent to organisations such as the LRC. To me, this simply further emphasises the importance of having a forum such as PLEA (Ireland) in which to consider the pharmacy perspective of such issues, and seeking to formulate considered contributions to discussion and debate on a wider scale.

On further conversation with the friend whose daughter had reached the age of 16 years, we agreed that the GP would likely deal with her daughter as an 'adult' should she require a prescription. Indeed, we probably reached a consensus that not only was he entitled to do so, but would be likely to assure her daughter that she was always free to consult the GP in absolute privacy!

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References:

- 1 • Fitzpatrick –v- K [2008] IEHC 104 per Laffoy J.
- 2 • North Western Health Board –v- W(H) [2001] 3 IR 622
 - Children and the Law: Medical Treatment. Consultation Paper. LRC CP 59 – 2009
 - Gillick v West Norfolk and Wisbech AHA (1985) 2 BMLR 11
 - Shannon, G. (2007). Report of the Special Rapporteur on Child Protection: A Report Submitted to the Oireachtas. November.
 - Wheeler, R. (2006) Gillick or Fraser? A plea for consistency over competence in children: Gillick and Fraser are not interchangeable. *British Medical Journal*. 332 (8 April): 807.

PLEA (Ireland), the Pharmacy Law and Ethics Association, was established during the meeting held on 03 March 2010, electing Cicely Roche MPSI as its chairperson and Jane De Barra BL MPSI as its secretary (plea.ireland@gmail.com). The next meeting will be in early June. New members all welcome.

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