**Journal of Prescribing Practice**

**A-Z of Prescribing for children**

**Kate Davies**

**Associate Professor, Paediatric Prescribing & Endocrinology**

**London South Bank University**

**L – Legal considerations**

There are many legal aspects to consider when entering into independent prescribing, alongside regulatory frameworks and ethical principles. Prescribing professionally requires an awareness of relevant laws underpinning prescribing practice (Gould and Bain 2022), but some laws and issues when prescribing for children should be considered.

Gillick competence and consent have already been covered in this series (Davies 2024), but exploring the child’s best interests is a concept that should also be examined. The Children Act (1989) is central to decision making with regards to children’s treatment, and focuses on the care, upbringing and the protection of children (Bridgeman 2021). Healthcare professionals are obliged to act on any concerns they may have if they perceive the child is at risk – and this can also be pertinent if the parent lacks capacity to exert parental responsibility (Griffith 2009). This also applies if it is not clear *who* has parental responsibility for the minor. Changing family demographics, however, also need to be considered (Davies 2023), with regards to step parents, same sex parents, or parents with acquired responsibility. If no-one is present with parental responsibility, or the parents – or the child – are unable to consent to aspects of treatment – then the healthcare professional can legally prescribe for the child if they are prescribing in the *child’s best interests.*

However, in order to act in the child’s best interests, the prescriber must be familiar with the BNFc (Davies 2023), be proficient in paediatric specific history taking (Davies 2024), be able to give the full information about the drug concerned, including any side effects, and prescribing the right dose (Keith 2015). Only when the prescriber is practising within their scope of practice can they be able to assess the child’s best interests, where guidance is given by the GMC (2020) (See Table 1)

|  |
| --- |
| Consideration of the views of the child or young person, if they are able, including any previously expressed preferences |
| The parents views |
| Views of others close to the child or young person, eg, grandparent |
| Any cultural, religious or other beliefs and values |
| Views of other healthcare professionals involved in providing care to the child or young person, and of any other professionals who have an interest in their welfare |
| Which choice – and there may be more than one - will least restrict the future options for the child or young person |

**Table 1: What to consider during an assessment of the child’s best interests**

Adapted from (GMC 2020)

Regardless, whilst it is important to consider the child’s best interests, it is vital to work *with* the parents – wherever possible – but inevitably, once a child is under a clinician’s care, then there is a legal duty to care for the *patient.* (Archard, Cave et al. 2024).

Once it is confirmed that a child needs treatment, then it is a legal and professional requirement (RPS 2021) that the prescriber must only prescribe within their specific field of competence, and only after having undertaken and passed the required training from a registered higher educational institute (NMC 2023). For healthcare professionals working with children, leaders of educational programmes must have the appropriate knowledge, skills and experience pertaining to paediatric specific teaching, if it is a paediatric specific programme.

Finally, prescriptions for children differ slightly to those to adults, in that the child’s age has to be written on the prescription, as well as their date of birth, if under 12 years of age (NICE 2023). Strengths of tablets or capsules have to be detailed: even though liquid formulations may be deemed more suitable for children (Davies 2024), many contain a lot of sugar which can clearly cause dental decay, so consider prescribing tablets where possible, as younger children may be able to swallow tablets (Rashed, Terry et al. 2021). However, if a liquid formulation cannot be avoided, and the total volume is less than 5mL, then an oral syringe will also be supplied, so additional teaching will be needed on how to administer the medication. The prescription itself should always detail the strength (eg mcg or mg) rather than the volume (mL) wherever possible.

Health care professionals caring for children and young people need to be aware of their own limitations when entering into a prescribing relationship. Qualified independent prescribers have to provide safe and competent care to their patients (Gagan 2018), supported with up to date focus on continuing their professional development. Aspects of children’s care is fluid, and care must be given to consider changes in health status, such as increase in incidences of metabolic syndrome (Al-Hamad and Raman 2017), cancer survivorship (Erdmann, Frederiksen et al. 2021), and gender identity (Abbasi 2024). As the scope of children’s health changes, it is inevitable that further developments concerning legal aspects will change.

Next article: M - Metabolism

**References**

(1989). Children Act. c.31. UK.

Abbasi, K. (2024). "The Cass review: an opportunity to unite behind evidence informed care in gender medicine." Bmj.

Al-Hamad, D. and V. Raman (2017). "Metabolic syndrome in children and adolescents." Transl Pediatr **6**(4): 397-407.

Archard, D., E. Cave and J. Brierley (2024). "How should we decide how to treat the child: harm versus best interests in cases of disagreement." Medical Law Review **32**: 158 - 177.

Bridgeman, J. (2021). "‘Our legal responsibility…to intervene on behalf of the child’: Recognising public responsibilities for the medical treatment of children." Medical Law International **21**(1): 19-41.

Davies, K. (2023). "B - BNFc " Journal of Prescribing Practice **5**(10): 418 - 419.

Davies, K. (2023). "The current state of paediatric non-medical prescribing." Journal of Prescribing Practice **5**(12): 518 - 524.

Davies, K. (2024). "F - Formulations." Journal of Prescribing Practice **6**(3): 122 - 123.

Davies, K. (2024). "G - Gillick competence." Journal of Prescribing Practice **6**(4): 156 - 157.

Davies, K. (2024). "H - History taking." Journal of Prescribing Practice **6**(5): 200 - 201.

Erdmann, F., L. E. Frederiksen, A. Bonaventure, L. Mader, H. Hasle, L. L. Robison and J. F. Winther (2021). "Childhood cancer: Survival, treatment modalities, late effects and improvements over time." Cancer Epidemiology **71**.

Gagan, M. (2018). "Legal aspects in nurse prescribing." Nurse Prescribing **16**(4): 187 - 189.

GMC (2020). 0-18 years: Guidance for all doctors. Assessing best interests. Manchester, General Medical Council.

Gould, J. and H. Bain (2022). "Professional, legal and ethical dimensions of prescribing. Part 2: legal and ethical." Primary Health Care **33**(1): 27-34.

Griffith, R. (2009). "The Mental Capacity Act 2005 in practice: best interests." Nurse Prescribing **7**(4): 172 - 175.

Keith, T. (2015). "Prescribing for children." InnovAiT: Education and inspiration for general practice **8**(10): 599-606.

NICE (2023). Prescribing in Children, National Institute for Health and Care Excellence.

NMC (2023). Standards for education and training, Part 3: Standards for Prescribing Programmes. London, Nursing Midwifery Council.

Rashed, A. N., D. Terry, A. Fox, N. Christiansen and S. Tomlin (2021). "Feasibility of developing children's Pill School within a UK hospital." Arch Dis Child **106**(7): 705-708.

RPS (2021). A competency framework for all prescribers. London, Royal Pharmaceutical Society.