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**A-Z of Prescribing for children**

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**G – Gillick competence**

It is important for independent prescribers to understand the concept of Gillick competence when caring for young people, and entering into a therapeutic prescribing relationship. In order to consent to treatment, an individual must be *able* to consent: and in order to be able to consent, they must be deemed to have capacity. Under current UK Law, adults are usually presumed to be competent in order to consent to treatment. This is only questioned if their decision seems unwise to the healthcare professional, and / or if it seems irrational (Larcher and Hutchinson 2010). With regards to children and young people, however, ability to consent is only possible if they are deemed to be ‘Gillick competent.’ This refers to the rights of a child who is under 16 years of age (Griffith 2016).

This ‘right to consent’ to medical examination and treatment was decided by the House of Lords in *Gillick v West Norfolk and Wisbech Health Authority* in 1986 (Griffith 2016). ‘Gillick’ refers to Mrs Victoria Gillick (see Figure 1), who wrote to the then Department of Health and Social Security (DHSS) in 1982, wanting confirmation and reassurance that her daughters – all under the age of 16 – would not be given advice regarding terminations or contraceptives without her specific consent.

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Figure 1: Mrs Victoria Gillick

Sourced: <http://news.bbc.co.uk/onthisday/hi/dates/stories/july/26/newsid_2499000/2499583.stm> (am happy for a different image to be used)

Mrs. Gillick asked this of the DHSS due to recent changes that they had made regarding how such advice can be given to under 16s, which she objected to. The DHSS felt that the advice or treatment is only appropriately handled by the prescribing Doctor, alongside their expert clinical opinion. Subsequently, Mrs Gillick then took the matter to court, but lost her case. This had huge repercussions for Doctors – and now other prescribing healthcare professionals. However, parental responsibility rights and consent issues warranted further discussion, which resulted in the development of further guidelines put forward by Lord Fraser: these are known as the Fraser Guidelines (Cornock 2018) (see Table 1). Lord Fraser’s principle concerns were focusing on the welfare of girls under the age of 16 who would not stop having sexual intercourse – whether or not they had been given contraception / contraception advice (Griffith 2021). He felt strongly that a Doctor should give such advice – AND treatment – to girls under the age of 16, in accordance with the guidelines he had set.

The prescriber can continue if they are happy:

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| 1 | That the girl under the age of 16 can understand the advice given. |
| 2 | That the Dr cannot persuade the girl to tell her parents, or all the Dr themselves to discuss the issue with her parents. |
| 3 | That the girl will continue in having sexual intercourse, with or without contraceptive treatment. |
| 4 | That if the girl does not receive the advice or treatment, then her physical or mental health is likely to suffer. |
| 5 | That it lies in the girls best interests to receive contraceptive advice and treatment , without the parents’ consent. |

Table 1: Fraser Guidelines (Griffith 2021).

Independent prescribers therefore need to be confident in assessing Gillick competence in children under the age of 16 years: this stretches to other medications and advice, for example, immunisations. Prescribers need to consider the child’s maturity and level of intelligence, which does not necessarily arrive at the start of puberty (Griffith 2013). Tied with maturity and intelligence will also be the prescriber’s own ability to assess if the child can understand aspects of choices to be mad, alongside any potential consequences, and how willing amd able the child is in order to make such informed choices. The prescriber must also ensure that the child understands why the treatment is being proposed, including any risks or side effects, what alternatives may be available, and what might happen if they did not take the medication (Griffith 2021).

Such discussions and decisions to be made by the child should also not be influenced by peers, family or friends, and the child should be able – if mature and intelligent enough – to make that decision freely (Larcher and Hutchinson 2010). Other influences might be emotional states, side effects of other medications, pain, or incorrect misinformation. It may be necessary to involve the parents or other members of the multidisciplinary team in the decision making process.

It has been over 40 years since ‘Gillick competence’ came into legal and ethical consent discussions, and it remains a valid component in prescribing practice today. However, arguments do continue in overly depending on Gillick competence as a decision-making tool (Bart, Hall et al. 2024), so prescribers need to think holistically in how to involve young people, and those with parental responsibility, in decisions about medical treatment.

The next article in the series will focus on H – History taking.

**References**

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