



# **Consent in Under 16s – the Issues for Irish General Practice**

**Ailís ní Riain MB MICGP MBA  
National Director, Women's Health  
Programme**

**November 2005**

---

## The Problem

---

General practitioners are frequently consulted by unaccompanied under 16s seeking medical care. This is a particular source of discomfort for many doctors, particularly in relation to requests for contraception. However, the legal issues relating to consent also apply to other treatments and prescribed medications for those under 16. But the decision in the case of contraception is further complicated by the legal situation pertaining to sexual intercourse also.

---

## Consent

---

The three basic elements of consent must all be present for consent to be valid. The consent must be:

- (i) voluntary
- (ii) given by someone with the capacity to give it and
- (iii) based on sufficient relevant information.

The particular issue in dealing with minors is their legal capacity to consent.

Internationally, recent thinking in bioethics displays a shift from a paternalistic ethic governed by doctors to one based on the patient's autonomy and integrity (Syse, 2000). Similarly, the law has moved away from automatically classifying individuals according to their status and towards examining the individual's capacity to consent (Mills, 2002).

---

## Consent in the under 16s - Current Situation in Ireland

---

The issue of treatment of under 16s in Ireland is a source of much confusion and there is no clear answer to the question "Does a person under the age of 16 have the right to consent to medical treatment that overrides the parental right of control?"

The age of majority in Ireland is **18 years**, or the time of marriage if this is at a younger age (Age of Majority Act 1985). Irish law recognises that one becomes an adult for the purposes of consent to medical and surgical treatment at the **age of 16** (Non-Fatal Offences against the Person Act 1997, Section 23). However, consent to contraceptive treatment is not detailed in this Act and it is unclear if it is to be treated differently to medical treatment. Where decisions concern contraception it is important to remember that it is unlawful to have sexual intercourse with a person under the **age of 17**.

There is no Irish legislation on the capacity of a minor under the age of 16 to consent to treatment nor has it been judicially discussed in any detail. The resulting uncertainty means that Irish medical professionals are, therefore, working in a legal minefield (Donnelly, 1995). There is a potential conflict between that minor's rights under Article 40.3.1 of the Constitution and the rights and duties of parents under Articles 41 and 42. Article 41 sets out to give explicit constitutional protection to the family and the institution of marriage. The family is seen under Article 41.1.2 as "the necessary basis of social order". Article 42.1 holds that

"...the State acknowledges that the primary and natural educator of the child is the Family and guarantees to respect the inalienable right and duty of parents to

provide, according to their means, for the religious and moral, intellectual, physical and social education of their children.”

The precise interpretation of Articles 41 and 42 remains controversial with some commentators, such as Tomkin and Hanafin (1995), arguing that, because of the special position of the family recognised in Article 41, minors are not entitled to the same recognition of autonomy that is often granted to them in other countries. However, the articles do not specifically refer to minors and the age of the “child” and “children” is not specified. It could be argued that the age of majority is not the constitutionally required cut-off point (Cusack 1994, Donnelly 1995). Other, more recent, commentaries such as that of Mills (2002) suggest that the child has his own rights, and that the minor’s rights evolve with the passage of time. It seems logical that the minor’s limited decision-making power should become greater as the child grows older.

The Medical Council (2004) states that “treatment must never be refused on grounds of moral disapproval of the patient’s behaviour” (Section 2.5) and that “if a doctor has a conscientious objection to a course of action this should be explained and the names of other doctors made available to the patient.” (Section 2.6)

Regarding consent and special circumstances (Section 18.3) it states

“If the doctor feels that a child will understand a proposed medical procedure, information or advice, this should be explained fully to the child. Where the consent of parents or guardians is normally required in respect of a child for whom they are responsible, due regard must be had to the wishes of the child. The doctor must never assume that it is safe to ignore the parental/guardian interest.”

---

## Fraser Guidelines arising from Gillick Case in the UK

---

In the absence of Irish precedent it is important to examine the experiences in other jurisdictions. There has been a growing tendency in court decisions from other jurisdictions to judge the legal capacity of a young person on the basis of maturity rather than age (Donnelly 1995, Mills 2002). Article 12 in the *UN Convention on the Rights of the Child* recognises the importance of focusing on a child's maturity rather than simply concentrating on the child's age. The position adopted in the UK is of special interest, both because of the proximity and because the Irish courts would be likely to take account of English law in this area if a case was taken in this jurisdiction. In the Gillick decision (*Gillick v West Norfolk and Wisbech Area Health Authority 1985*), English law vests considerable decision-making powers in the mature minor. It concerned a mother's attempts to stop her daughters, who were under 16, from being prescribed the oral contraceptive pill without her knowledge or consent. The court decided that children did have a right to consent to medical treatment and one judge stated

"The parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed".

The judgement outlined criteria to be addressed (Appendix) and also stated that

"...it is not enough that she should understand the nature of the advice which is being given; she must also have a sufficient maturity to understand what is involved."

This then requires the doctor to make a decision based on clinical judgement. The decision taken is based on subjective criteria, essentially. There is no clear yardstick as to how a minor's maturity is to be judged. Nor is it spelt out how the patient's parents should be treated. The doctor is given the responsibility of making a decision in the best interest of the patient. British GPs are advised to record the reasons for making this decision in the medical record, in order, if necessary, to defend this decision in court. This position provides the GP with a secure place in the medical care of adolescents. It identifies medical professionals as the people who are most likely to be in a position to make a fair judgement on the maturity of the minor. It frees the GP to act responsibly.

**This law and the resulting guidelines apply to the British situation, only. They have no legal validity in Ireland.**

Subsequently, guidance has been issued for UK doctors on judging the *Gillick* competence of a child (The Fraser guidelines - detailed in the Appendix). In addition to outlining the legal conditions, this document also provides general advice for GPs and re-iterates the duty of confidentiality owed to a person under 16.

### Withholding Consent

---

It seems logical that a patient "of sound mind and adult years" capable of giving consent to a particular treatment is similarly free to refuse his consent to the same treatment. In Ireland, the right to refuse medical treatment is enshrined in the unenumerated rights protected by the State under the Constitution (Article 40.3.1). Different concerns may come into play in the case of the withholding of consent by minors. While the courts in many countries recognise the "*Gillick* competent" minor's right to seek and to consent to treatment, they are considerably more reluctant to accept a minor's decision to refuse treatment and will more readily uphold the right of

the parents or the court to be the final arbiters of whether the minor's refusal is valid (Mills 2002). This was explored in one English case that concerned a minor's decision to refuse psychiatric medication. The girl's decision was over-ruled by the court, which decided that treatment should be given notwithstanding the child's refusal (*re R (a minor) (wardship: medical treatment) 1991*). The impression is that the courts are happy to permit a minor to take decision consistent with improving his health, but not decisions that would be dangerous to his health or life.

---

### Conclusion

---

There is no certainty as to what decision the Irish courts would take regarding the provision of treatment to under 16s without parental consent. It has been argued that they would likely separate out the right to consent to medical treatment from contraceptive treatment, and that they would be likely to accept the "mature minor" approach for the former but perhaps not the latter. However, it could also be argued that the increasing recognition in the Irish courts of the autonomy of minors and the evolving social and political climate make it less likely that contraceptive treatment would be singled out as time goes by without a legal challenge. However, the fact that sexual intercourse is not lawful in those under 17 might make this continuing distinction supportable.

## Recommendations

---

- The legal situation regarding consent and minors remains confused and there is no indication that legislation addressing the issue is imminent. However doctors, and GPs in particular, encounter this issue in clinical practice on a regular if not daily basis. Therefore, Irish guidelines would be helpful but would be difficult to draw up in light of the legal uncertainty.
- In the meantime, it is the responsibility of each doctor to take a reasoned decision whether or not they will provide treatment without parental consent in each individual situation. If the decision is not to prescribe this should be communicated to the young person in a non-judgemental manner. If the decision is to prescribe treatment the doctor would be well advised to document reasons for prescribing in the medical record. These would likely take the form of meeting the Fraser ruling competence criteria (as outline in the Appendix).
- Doctors are reminded of their duty of confidentiality to patients, including the under 16s. It is recommended that this confidentiality policy be detailed in the practice leaflet and/or website and that this information be displayed in reception areas so that young people will be made aware of it.

## References

---

Cusack D (1994). Patient consent – where do you stand? *Forum* December 19-20.

Donnelly M (1995). Capacity of Minors to Consent to Medical and Contraceptive Treatment. *Medico-Legal Journal of Ireland* 18-25.

Medical Council. *A Guide to Ethical Conduct and Behaviour* (6<sup>th</sup> Edition 2004). Dublin: Medical Council.

Mills S (2002). Consent. In: *Clinical Practice and the Law*. Dublin: Butterworths pp 59-88.

Syse A. (2000). Norway: valid (as opposed to informed) consent. *Lancet* 356: 1347-8.

Tomkin D, Hanafin P (1995). Consent. In: *Irish Medical Law*. Dublin: Round Hall Press, pp 27-49.

## Appendix: Fraser Guidance

---

The 1985 House of Lords' ruling in the Gillick case established the current legal position in England and Wales that people under 16 who are able fully to understand what is proposed and its implications are competent to consent to medical treatment regardless of age. Thus, people under 16 are legally able to consent on their own behalf to any surgical, medical or dental procedure or treatment if, in the doctor's opinion, they are capable of understanding the nature and possible consequences of the procedure. Clearly, the more serious the medical procedure proposed, a correspondingly better grasp of the implications is required.

Doctors should particularly consider the following issues when consulted by people under 16 for contraceptive services:

- Whether the patient understands the potential risks and benefits of the treatment and the advice given;
- The value of parental support must be discussed. Doctors must encourage young people to inform parents of the consultation and explore the reasons if the patient is unwilling to do so. It is important for persons under 16 seeking contraceptive advice to be aware that although the doctor is legally obliged to discuss the value of parental support, the doctor will respect their confidentiality;
- The doctor should take into account whether the patient is likely to have sexual intercourse without contraception;
- The doctor should assess whether the patient's physical or mental health or both are likely to suffer if the patient does not receive contraceptive advice or supplies;
- The doctor must consider whether the patient's best interests would require the provision of contraceptive advice or methods or both without parental consent.

Extract from *"Confidentiality & People under 16 – Guidance issued jointly by the BMA, BMSC, HEA, Brook Advisory Centres, FPA and RCGP."*