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ARTICLE

Consent in minors: the differential treatment of acceptance and refusal. Part 2 Minors' decision-making and the reach of their capacity

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SUMMARY

This is the second of a pair of articles reviewing the topic of consent in minors. Both articles have a particular emphasis, drawing on theory and case law, on the differential treatment of acceptance and refusal in minors. This article considers the concept of capacity in young people (aged 16 and over) and competence in children (under the age of 16) by reviewing underpinning statute and case law with particular reference to England and Wales. This provides a platform for consideration of the reach of capacity in minors with regard to acceptance and refusal of treatment. In doing so the article explores the key, but still elusive, ingredient of maturity, which has significance to the process. Fictitious vignettes allow consideration of the application of the concepts of maturity and autonomy in clinical practice. The article also considers the potential for the UK's Parliament to make changes to current statute regarding consent in minors.

LEARNING OBJECTIVES

After reading this article you will be able to:

- discuss adolescent decision-making and how it compares with adult decision-making
- better understand the 'reach' of capacity in young people and competence in children
- understand the justification for the differential treatment of acceptance and refusal.

KEYWORDS

Consent and capacity; ethics; human rights; philosophy; psychiatry and law.

Consent to treatment in minors can be a complex and confusing issue in practice. The current position in England and Wales involving the ability of the capacitated minor to give consent to accept treatment, while having only limited ability to refuse, presents challenges to clinicians. This is the second of a pair of articles reviewing consent in minors. The first article (Hawkins 2023) explored the concept of autonomy, its relevance in clinical practice and factors that might interfere with its 'purity'. It then gave an overview of minors' rights, and the way that UK and European courts are representing those rights in their judgements. This second article builds on the first and explores the way minors make decisions, the common law and statutory legal position regarding consent, the reach of consent in minors, and the justification for the differential treatment of acceptance and refusal.

A contemporary treatment case

In 2019 a case was brought against the National Health Service (NHS) Gender Identity Development Service (GIDS) by a parent of a 15-year-old on the GIDS waiting list, along with a former nurse who had worked at a GIDS satellite site (*Bell and Another v Tavistock and Portman NHS Foundation Trust* [2020]). The complaint was that evidence regarding hormonal pubertal blockade was unclear and that true informed consent could not be given. In the process of filing the case, the nurse passed her role in the complaint to Keira Bell, then aged 23, who had been prescribed hormone blockers aged 16 by the GIDS, subsequently received testosterone and surgical intervention and later regretted her transition.

Keira Bell spoke to the BBC about her pathway, describing the way that 'one step led to another' and that she felt she 'should have been challenged on the proposals or the claims that I was making for myself' and that if she had been 'that would have made a big difference'. She spoke of the way that she was 'allowed to run with this idea that I had, almost like a fantasy as a teenager, and it has affected me in the long run as an adult' (Holt 2020).

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The High Court (*Bell v Tavistock* [2020]) considered the fact that the vast majority of those prescribed hormone blockers proceed with cross-sex hormones, with resultant irrevocable physical effects. In addition, it reviewed the limited evidence base in relation to pubertal blockade and its efficacy. It found that 'there will be enormous difficulties in a child under 16 understanding and weighing up this information and deciding whether to consent to the use of puberty blocking medication'. It concluded that it was 'highly unlikely that a child aged 13 or under' and 'doubtful that a child aged 14 or 15' could understand and weigh up the long-term risks and consequences of such a decision. It went on to say that in those over 16, 'authorisation of the court should be sought' (because of the presumption that they have the ability to consent, and in view of the potential serious consequences of the treatment (paras 151–152). In giving this judgment, the High Court departed from the seminal *Gillick* case (see discussion below), which had established that competent children could make their own decisions in relation to accepting treatment.

The case was taken to appeal (*Bell and Another v Tavistock and Portman NHS Foundation Trust* [2021]). The Court of Appeal recognised the 'difficulties and complexities associated with the question of whether children are competent to give consent'. It also noted that 'clinicians will inevitably take great care' to be sure that 'the consent obtained from both child and parent is properly informed by the advantages and disadvantages of the proposed course of treatment' and its 'long-term consequences'. However, it overturned the ruling of the High Court, effectively repositioning *Gillick* as the appropriate guidance for the under-16s (paras 91–94).

Notably, the Supreme Court refused the application to appeal in 2022, on the basis that it did 'not raise an arguable point of law'. By so doing, as the appeal court of greatest authority in UK law, the Supreme Court gave its support to the existing law regarding consent in minors – which will be explored in this article (Supreme Court 2022).

Key questions posed by *Bell v Tavistock* are listed in Box 1.

Minors' decision-making and risk-taking

The literature on decision-making in minors remains dominated by conventional stage theories of child development. The archetypal stage theory, that of Piaget – which outlined discrete stages of intellectual development, through which a child must pass en route to adulthood – has been criticised for its bias towards European norms and the study of children in experimental rather than everyday settings (Lansdown 2005). Separate cultural theories have been developed which claim that application of stage theories leads to a 'consistent underestimation' of children. However, such alternative theories have 'not sufficiently permeated […] to influence law, policy and practice impacting on children's lives' (Lansdown 2005). The presumptions of the dominant theories tend to 'foster oppressive stereotypes' and can propagate the myth of the 'supposed chasm between foolish child and wise adult' (Alderson 1996).

Such myths overlook the sophisticated ability to reason and understand which minors indisputably have. There is now no significant doubt that individuals show improvements in reasoning, information processing and expertise as they develop from childhood into middle adolescence (Steinberg 2005). In so doing they 'become more capable of abstract, multidimensional, planned and hypothetical thinking' (Steinberg 2005). An expansive literature, dating back some 40 years, demonstrates that the performance of 14-year-olds is broadly equivalent to that of two different adult age groups – aged 18 and 21 – on tests of legal competence (Weithorn 1982). This conclusion has remained unchallenged 'in the past several decades' (Steinberg 2005). This might suggest that formal tests of legal competence could be aligned to those used in adulthood for any minor over the age of 14.

The literature is thus of one voice in relation to the ability of adolescents to pass tests of legal

BOX 1 Key questions posed by the *Bell v Tavistock* case

- How much autonomy should be afforded to a minor? (explored in part 1 (Hawkins 2023))
- How much should clinicians allowing minors to make grave decisions consider restricting current autonomy to protect future autonomy (the so-called 'imaginative leap')? (explored in part 1 (Hawkins 2023))
- How should minors' decision-making be considered in the context of their rights? (explored in part 1 (Hawkins 2023))
- How exactly do minors make decisions? (current article)
- How are competence and capacity to be assessed? (current article)
- How much are and should minors be afforded the right to accept treatment? (current article)
- How much are and should minors be afforded the right to refuse treatment? (current article)
- How does the gravity of the decision to be made move the balance of the right to refuse? (current article)

(*Bell and Another v Tavistock and Portman NHS Foundation Trust* [2020], [2021])

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competence. However, there is an additional literature, which is more cautionary, about the influence of social and emotional context on adolescents' decision-making. Steinberg (2005) noted that 'adolescence is a heightened period of vulnerability specifically because of gaps between emotion, cognition and behaviour'. Adolescent egocentrism and a supposed concept of personal invulnerability have been put forward as reasons why decisions by minors are unstable and lead to negative outcomes. Studies have indeed found evidence of optimism bias and notions of invulnerability – but interestingly, no more so in adolescents than in adults. Indeed, it is confirmed that adolescents tend to engage in a decision-making process that involves a balancing of risks (Millstein 2002) and there is no evidence that either egocentrism (Rodham 2006) or perceptions of invulnerability have a specific effect (Goldberg 2002; Rodham 2006; Knoll 2015). These findings demonstrate just how inadequate have been the instinctive assumptions about adolescence and the theories they supported.

Although both adolescents and adults take more risks in groups of peers than when alone, that effect has been found to be more evident during middle and late adolescence than in adulthood (Gardner 2005). This has been confirmed, supporting the theory that as adolescents step away from the authority of adults, they place 'higher value on the opinions of other teenagers', with acceptance by their peer group having particular importance (Knoll 2015).

So, despite the previous theories about cognitive capability, it seems that when adolescents do engage in risky behaviour, it is '*despite* knowing and understanding the risks involved' – instead, in 'real life situations, their actions are largely affected by feelings and social influence' (Steinberg 2005). This understanding seems to coincide with the well-recognised central nervous system reorganisation during which 'regulatory systems are gradually brought under the control of central executive functions, with a special focus on the interface of cognition and emotion' (Steinberg 2005). The development of this aspect of the adolescent mind is not, however, in step with the intensity of the 'major emotionally laden life dilemmas' that they confront (Steinberg 2005).

This comparative vulnerability of adolescent decision-making to feelings and social influence, understood to be part of internal reorganisation of regulatory systems, appears to be settled by the development of an internal cerebral executor with command over the interface between cognition and emotion. Any discussion of the concept of adolescent autonomy must therefore broaden its reach beyond pure tests of cognitive skill. It must attend to this specific vulnerability. The pursuit of a legal understanding of a minor's capacity that considers this vulnerability is pivotal to their ability to self-determine.

Young people and capacity – statutory direction and common law default

Young people (those 16 and 17 years of age) fall under the auspices of the Family Law Reform Act 1969. By its authority conferred under section 8 (1): 'The consent of a minor who has attained the age of sixteen years […] shall be as effective as it would be if he were of full age'. Issues related to decision-making capacity thus fall under the jurisdiction of the Mental Capacity Act 2005 (MCA).

Capacity is assessed in line with the tests in sections 2 and 3 of the MCA. The draft new Code of Practice for the MCA (currently under consultation) that supports the Liberty Protection Safeguards (LPS) makes it clear that section 3 should be applied before section 2, to be sure that decision-making capacity is assessed before a diagnostic assessment (HM Government 2022, para 4.12) (Box 2).

In fact, the MCA applies to young people (over the age of 16) in its entirety, apart from in four important respects: three statutory (lasting powers of attorney, advanced directives and the making of a statutory will), and one provided by its own Code of Practice (Department for Constitutional Affairs 2007), which is of interest here. The Code throws a line to a different way of thinking by saying that if young people are 'unable to make a decision for some other reason, for example because they are overwhelmed by the implications of the decision, the Act will not apply and the legality of any treatment should be assessed under common law principles' (para. 12.13). The common law principles in

BOX 2 Capacity assessment using the Mental Capacity Act 2005 (MCA)

Stage 1: Section 3 of the MCA – a four-stage 'functional test'

- The ability to understand the information relevant to the decision
- The ability to retain that information
- The ability to use or weigh up that information as part of making the decision
- The ability to communicate the decision

Stage 2: Section 2 of the MCA – 'diagnostic test'

The person lacks capacity 'because of an impairment of, or disturbance in the functioning of, the mind or brain'.

question are those derived from the seminal case of *Gillick* (see the section 'Children and competence' below). As will be shown, this reverts to a different conception of decision-making capacity and allows clinicians to take a broader view beyond MCA capacity towards competence. This position is confirmed in the draft new Code (HM Government 2022, paras 21.19 and 21.20). We contend that the draft Code may be referring (either deliberately or inadvertently) to the specific vulnerability in decision-making that is present in all minors and highlighted by the literature on decision-making that we noted in the previous section.

Interestingly, the draft code makes mention of the United Nations Convention on the Rights of the Child (UNCRC) (HM Government 2022, para 21.3). The proposed Liberty Protection Safeguards, through this draft Code, establish that if a young person lacks capacity as defined in the MCA, before establishing best interests in line with section 4 of the Act, 'professionals may [...] choose to seek consent from those with parental responsibility', provided that the person with parental responsibility is deciding 'based upon what is in the young person's best interests' (HM Government 2022, para. 21.16). But those with parental responsibility, in giving consent to treatment, 'cannot consent to arrangements that amount to a deprivation of liberty on the young person's behalf' (para. 21.75). In such a situation a Liberty Protection Safeguards authorisation will be required (para 21.63) (Box 3).

Children and competence – the common law position

For the sake of clarity, we contend that the contemporary debate regarding competence in children (those under the age of 16) changes orientation between a narrow and a broad conception: narrow, in that the focus should align with decision-making capacity – as per the MCA above; and broad, in that, alongside decision-making capacity, complex considerations of maturity need exploration before endowing the child with the authority to decide. This distinction is seen in the different emphases of the lead judgments in the *Gillick* case (*Gillick v West Norfolk and Wisbech Area Health Authority* [1986]). Lord Fraser seemed to move towards a narrow conception. Lord Scarman, however, read a broader, developmental maturity into the concept of competence (Box 4).

There is no real doubt that the Lords, despite their differing approaches, were attempting to capture something of the individual developmental context and, in so doing, were pursuing the concept of maturity. If there remains any doubt that Lord Scarman was attempting to provide a principle of solid utility, but with sufficient individual flexibility, it is settled by the following: 'If the law should impose on the process of "growing up" fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change'.

In the first of the so-called refusal cases (Box 5), *Re R (A Minor) (Wardship: Medical Treatment)* [1991], Lord Donaldson refined Lord Scarman's definition and moved further from Lord Fraser's position. The settled and accepted legal definition of competence in children lies in an amalgam of Lord Scarman from *Gillick* and Lord Donaldson from *Re R* (Box 6).

In two more recent cases involving medical treatment and consent, the judges were, however, inclined to revise this settled conception and definition of competence as above and instead to align it with the test of decision-making capacity (and hence the MCA) applied to young people – in *Re S (A Child) (Adoption: Consent of Child Parent)* [2017] the judge regarded it as 'appropriate, and indeed helpful, to read across to, and borrow from, the relevant concepts and language of the Mental Capacity Act 2005'; the High Court judgment in *Bell v Tavistock* [2020] took a similar approach. However, at the crucial point of applying the capacity test, both reverted to considerations of maturity which needed to be made before endowing the

BOX 3 Clinical guidance to young people's decision-making regarding treatment

- Establish capacity (as in Box 2)
- If capacity is lacking, identify the person with parental responsibility
- Allow the person with parental responsibility to consent to treatment
- The consent provided by the person with parental responsibility must be in keeping with the best interests of the young person
- The consent provided by a person with parental responsibility cannot authorise a deprivation of liberty
- If consent amounts to a deprivation of liberty, then a Liberty Protection Safeguards (LPS) authorisation will be required
- If no person with parental responsibility is willing or available to consent, then establish best interests as per section 4 of the Mental Capacity Act 2005

(Derived from HM Government 2022)

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BOX 4 The *Gillick* case – Lord Fraser and Lord Scarman

The *Gillick* judgment found that:

- minors of 'sufficient age and understanding' should be allowed to give consent to proceed
- it established the notion of the competent minor
- the consent of the competent minor should allow treatment to proceed without parental oversight if the clinical case demanded it.

Lord Fraser (narrow conception)

Competence represents a state of being 'capable of understanding what is proposed, and of expressing his or her own wishes'.

Lord Scarman (broad conception)

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'.

Lord Scarman on maturity

'There are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are risks to health of sexual intercourse at her age'.
(*Gillick v West Norfolk and Wisbech Area Health Authority* [1986])

BOX 5 Summary of refusal cases

Re R [1991] involved a 15-year-old child suffering with psychosis who refused medical treatment. At the time of her refusal, she appeared rational. The local authority, acting in their role as parent, felt her to be competent and withdrew their consent to treatment. At the High Court, the judge concluded that parents should not be allowed to override competent refusal. At the subsequent Court of Appeal, Lord Donaldson made a distinction between capacity to give consent and to refuse. He stated that the consent of a competent minor or that of the parent would be sufficient to proceed with treatment, whereas refusal of both the minor and the parent would be required to prevent treatment.

Re W [1992] involved a 16-year-old with anorexia nervosa who refused treatment in a specialist hospital. Despite falling under the auspices of the Family Law Reform Act 1969 as a young person, the court overruled her refusal. Lord Donaldson, having been soundly criticised for his judgment in *re R*, examined the Act and found that it allowed for the court or the parent of the young person whose refusal might result in 'irreparable consequences' to override the refusal.
(*Re R (A Minor) (Wardship: Medical Treatment)* [1991]; *Re W (A Minor) (Medical Treatment)* [1992])

BOX 6 The settled common law conception of competence in children

Lord Scarman in *Gillick*

'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.'

Maturity encompasses 'moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and […] risks to health of sexual intercourse at her age'.

Lord Donaldson in *Re R*

The judgement of competence requires 'an assessment of mental and emotional age, as contrasted with chronological age […] What is involved is not merely an ability to understand the nature of the proposed treatment […] but a full understanding and appreciation of the consequences both of the treatment in terms of intended and possible side effects, and, equally importantly, the anticipated consequences of failure to treat'.
(*Gillick v West Norfolk and Wisbech Area Health Authority* [1986]; (*Re R (A Minor) (Wardship: Medical Treatment)* [1991])

minor with decision-making authority. In these cases, the lure of a simple test of decision-making capacity could be powerfully felt. But when attempts were made to apply it, with bold assertions about its reach, aspects of maturity and future orientation were felt to be crucial. Such considerations would not be expected when using the capacity test in young people as per the MCA as above.

So, each time the UK courts have tried to redefine child competence within the boundaries of decision-making capacity as per the MCA, they pause and note the need for an elusive ingredient that attends to concerns about developmental maturity. It seems that the bar of Gillick competence is set higher than that of decision-making capacity, since decision-making capacity is a necessary but not sufficient component of competence. Indeed, one commentator argued that that the test of child competence 'is sufficiently exacting that many adults might fail it' (Bainham 1992). Various tools have been designed that assess decision-making capacity in children and young people. These include the Competency Questionnaire – Child Psychiatric version (CQ-ChP) (Billick 1998), the Competency Questionnaire – Pediatric version (CQ-Peds) (Billick 2001), the Hopkins Competency Assessment Test (HCAT) (McAliley 2000) and the MacArthur Competence Assessment Tools for clinical research (MacCAT-CR) (Appelbaum 2001) and for treatment (MacCAT-T) (Grisso 1998).

These are based on the four-stage model of decision-making capacity as per the MCA (Box 2). They all have reasonable interrater and test–retest reliability, but their clinical validity is unknown as there is no gold standard with which to compare. Indeed, a Cochrane review of the available tools was published in 2014 (Hein 2014) but withdrawn in 2015 (Hein 2015) on the basis that there was no clear diagnostic gold standard against which to compare the reviewed tests. In being based on the four-stage model, they are more likely to hold some validity in relation to young people, whose capacity is examined through the same lens, rather than children, whose test of Gillick competence requires additional ingredients (see below).

The elusive ingredient – maturity – and its definition

Lord Scarman, in *Gillick*, explored the concept of the requisite maturity inherent in judgement of competence (Boxes 4 and 6). Other international jurisdictions have also turned their mind to maturity. A sideways glance to these provides profitable cross-reference.

The Canadian Supreme Court, in *AC and others v Manitoba (Director of Child and Family Services)* [2009], a case of refusal of life-sustaining treatment by a minor, drew heavily on *Gillick* as an exemplar. It noted the tension between rising adolescent autonomy and the state's protective duty. In reviewing decision-making, the judgment noted that 'while many adolescents may have the technical ability to make complex decisions, this does not always mean that they will have the necessary maturity and independence of judgement to make truly autonomous choices'. In relation to maturity, it further observed 'there is no simple and straightforward means of definitely evaluating – or discounting – the myriad of subtle factors that may affect an adolescent's ability to make mature, stable and independent choices in the medical treatment context'. It accepted that in most day-to-day clinical scenarios, the decisions are not grave, and painstaking assessment is not required. But when grave and irreversible decisions are faced, careful evaluation of maturity is needed.

In Belgium, euthanasia law allows, in certain circumstances, minors (with support from their families) to shorten their potential suffering prior to inevitable death from terminal illness. It demands assessment of developmental maturity as part of its framework. It names the requisite ability as the 'capacity for discernment'. This 'relates to the ability of the minor to understand the real implications of his euthanasia request and its consequences' (van Assche 2018). The pursuit of maturity is central to it.

Establishing a minor's capacity for discernment involves consideration of:

- the nature, purpose and efficacy of the intervention
- risks and benefits
- the sophistication required to understand the information and assess potential consequences
- the intellectual and emotional characteristics of the minor
- family and social issues
- stability of the minor's views.

It is evident that, in grave situations, domestic courts wish to add something to decision-making capacity to attend to the issues of maturity. Some attempt to provide guidance, and some sidestep the debate, preferring to suggest that the capacity test from the MCA is commensurate with the task. It is equally clear that capacity as per the MCA neither aligns with the settled common law position for the assessment of competence in children (Boxes 4 and 6) nor even vaguely approaches the kind of considerations of international courts.

Box 7 outlines a clinical toolkit for assessment of Gillick competence in practice.

The reach of capacity and competence in minors

Acceptance of treatment

Young people (16 and older) fall under the guidance of the Family Law Reform Act 1969 and the MCA. For the purposes of acceptance of treatment, they are equivalent to adults and there is a presumption

BOX 7 Clinical assessment of Gillick competence

Step 1 Decision-making capacity

- The ability to understand the information relevant to the decision
- The ability to retain that information
- Th ability to use or weigh up that information as part of making the decision
- The ability to communicate the decision

Step 2 Consideration of maturity

- The short-term impact of making the decision to accept or to refuse on family relationships
- The long-term impact of making the decision to accept treatment in terms of effects and side-effects
- The short- and long-term consequences of failing to accept treatment

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of capacity until proven otherwise (MCA 2005, section 1(2)).

Children (under 16) fall under the guidance of *Gillick*, which established the right of the competent child to consent to accept treatment. It effectively established a presumption that children are not competent to make decisions until proven otherwise. This was later given post-Human Rights Act ratification and applicability 'to *all* forms of medical advice and treatment' by the High Court (*Re (Axon) v Secretary of State for Health* [2006]). Moreover, as mentioned above in relation to *Bell v Tavistock*, the Supreme Court has recently declined further appeal, and in so doing, effectively confirms the conclusion of *Gillick* and *Axon*.

It is, of course, the role of clinicians to disprove and weigh the evidence for and against the above presumptions. The burden thus falls on clinicians to prove incapacity in a young person and to prove competence in a child.

Refusal of treatment

Despite the above empowerment of minors' capacity and competence in relation to acceptance of treatment, refusal is treated quite differently. *Gillick* did not represent the 'eclipse of parental rights' that it was presumed to be, and parental rights remain 'albeit in a state of potential rather than derogatory force' (Eekelaar 1986).

The two refusal cases, *Re R* [1991] and *Re W (A Minor) (Medical Treatment)* [1992] (Box 5), confirmed the concurrent rights of parents to give consent on a minor's behalf and the ability of parents and the courts to override the refusal of a capacitated/competent minor (any minor, that is, under the age of 18). Lord Donaldson, giving the lead judgment in both cases, noted that a minor's refusal 'is a very important consideration in making clinical judgments and for parents and the courts in deciding whether themselves to give consent', with that refusal of increasing importance with 'age and maturity' (*Re W* [1992]). However, 'No minor of whatever age has the power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and *a fortiori* by the court' (*Re W* [1992]) – *a fortiori* meaning 'from the stronger argument', i.e. the power of the court is greater than that of the parent.

The contentious issue, which led to academic criticism of Lord Donaldson, was the perceived disparity between Lord Donaldson as above and the words of Lord Scarman in *Gillick* (Bainham 1992; Thornton 1992). Lord Scarman had suggested a precipitate, absolute, cessation of parental rights to consent as follows: 'I would hold that as a matter of law 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' (italics added; *Gillick* [1986]). Lord Scarman had explored the Family Law Reform Act in deriving this view. Lord Donaldson made a detailed review of the intention of, and the common law position prior to, the Act. He was emboldened by that review and noted the specific wording of section 8(3): 'Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted'. Since the ability of parents to consent to the treatment on behalf of their child was the common law position prior to the Act, his argument that parents be allowed to provide consent on behalf of a minor appears robust and does stand up to scrutiny. Lord Scarman's sweeping conclusion from *Gillick* (see the section 'Children and competence' above) does seem to be at odds with his general comments within in the same judgment. Specifically, his warning about the 'artificiality' and 'lack of realism' that would arise if the law should 'impose on the process of "growing up" fixed limits when nature knows only a continuous process' (*Gillick* [1986]).

Lord Donaldson was steadfast in his view that the 'staged development of a normal child' was at issue and that even when mature enough to consent to a more straightforward examination and treatment they 'remain incapable of deciding whether to consent to more serious treatment' (*Re R* [1991]).

The judgment in *Re X* contemporised the issue and noted that the conclusions of the refusal cases 'have been consistently followed and applied by the judges down the years'. It listed eleven cases where they had been applied and commented that 'In none of these cases […] did the judges give the slightest indication of any doubt as to whether the decisions […] were good law or the slightest hint that perhaps the law as stated in them need reconsideration' (*Re X (A Child) (No 2)* [2021]).

The potential for Parliament to intervene

Domestic (*Gillick* [1986] – comments of Lord Scarman in the previous section) and international courts (*AC v Manitoba* [2009] – 'rigid statutory distinction […] would fail to reflect the realities of childhood') have expressed concern about the imposition of fixed statutory age limits on the reach of capacity. However, there are also references to the potential for Parliament to intervene. The judgment in *Re W (A Minor) (Medical Treatment)* [1993] commented that to confer 'complete' autonomy on minors was 'a matter of social policy with which Parliament can deal […] if it wishes to'.

Re X [2021] noted that until Parliament chooses to step in, the minor 'whether Gillick competent or 16 or over, is not, as a matter of our domestic law autonomous in the same way as an autonomous adult'.

Proposed amendments to the Mental Health Act 1983 regarding minors' admission to psychiatric units under parental responsibility, although welcomed at the joint parliamentary committee stage, were not enacted in the amended Act (Department of Health 2004; Joint Committee on the Draft Mental Health Bill 2005). These included:

- see children as a special group
- protect them with additional safeguards
- extend those safeguards to young people.

Instead, the choice was made to give guidance in its accompanying Code of Practice (Department of Health 2015), conceptualised as 'the scope of parental responsibility'. The term replaced the term 'zone of parental control' used in the previous Code of Practice from 2008. It has been suggested that the concept of the scope of parental responsibility was an attempt to formalise the rising autonomy of minors (Hawkins 2011) and to provide safeguards demanded by European case law (Akerele 2014). It is, however, fraught with nebulous statements and fails to enunciate the legal subtlety in this area. The revised Mental Health Act, notably, was not silent in relation to such matters in minors: see, for example, guidance in section 131(4) on preventing parental consent to admission for a young person aged 16–17. However, it did not offer a root and branch review of the autonomy and rights of minors.

A sliding scale of capacity or moving the goalposts?

Some academic commentators are unswerving in their pursuit of a single, operationally practicable definition of decision-making capacity in minors. In their opinion, when the requirements are met, minors will be entitled to self-determination. Their avid wish is met in the domestic courts, with a caution about the implications of investing children with unfettered rights to self-determination. Lyons (2010) noted that there had been seven cases of minors before the courts involving refusal of life-saving treatment. The courts invoked two sorts of legal device to override the refusal (Box 8) – specific incapacity and welfare. What shines through in these cases is the prohibitive reticence of the domestic courts to allow minors to make decisions that would shorten their lives. This is not a 'never' but simply a 'not now' argument. All note the importance of taking risks, but all feel a moral obligation to step in to prevent ultimate harm. Examples of this come from conclusions of judgments in life-threatening self-determination cases:

- Lord Donaldson (*Re W* [1993]): 'for it is only by making decisions and experiencing the consequences that decision-making skills will be acquired', a process which involves 'giving minors as much rope as they can handle without an unacceptable risk that they will hang themselves';
- Justice Ward (*Re E (A Minor) (Wardship: Medical Treatment* [1993]): 'There is compelling […] force in the submission […] that this court […] should be very slow to allow an infant to martyr himself'.

This reticence in grave situations sits well with the well-established case-law principle that the 'amount' of capacity must rise to be 'commensurate with the gravity of the decision […]. The more serious the decision, the greater the capacity required', i.e. a sliding scale (*Re T (Adult Refusal of Treatment)* [1992]). The principle was extended to minors in *Re R* [1991] and updated in Bell *v Tavistock* [2020]: 'where the consequences of the treatment are profound […] it may be that *Gillick* competence cannot be achieved'.

The derived position at law implies a belief that children should survive at all costs, and that it is not until after the age of majority (age 18) that the protective parental role (including the proxy parental role of the state) can be fully released. This is reminiscent of the concept of curtailing current autonomy to safeguard the potential for future autonomy described in the first article (Hawkins 2023). Perhaps societal conscience is better able to tolerate the occasional tragic case of treatment refusal and death after the age of majority. But the courts, in representing that conscience, are abundantly clear that minors should not be allowed

BOX 8 Justification used in the domestic courts to override the refusal of a minor

Specific ways of finding incapacity

- The illness destroys the ability to reason
- The decision is so grave that the 'amount' of capacity is beyond the reach of even a very intelligent adolescent
- The provision of the type of information required to make a decision in a grave situation would be too disturbing for the minor.

Welfare

- The minor should be protected from themselves and given the 'chance to live a precious life'.

(Lyons 2010)

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self-determination if it would have irreversible consequences.

In such decisions, beneficent welfarism and paternalistic protectionism prevail. At law, incontrovertibly, acceptance and refusal are treated differently and almost any legal device is used to justify paternalistic interference when refusal has grave consequences.

The tension between autonomy and the right to life

The UK courts exert a prohibitive reticence to allow minors to shorten their lives. Any available mechanism is found at law to justify that position (Box 8). This inherent position limits minors' autonomy. The UK courts are also clearer in examining decisions from the perspective of the rights of the minor (see part 1 (Hawkins 2023)).

When the domestic courts adopt the derived position, they create tension between individual articles of both the European Convention on Human Rights (ECHR) and the United Nations Convention on the Rights of the Child (UNCRC), notably:

- the tension in the ECHR between Article 2 (the right to life) and Article 8 (the right to respect for private and family life)
- the tension in the UNCRC between Article 6 (the recognition that every child has the inherent right to life) and Article 12 (the assurance that the views of a child will be given due weight in accordance with the child's age and maturity).

Such tensions were most clearly examined in *Re X* [2021]. The tension created between rights was noted, and preservation of life was observed to override concerns about infringement of both Article 8 of the ECHR and Article 12 of the UNCRC.

We are reminded that the rights of the ECHR are 'formulations […] of aspects of the good life, not the bad, and should be interpreted in a way that enhances a person's life' (Fortin 2006). Furthermore, to endorse minors' rights on an equal footing with those of adults would mean 'dissolution of the child labor, mandatory education, statutory rape laws, and child neglect statutes' and in doing so it would 'give children rights for which they are ill prepared' and 'leave them more vulnerable than they presently are' (Ross 1997).

The derived legal position – justifiable intrusion or 'palpable nonsense'?

Harris (2003) determinedly attacked the notion of differential treatment of acceptance and refusal, referring to it as 'palpable nonsense'. In his view, to be informed sufficiently to decide to accept treatment is to understand the consequences of refusal: 'consents and refusals are the Janus Faces of autonomous capacity' in all cases, 'including that of life and death.' By overriding a competent child's refusal of treatment, 'we are behaving as good adults should towards incompetent children' but 'are not […] obtaining consent or respecting autonomy […]. We are securing acquiescence – quite another thing'. Such academic argument is important in allowing robust scrutiny of the issue, but there has been caution expressed about the those who live 'amongst the dreaming spires of the Academy' rather than the 'robust and ultimately pragmatic world of the court room' (*Re X* [2021]).

In contrast, Gilmore & Herring (2011) offered an elegant and delicately crafted blend of law and ethics, which drew on Coggon's tripartite model of autonomy (see part 1 (Hawkins 2023)). They noted that refusal 'is not always simply the obverse of consenting to a particular treatment' (Gilmore 2011). They made a clear distinction between two types of refusal: refusal of a specific treatment while remaining open to the idea of an alternative; and refusal of all treatment. Self-evidently, refusal of all treatment holds graver consequences and 'requires the patient to direct his or her mind in different directions, and thus to answer different questions'. They justified the separation of acceptance and refusal in three ways. First, based on the sliding scale described above. Second, that some decisions demand a 'rich' form of autonomy and some do not. Third, that decisions taken by minors have impacts on family relationships, and those impacts are greater depending on the gravity of the decision. Their model demands a richer form of autonomous decision-making capacity for refusal of all treatment in grave situations. This fits with the idea of a test of competence that demands decision-making capacity plus an appraisal of maturity.

A practical exercise in examination of the derived position

The use of two fictitious vignettes allows an exploration of the derived position described in this article (Box 9). Both Amelia and Brody are operating with Coggon's best desire autonomy (as elucidated in part 1 (Hawkins 2023)). But Brody's situation is graver and demands a more sophisticated engagement with the clinical advice. He will have to demonstrate more maturity and more competence to have his autonomous choice respected. This supports the sliding scale of competence described in case law (*Re T* [1992]).

Both Amelia and Brody must show greater reflection than a person accepting all treatment. But the refusal of all treatment by Brody requires him to move his mind in a different direction again to

BOX 9 Illustrative case vignettes of Amelia and Brody

Amelia, a 15-year-old in an out-patient psychiatric clinic, wishes to explore potential treatment for a depressive disorder. The matter for discussion is the addition of medication to an existing psychological therapy. She listens to the information about the treatment and its effects and side-effects; enters a discussion with the assessing clinician both in the presence of her parent and alone; and returns the following week and declines medication, preferring instead to continue psychological treatment for an agreed period of time, subject to review.

Brody, a 15-year-old, also suffering with a depressive disorder, already having had out-patient treatment as above, takes a serious, life-threatening overdose. The matter for discussion is urgent hepatic support, which needs to be offered immediately. He listens to the information provided by the physicians specialising in physical health, with his usual specialist in mental health alongside; enters into a discussion with the assessing clinician both in the presence of his parent and alone; and he declines hepatic support and all other treatment in the knowledge that he is most likely to suffer acute hepatic failure and die.

Amelia. Not just to move his mind, but to engage in different thought processes and be seen to be doing so. Thus, differential treatment of acceptance, refusal of treatment with minimal consequences and refusal of treatment with grave consequences appears logically justified.

Amelia's decision would be likely, in everyday clinical practice, to be fully respected. Brody's decision would be listened to, but it would be likely that medical professionals, with parents alongside, and perhaps the court, would seek to secure acquiescence by any legal device that preserved life. This might be to raise the bar of competence, to use concurrent parental consent, to use the Mental Health Act or use the authority of the court. His voice would be heard, but his autonomy would not be fully respected.

Thus, in everyday clinical practice, autonomy can be fully respected. In grave situations, a minor's voice and opinions might be heard, but the preservation of life would dominate the clinical decision. In such a situation, any legal and available means would be used to limit the exercise of autonomy. This position is compatible with the rights agenda and is, in our opinion, ethically justifiable.

Conclusions

Systematic studies over the past 40 years have established that minors' ability to pass tests of decision-making capacity is equivalent to that of adults from the age of 14. They are, however, vulnerable to the effects of peer influence and emotion at a time when their social challenges are especially intense. Any test of competence in minors should extend beyond pure decision-making capacity and take heed of that vulnerability.

Statute (the Family Law Reform Act 1969) has afforded young people a rebuttable presumption of capacity. Common law (*Gillick* [1986]) has afforded children a rebuttable presumption of incompetence. The signal arising from common law adds an additional ingredient to decision-making capacity to create competence in children, and the additional ingredient is maturity. That notion of maturity encapsulates the specific vulnerability in decision-making in minors, but a settled definition of maturity eludes the domestic courts.

Once capacity or competence in minors is established, it has considerable reach in permitting autonomous self-determination in the healthcare context. The ability to give consent to treatment and to make day-to-day decisions to refuse is protected and fully respected. In grave cases, with life-limiting or life-threatening implications, the domestic courts reserve their own inherent jurisdiction to override refusal as well as the concurrent parental right to give consent. Various legal devices and justifications are used, but they amount to beneficent welfare protectionism superseding autonomy. The reach of minors' autonomy is incomplete, and fundamentally, the concept of protection of future autonomy by infringing current autonomy, as well as the central veneration of life under the ECHR and UNCRC, are used as the ethical justifications.

Autonomy is thus highly relevant in clinical practice. Its respect can be absolute and determinative in everyday clinical scenarios. The concept of maximising autonomy by correcting, as far as possible, impediments to its delivery is important. It sits well with the intention of the UNCRC in the minor finding, testing and honing their voice of self-determination in a social context that values that voice and respects its rising capability. However, that rising authority is braced by the protective overview of parents and the state, and in grave situations the examination of maturity enveloping the capacity of the minor is fundamental, and needs to be deeper and more considered. There is no settled conception of maturity and no 'judicial divining rod that leads to a "eureka" moment for its discovery' (*AC v Manitoba* [2009]).

The current position reminds us that 'children are human-becomings not full human beings and the only way to respect children's autonomy is to protect it until they achieve full maturity' (Alderson 1996). Even J.S. Mill in 1859, who provided resounding commitment to the right to self-determination, prophetically recognised that it was

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its practice that galvanised decision-making by saying 'perception, judgment, discriminative feeling, mental activity, and even moral preference, are exercised only in making a choice […]. The mental and the moral, like the muscular powers, are improved only by being used' (Mill 1859: 2006 reprint, ch. 3, p. 67).

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MCQ answers
1 b 2 c 3 a 4 d 5 c

Bell and Another v Tavistock and Portman NHS Foundation Trust (University College London Hospitals NHS Foundation Trust and other intervening) [2021] EWCA Civ 1363.

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MCQs

Select the best option for each question stem

1 In relation to decision-making in minors:

a cultural theories hold centre stage
b the performance of 14-year-olds on tests of legal competency is equivalent to that of 21-year-olds
c perceptions of invulnerability in adolescents are the major force in decision-making
d adolescents disregard the opinions of peers in making decisions
e adolescents take more risk when alone rather than in groups.

2 In relation to the concept of maturity:

a it was not discussed in the lead judgments in *Gillick*
b *AC v Manitoba* suggested that there might a 'judicial divining rod' for its discovery
c the Belgian concept of the 'capacity for discernment' held that stability of minors' views was important
d is dealt with suitably in the decision-making capacity test of the Mental Capacity Act
e is of no relevance in the judgement of minors' capacity.

3 In relation to capacity and competence under UK law:

a those over the age of 16 have a rebuttable presumption of capacity
b those under the age of 16 have a rebuttable presumption of competence
c concurrent parental consent is of no relevance after the age of 16
d concurrent parental consent is discarded once Gillick competence is achieved
e the conclusion of the refusal cases is frequently questioned by judges in court.

4 Which of these are 'devices' used by the courts to limit the autonomous decision-making of minors?

a the minor is not old enough
b the minor has not been afforded access to an advocate
c the minor has been provided with too little information
d the minor should be protected from themselves and permitted the chance 'to live a precious life'
e the minor has not spoken to their parents.

5 In relation to the differential treatment of acceptance and refusal:

a legal judgments prioritise Article 8 of the ECHR over Article 2 of the ECHR
b legal judgments suggest that Article 12 of the UNCRC should be the single defining principle in respecting autonomy
c it has been attacked as 'palpable nonsense' by one commentator
d refusal is the 'obverse' of acceptance
e recent cases have prioritised autonomy over the preservation of life.

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