Mature Minors and the Refusal of Medical Treatment: A Misuse of Gillick?

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Abstract

This thesis aims to explore and critique the current law governing the refusal of medical treatment by mature minors. Through assessment of the application and interpretation of the current law, the legal picture is found to be unsatisfactory. The law in this area is riddled with confusion. This thesis aims not only to call for reform within this area, but to question the validity of the infamous *Re R* and *Re W* cases. This thesis will explore refusal cases involving mature minors, criticising the judiciary's apparent avoidance of the difficult issues within this area. It shall be argued that the courts have avoided embracing mature minors' autonomy by manipulating, or even ignoring, the *Gillick* test when deciding whether a child deserves capacity. As such, the law is in need of urgent clarification.

This thesis shall argue that the law in this area, currently appearing to prevent competent minors being granted capacity, is incompatible with the United Kingdom's obligations under the European Convention on Human Rights and the UN Convention on the Rights of the Child. Finally, this thesis concludes by stating that most suitable route for reform would be through the judiciary, whilst emphasising the importance of society's willingness to embrace children's independence, abilities, and rights as a crucial aspect of reform. Ultimately, this thesis aims to argue that competence should, as a general rule, lead to determinative capacity for mature minors.

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Chapter I: Introduction

Despite the fact that medical law now places greater emphasis on patient autonomy over excessive paternalism as its central concept,[1] there is yet to be a case heard by the judiciary in which a mature, competent minor has been allowed to refuse medical treatment. Following from this fact, this thesis aims to find out *why* the judiciary appear so reluctant to grant autonomy to competent, mature minors. It aims to demonstrate that the courts are clutching to their paternalistic control of minors, despite human rights obligations and children's rights progress appearing to require an increased respect for autonomous and competently made decisions. Despite evidence of understanding and intelligence on behalf of the children involved, the judiciary have employed a plethora of dubious tactics to prevent the minor exercising autonomy.[2] This reluctance is most starkly apparent where the result of allowing that child control over their medical treatment would be the child's death or serious injury. As such, this thesis shall focus on the refusal of life-saving or life-prolonging treatment.

The famous and largely celebrated *Gillick* case created an unprecedented test for the competence of minors below the age of 16.[3] Previously, only the rights of children aged 16-17 to consent to treatment had been directly addressed in legislation.[4] Hence, the *Gillick* judges had to consider whether those under 16s had the potential to make their own decisions regarding treatment without parental consideration.[5] Lord

[1] For example, see *R (on the Application of Burke) v GMC* [2005] 3 FCR 169, [30] (Lord Phillips MR); *St George's Heathcare NHS Trust v S* [1998] 3 WLR 936, 950 (Judge LJ); Andrew Grubb, 'Refusal of Treatment (Child): Competence' (1999) 7(1) *Medical Law Review* 58, 59; JJ Chin, 'Doctor-patient Relationship: from Medical Paternalism to Enhanced Autonomy' (2002) 43(3) *Singapore Medical Journal* 152, 152.
[2] Jane Fortin 'The *Gillick* Decision- Not Just a High-Water Mark' in Stephen Gilmore, Jonathan Herring and Rebecca Probert (eds), *Landmark Cases in Family Law* (Hart Publications 2011) 121.
[3] *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112.
[4] Family Law Reform Act 1969, s8.
[5] *Gillick* (n 3) 182 (Lord Scarman).

Scarman concluded that such children cannot be seen to be entirely reliant on parental involvement until the Family Law Reform Act (hereinafter FLRA) applies, and proceeds to create the famous *Gillick* competence test.[6] In sum, the *Gillick* case provided that children would have the competence to decide whether or not they had medical treatment if they could demonstrate 'sufficient intelligence and understanding' of that procedure.[7] Nevertheless, the liberal nature of this test, granting a greater degree of autonomy to competent minors, was short-lived. In the early 1990s, Lord Donaldson sought to restrict the rights *Gillick* competence would grant to mature minors.[8] Although the details of these cases will be discussed further within Chapter II, ultimately Lord Donaldson's judgments meant that even if undeniably competent, a minor may still be overridden in their refusal of medical treatment where the outcome would be life-threatening or could lead to serious injury.[9] Despite this green light to override even competent minors, the judiciary have subsequently tended to avoid the direct application of his judgments. Instead, they have tended to find the minors involved to be lacking in competence through dubious manipulation of the *Gillick* test or even failure to apply it entirely. These cases shall be the focus of this thesis.

This thesis aims to highlight and condemn the current judicial approach regarding mature minors' refusals of medical treatment and cut through the fog which surrounds the current law. Due to the avoidant tactics of the judiciary, minors are left in the dark regarding their rights. It is unclear whether a minor could ever be competent enough to be granted full capacity over their medical decisions where the outcome would be

[6] ibid 182-189.
[7] ibid 188-9.
[8] *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11; *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64.
[9] ibid 81-2 (Lord Donaldson).

death or serious injury. Ultimately, this thesis aims to prove that the law in this area is primarily in need of clarification. Secondly, it shall aim to support the conclusion that this clarification should come in the form of accepting competent minors' decisions where they are made with sufficient understanding and autonomy, even if the consequences are hard to accept.

Definitions

Academics within this area have taken many different definitions of the key terms 'competence' and 'capacity'.[10] In order to ensure clarity throughout, this thesis shall firstly set out its own definitions of these terms. For the purposes of this thesis, 'competence' shall be used to describe the satisfaction of the legal tests within *Gillick* for under 16s, and the Mental Capacity Act (hereinafter MCA) test for 16-17 year olds and adults above the age of majority. Within Chapter V, the concept of competence also requiring an element of autonomy which may go beyond these formal legal tests shall also be explored.[11] Overall, 'competence' is intended to describe mental abilities to understand relevant information and properly exercise decision-making abilities. On the other hand, the term 'capacity' shall be used to signify the acceptance of the individual's choice as determinative at law. As such, a child could be seen to have high levels of maturity and intelligence in the *Gillick* sense, meaning that they have the mental abilities to decide for themselves, but if the judiciary choose to intervene with that decision and deny them determinative choice, this child would have competence, yet lack capacity.

[10] For example, see use of the terms within: Emma Cave, 'Maximisation of Minors' Capacity' (2011) 23(4) *Child and Family Law Quarterly* 431, 433 and Shaun D Pattinson, *Medical Law and Ethics* (Fourth Edition, Sweet and Maxwell 2014) 136.

[11] This shall refer to the development of the inherent jurisdiction. See discussion within: Jonathan Herring, *Vulnerable Adults and the Law* (Oxford University Press 2016) 54.

Finally, it shall serve as useful to predetermine terms used to refer to particular sets of cases throughout this thesis. The phrase 'retreat cases' shall be used to refer to the *Re R* and *Re W* cases. These cases shall be explored further within the subsequent chapter, and this term was chosen due to their reputation as the cases which encompass the infamous 'retreat from *Gillick*'.[12] Additionally, the term 'refusal cases' shall be used to refer to the judicial cases involving a mature minor refusing life-saving or life-prolonging treatment following the controversial dicta within the retreat cases.

Finally, the term 'minors' should be taken to encompass all individuals under the age of majority, unless the term 'young adult(s)' is used, in which case this refers exclusively to those of 16 and 17 who attract the principles within section 8 of the FLRA. Adults shall, of course, refer to those over the age of majority.

Chapter Breakdown

In order to demonstrate this thesis' intended conclusion, four substantial chapters shall address the main areas of interest. Issues which shall be explored involve the validity of the retreat cases, the judicial reasoning employed within the refusal cases and the relevant human rights obligations and concurrent progress within the law more generally regarding autonomy and paternalism. All of this shall lead to a discussion of the potential reform options for this area of law, suggesting that the judiciary should aim to resolve their own mistakes.

Firstly, Chapter II shall act as an introduction to the key case law within this area. The pivotal *Gillick* case and its relevant test for competence for under 16s shall be discussed, and its impact on issues such as parental rights and capacity explored. Next, this chapter shall explore the *Re R* and *Re W* cases, which placed a limit on minors'

[12] Rachel Taylor, 'Reversing the retreat from *Gillick*? *R(Axon) v Secretary of State for Health*' [2007] *Child and Family Law Quarterly* 81, 94.

chances of being granted decision-making capacity even where they can demonstrate a high level of competence.[13] It shall aim to cast doubt on the validity of the reasoning within the retreat cases, drawing on their inherent incompatibility with *Gillick* as well as general flaws within the judgments of Lord Donaldson. It shall be evidenced that Lord Donaldson's reasoning in limiting the power of *Gillick* competence is ultimately unconvincing. Overall, the aim of this chapter is to set the scene for the controversy which followed the retreat cases, providing a potential explanation for judicial reluctance to apply their principles in a direct manner.

Next, Chapter III shall explore the refusal cases. Following the retreat cases, a torrent of criticism poured over Lord Donaldson's judgment due to its overtly and overwhelmingly paternalistic outlook.[14] This thesis aims to show that this controversy led to judicial reluctance to apply the judgments within subsequent cases where a mature minor refused with potential competence. Rather than embracing fully the idea that a competent child can be denied capacity, this chapter aims to show that the judiciary have instead chosen to manipulate and even ignore the *Gillick* test in order to conveniently find the child involved lacking in competence. This allows for a less controversial override of the minor's wishes, making the judiciary's job a little easier when it comes to exercising paternalism. This chapter aims to condemn these judicial tactics, utilising case law examples to demonstrate the injustice done to mature minors through dubious findings of incompetence. The overall aim of this chapter is to expose

[13] *Re R* and *Re W* (n 8).
[14] For example, see: Alexander McCall Smith, 'Consent to Treatment in Childhood' (1992) 67(10) *Archives of Disease in Childhood* 1247, 1248; Ian Kennedy, 'Consent to Treatment: The Capable Person' in Clare Dyer (ed), *Doctors, Patients and the Law* (Blackwell Scientific Publications 1992) 58-9; Graeme Austin, 'Righting a Child's Right to Refuse Medical Treatment: Section 11 of the New Zealand Bill of Rights Act and the *Gillick* Competent Child' (1992) 7(4) *Otago Law Review* 578, 578 and 583.

the confusion currently evident within this area of law, largely as a result of the judiciary's avoidance of the hard-hitting issues.

Chapter IV shall follow this conclusion and suggest what the focus of the law should be regarding any subsequent reform. It shall explore the huge changes which have occurred within the law in the two decades since the retreat case were concluded. In particular, the focus of this chapter shall be on the progress made with regards to autonomy and human rights as a result of the UN Convention on the Rights of the Child (hereinafter UNCRC or CRC), the Human Rights Act 1998 (hereinafter HRA) and judicial progress made within medical law more generally in replacing paternalism with patient autonomy as its central concept. As a result of the increased prominence of autonomy rights, this chapter aims to counteract claims that the confusion within this area of law should be remedied by revoking all rights of minors to refuse until they reach the age of majority. It shall be demonstrated that such a conclusion, although undoubtedly bringing about clarity for minors' rights, would be incompatible with human rights obligations. As such, any reform ought to embrace the competence of minors and allow such abilities to lead to real control over their decisions.

Chapter V shall consequently explore the routes through which reform could be achieved within this area. The potential for judicial change through common law principles and the HRA shall be explored as a potential route for positive change, as well as exploring the possibility of legislative change in the form of extending the MCA to under 16s. In addition, the all-important *likelihood* of such changes being made shall also be critically assessed. The conclusion shall be that there is currently a restrictive reluctance to embrace the abilities of even mature, competent minors to have meaningful control over their own medical decisions, especially where the

consequences of such autonomy would be death or serious harm for the child. The most poignant obstacle, it shall be suggested, is a social barrier to change. There remains reluctance to let go of the dichotomy between childhood and adulthood which reinforces harmful and inaccurate stereotypes regarding children as inherently weak, illogical, and vulnerable beings.[15] As such, this final chapter shall suggest that the law cannot realistically expect true, all-encompassing change for minors until smaller steps towards addressing these stereotypes are taken. It shall be concluded that the most suitable branch to tackle such a task is the judiciary, due to the common law's piecemeal approach to reform. Ways in which the barriers to embracing minors' autonomy rights can be broken incrementally shall be suggested, with the implication that any broad reform in the future would be more easily accepted if the stance regarding minors' rights to refuse life-saving treatment was done with a steady pace. The end goal would be the overrule of the antiquated retreat cases, and the acceptance that minors acting with full competence and autonomy deserve to be granted decision making capacity without interference.

Overall, this thesis aims to expose the judiciary's avoidance of the challenge which comes with allowing competent minors meaningful capacity and autonomy. Although it is difficult to accept that a child can choose to refuse life-changing treatment, if that decision is made with competence and understanding of the consequences, that child has earned the right to be the arbiter of their own fate. Adults may disagree with the decisions of mature, competent minors, but the decisions are ultimately their own to make.[16] Competence ought to lead to the recognition of real rights for minors, and the

[15] Priscilla Alderson, 'Competent Children? Minors' Consent to Health Care Treatment and Research' (2007) 65 *Social Science and Medicine* 2272, 2276.
[16] Sheila AM McLean, 'Whose Decision is it Anyway?' *The BMJ.com* (14 November 2008) <http://blogs.bmj.com/bmj/2008/11/14/sheila-mclean-whose-decision-is-it-anyway/> accessed 21 June 2017.

possibility of minors being mature enough to attain this lucrative status must be embraced. To deny competence and subsequent capacity to an intelligent, autonomous child in order to avoid confronting the difficult moral questions raised by the retreat cases is demeaning and unnecessary. Once competent, that child should be trusted to make their decision having considered all the available information and their own personal beliefs and convictions. To intervene with such decisions is to exercise unnecessary and excessive paternalism. Such interventions should be limited to children who are truly in need of judicial protection. This thesis calls for the judiciary to step up to the challenge of reforming the law, and to embrace capacity for competent minors despite the difficult moral issues involved.

Chapter II: Minors' Capacity and the Law

This chapter will seek to explore the current law which governs the highly-contested area of children's capacity. It is a subject riddled with controversy and confusion, making this task no simple endeavour. Primarily, the all-important *Gillick* case shall be discussed.[1] The meaning of this ground-breaking authority shall be examined in the context of academic discussion, and its main issues of contention addressed. This chapter will attempt to conclude what exactly was meant by 'understanding' and the consequences of a minor's attainment of *Gillick* competence for parental rights as well as exploring the law relating to 16 and 17 year olds under the FLRA. Following this, the so-called 'retreat from *Gillick*'[2] shall be critically discussed. It shall be argued that these cases are questionable authorities in terms of their status as precedent as well as their compatibility with the judicially superior *Gillick* case.

Ultimately, it shall be concluded that the law in this area is far from clear cut. It shall set the stage for further critique of the application of these already questionable case authorities by the judiciary, which shall be the focus of the subsequent chapter.

The *Gillick* Case

The *Gillick* case has attained fame in the legal community; it altered the status of children in English law cataclysmically.[3] The case began somewhat mundanely, with written correspondence between a devoutly religious mother and her doctor's surgery. The eponymous Mrs Gillick sought assurance that none of her daughters could obtain contraceptive advice from their doctor in the future without her consent whilst they

[1] *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112.
[2] Rachel Taylor, 'Reversing the retreat from *Gillick? R(Axon) v Secretary of State for Health*' [2007] *Child and Family Law Quarterly* 81, 94.
[3] Jane Fortin, 'The *Gillick* Decision– Not Just a High-Water Mark' in Stephen Gilmore, Jonathan Herring and Rebecca Probert (eds) *Landmark Cases in Family Law* (Hart Publications 2011) 212.

were under 16 years of age. She took the issue to court, hoping to obtain judicial confirmation that children had no right to autonomy in terms of consent to medical treatment until they reached 16.[4] Whilst Mrs Gillick was unsuccessful in her legal endeavours, this House of Lords case nevertheless had a profound impact in medical consent law and beyond. It gave an unprecedented legal test for the competence of under 16s, allowing them to consent to treatment without parental involvement.[5] This test, mentioned in both Lord Fraser and Lord Scarman's judgments, states that the minor must demonstrate 'sufficient intelligence and understanding' of the procedure proposed in order to demonstrate their competence to decide.[6] The fine details of the case are hotly contested, and although impossible to address every controversy in detail, this chapter shall begin by attempting to clarify the main issues relating to children's rights to control their own medical treatment.

Gillick, parental rights and refusal rights

One issue addressed within *Gillick* was the status of parental rights regarding children with competence. Although contested as a result of later cases,[7] Lord Scarman states that parental rights to decide whether their child will have medical treatment will 'terminate' upon the child's attainment of *Gillick* competence.[8] Although this appears a clear-cut answer regarding the endurance of parental rights over their competent child, this issue requires further exploration.

Some feel that the issue was unclearly settled within *Gillick*. This is because Lord Scarman and his fellow judges make some confusing and at times contradictory

[4] At which age a minor would obtain protection through section 8 FLRA.
[5] Anthony Perera, 'Can I Decide Please? The State of Children's Consent in the UK' (2008) 15 *European Journal of Health Law* 411, 413.
[6] *Gillick* (n 1) 114.
[7] See discussion of *Re R* and *Re W* from page 8 onwards.
[8] *Gillick* (n 1) 188-9 (Lord Scarman).

statements about parental rights. Whilst stating that parental rights to determine medical treatment for the child 'terminate' once the child is competent, Lord Scarman also admits that parental rights 'do not wholly disappear until the age of majority'.[9] Some, such as Stephen Gilmore, see this as evidence that the *Gillick* judgment was not as liberal as it has been interpreted as in subsequent years.[10] He feels that it is difficult to say that parents have no rights upon the child's attainment of competence, and that due to the above contradiction he cannot accept that *Gillick* competence was intended to lead to absolute autonomy for the child.[11]

Nevertheless, with respect, this interpretation can be questioned. Although Lord Scarman stated that parental rights can endure until majority, this is an incredibly broad statement. Parental responsibility encompasses a wide range of issues, including where the child resides, where they go to school, what religious practices they experience and so on. As such, it is suggested that although appearing contradictory, Lord Scarman's comments about the termination of rights were in fact limited to the context of consent to, or veto of, medical treatment. The other, plentiful rights and duties a parent possesses will endure even if this more limited right regarding treatment is terminated upon the child's satisfaction of the *Gillick* test. As such, both statements may be true, rather than being inherently contradictory as Gilmore suggested.[12]

The idea that parental rights can be limited once competence is attained is also evident in Lord Fraser's comments. He states that 'the degree of parental control actually exercised over a particular child [varies] considerably according to his understanding

[9] ibid 183-4.
[10] Stephen Gilmore, 'The Limits of Parental Responsibility' in Rebecca Probert, Stephen Gilmore and Jonathan Herring (eds), *Responsible Parents and Parental Responsibility* (Hart Publishing 2009) 64.
[11] ibid 25 and 75.
[12] ibid 75.

and intelligence' and, further, that to believe that a child remains within the parent's complete control until they reach majority is unrealistic.[13] Consequently, this hints that parental rights may continue to exist once the child attains competence but, as described by Bainham, in a 'qualified' form.[14] This qualification prevents interference with competently made decisions regarding treatment, but will not limit parental abilities to exercise control over the child within other fields. Similarly, Lord Scarman states that parental rights relating to the child only endure for as long as they are needed to protect the child.[15] Once competent, arguably that child is no longer in need of protection regarding treatment decisions. They have proven themselves intelligent enough to assess their own needs, hence dispelling the need for parental control and intervention. Again, this supports the conclusion that once competence has been attained, parental rights must yield in some way. As such, this thesis purports to show that on strict reading of Lord Scarman's judgment, parents should not retain the ability to override the decision of a *Gillick* competent minor. In other words, competence under *Gillick* should grant the child the capacity to decide regardless of parental wishes, providing there are no reasons to doubt the child's autonomy.[16]

On a similar note, it is important to clarify exactly what rights *Gillick* grants to minors. Once able to prove their competence, it has been commonly assumed that this confers upon the child the right to consent *and* refuse proposed medical treatment.[17] Although the case itself only involved issues of consent, to interpret the *Gillick* test as limited to

[13] *Gillick* (n 1) 171.
[14] Andrew Bainham, *Children, Parents and the Law* (Sweet and Maxwell 1988) 49.
[15] *Gillick* (n 1) 185.
[16] The potential difference between competence and true autonomy shall be explored within Chapter V.
[17] Joe Brierley and Victor Larcher, 'Adolescent autonomy revisited: clinicians need clearer guidance' (2016) 42(8) *Journal of Medical Ethics* 482, 483.

these facts would arguably be overly restrictive. This is especially poignant when the words of Lord Scarman are examined:

> 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. (emphasis added)[18]

Lord Scarman explicitly states that parents lose their right to decide whether their competent child will *or will not* have medical treatment. This suggests that the power to decide 'whether or not' to have treatment will transfer to the child upon their satisfaction of the *Gillick* test. As such, the powers conferred by *Gillick* encompass both a right to consent to and refuse medical treatment. This argument is supported within the academic community, with most agreeing that *Gillick* gave children a real choice in their treatment– any other conclusion would be illogical.[19] To allow a child with sufficient competence to agree with a medical practitioner, but prevent that same child disagreeing despite equivalent levels of intelligence and understanding of both circumstances would grant no real rights at all. As stated by Eekelaar, without choice, rights would be mere duties.[20] Consequently, it would be irrational to exclude refusal rights without more obvious exclusion of such a right being evident within the *Gillick* judgments. When coupled with the explicit words of Lord Scarman, any alternative conclusion limiting these rights would be strained. Nevertheless, once more, this assertion has been cast into doubt by subsequent case law, to be discussed in detail shortly.

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[18] *Gillick* (n 1) 188-9 (Lord Scarman).
[19] For example: JA Devereux, DPH Jones and DL Dickenson, 'Can children withhold consent to treatment?' (1993) 306 *British Medical Journal* 1459, 1460; Taylor (n 2) 83.
[20] John Eekelaar, 'The Importance of Thinking that Children have Rights' (1992) 6 *International Journal of Law & the Family* 221, 227.

Defining 'understanding'

The test for minor's competence is one of 'sufficient intelligence and understanding' relating to the procedure involved. However, what is meant by 'understanding'? This is a question addressed by both leading judgments within *Gillick*, yet with potentially contradictory conclusions.[21]

Lord Fraser's judgment deals with the issue in less detail, however appears to suggest that minors only need to demonstrate limited understanding to achieve competence. Striking some similarity with the standards set for adults, he suggests that the minor need only understand the basic issues involved with the procedure itself, rather than delving into deeper concepts such as consequence and social impact.[22] This standard would mean that, although allowing variation for standards of competence for differing procedures depending on their complexity, competence would be quite achievable for minors with intelligence and maturity. Nevertheless, despite showing support for his fellow Lord's judgment in general, Lord Scarman developed the concept of 'understanding' far beyond Lord Fraser's standards.

Lord Scarman took a more holistic view of the standards to be achieved. He suggests that, in the context of contraceptive treatment, issues such as the social and moral concerns which may arise as a result of pregnancy must be understood for the minor to have competence.[23] This is certainly a high threshold, and one that goes beyond what is required of adults.[24] Whereas Lord Fraser's standards seem fairly low, Lord Scarman requires much more of mature minors before granting competence. Despite its strong requirements, it is suggested that Lord Scarman's judgment is the better

[21] PN Parkinson, 'The *Gillick* Case– Just What Has it Decided?' [1986] *Family Law* 11, 11.
[22] *Gillick* (n 1) 170 (Lord Fraser).
[23] ibid 189 (Lord Scarman).
[24] David Archard, *Children: Rights and Childhood* (Third Edition, Routledge 2015) 119.

option for the *Gillick* test. Arguably because of his high threshold, minors who manage to overcome this and satisfy *Gillick* should be allotted more respect regarding their choices. In other words, the high threshold makes it easier to conclude that children with competence deserve an absolute right to capacity, and the right to 'make their own mistakes' as Eekelaar describes it.[25]

It is also arguable that the two judgments were not intended to be contradictory, as Lord Fraser's discussion of understanding is very much limited compared to that of Lord Scarman's. This is because Lord Fraser merely mentions that a minor must 'be capable of understanding what is proposed' in terms of treatment, without developing his meaning of 'procedure' nor the requirements meant by 'understanding'. [26] Conversely, Lord Scarman goes on to flesh out the concept of understanding to include the consequences and social impact of the decision. As such, it is possible that Lord Scarman's judgment was intended as the authority on the matter, or even as complimentary and supplementary to Lord Fraser's comments due to its more extensive exploration of understanding.

As shall be seen within Chapter III, Lord Scarman's higher standard appears to be the one embraced by the judiciary in later refusal cases. Nevertheless, this standard is once more cast into doubt due to judicial tendencies to expect exceptional levels of understanding from minors. As a result, some critique the *Gillick* test as being far too vaguely formulated.[27] *Gillick* is by no means a perfect test. After all, terms such as 'intelligence' and 'understanding' are undeniably open to a variety of interpretations.

[25] John Eekelaar, 'The Emergence of Children's Rights (1986) 6(2) *Oxford Journal of Legal Studies* 161, 181-2.
[26] *Gillick* (n 1) 169 (Lord Fraser).
[27] Emma Cave, 'Adolescent consent and confidentiality in the UK' (2009) 16(4) *European Journal of Health Law* 309, 316.

As a result, some feel that the test is too easily 'manipulated'.[28] As shall be seen within Chapter III, this argument appears to have rung true for mature and arguably competent minors seeking to assert their rights to refuse serious or life-saving medical treatment. The test has been used to require unattainably high standards of competence for minors, allowing paternalism to take precedence despite the intended and praised liberal nature of *Gillick.*

Nevertheless, this is not a reason to abandon the *Gillick* test altogether. Although some suggest that a more suitable option would be to revert to an age-based standard, preventing independent decision making on medical issues until the age of 16, this would cause troublesome rigidity in the law.[29] As highlighted by Lord Scarman in his own judgment, the law in this area is bound to be somewhat vague.[30] This vagueness allows for a precious amount of flexibility in the law, as decisions within the medical context can vary heavily depending on individual circumstance.[31] When competence is a concept so inherently connected with the idea of evolving capabilities, to resort to age-based standards would be an affront to the largely heralded progressive nature of *Gillick* in terms of children's rights to autonomy. As such, this thesis does not aim to criticise and offer alternatives to the *Gillick* test, but to assess its application and manipulation within refusal cases.

The Family Law Reform Act 1969: 16-17 year olds

Although not central to the theme of this thesis, as the focus shall be on the application of the *Gillick* test rather than statutory provisions, it is worth mentioning the role of the FLRA in relation to minors' medical consent law. Predating *Gillick,* this statute

[28] ibid.
[29] *Gillick* (n 1) 186.
[30] ibid.
[31] ibid.

marks another glimmer of progress for children's rights to self-determination, albeit in a more limited sense. Section 8(1) relates to the status of 16 and 17 year olds. It reads:

> The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, *shall be as effective as it would be if he were of full age*; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian. (emphasis added)

This section, therefore, recognises the same rights for mature, competent young adults to consent as those above the age of majority. It is largely accepted that the FLRA grants young adults a presumption of capacity, akin to the one applicable to adults under section 1(2) of the MCA. As such, their rights to consent to treatment are much more easily attained than under 16s who enjoy no such presumption. Nevertheless, this provision has been fairly consistently interpreted as applying solely to consent.[32] As such, even 16-17 year olds appear to hold lesser rights to refuse than their adult counterparts.

Nevertheless, the real legal issue comes with cases of refusal. If, as has been demonstrated in judicial discussion, the FLRA's full force is limited to consent alone then 16-17 year olds lose the protection of this Act when they seek to assert their rights to refuse treatment. In other words, 16-17 year olds still do not enjoy determinative control of their medical treatment if they are seeking to refuse. This places young adults at a distinct disadvantage to those over the age of 18, as once more they cannot be said to have the right to refuse without adult interference and approval.

[32] Lynn Hagger, *The Child as Vulnerable Patient: Protection and Empowerment* (Ashgate 2009) 27.

Another controversy which arises as a result of this provision is the relevant legal test to apply to assess competence to make decisions regarding medical treatment. It is not made obvious whether the correct test would be *Gillick*, upon which satisfaction grants the same rights to consent and refuse as adults have, or whether the adult test applies as a replacement for *Gillick* for minors over the age of 16.[33] Cave argues that the MCA test alone is too low a standard to provide adequate protection to minors, and as such any application of the MCA would have to be bolstered by common law protections.[34] However, Pattinson contests that the FLRA seeks to treat 16-17 year olds as if they were 'of full age', meaning that the relevant law would be the test applicable to adults, i.e. sections 2 and 3 of the MCA.[35] The MCA's inclusion of 16 and 17 year olds does favour the idea that the MCA test has applicability in some regard to young adults, nevertheless, the issue is yet to be definitively addressed and resolved. The issues regarding the agreeability of the MCA test in assessing *all* minors' competence with sufficient regard to autonomy shall be further explored within Chapter V. Truthfully, both approaches may not be as incompatible as was first though, as Pattinson has also advocated for the use of the inherent jurisdiction to fill gaps within the MCA's definitions of competence, which echoes Cave's suggestions for common law reinforcements on the adult test.[36]

The test to be applied when assessing the competence of over 16s is therefore uncertain, as even the case law paints a confusing picture of the relevant law. It has not yet been explicitly acknowledged which test the law will take as determinative in

[33] Note that the FLRA predates the MCA considerably, and the MCA does not mention its effects on the former Act, muddying the waters as to the more recent Act's impact on 16 and 17 year olds.
[34] Emma Cave, 'Goodbye *Gillick*? Identifying and resolving problems with the concept of child competence' (2014) 34(1) *Legal Studies* 103, 104.
[35] Shaun D Pattinson, *Medical Law and Ethics* (Fourth Edition, Sweet and Maxwell 2014) 161-2.
[36] Shaun D Pattinson, *Medical Law and Ethics* (Fifth Edition, Sweet and Maxwell 2017) 143 (forthcoming).

relation to a young adult refusing treatment. In a recent case, a 17-year-old's ability to refuse treatment was discussed in relation to both the common law *and* statutory tests for competence.[37] Despite arguably satisfying both tests, her autonomy to decide was still denied. As such, the 'correct' test may indeed be irrelevant, as satisfaction of neither can apparently lead to unquestioned capacity to decide. What is clear is that this is yet another circumstance where mature minors are left in the dark concerning their legal rights.

The 'retreat' cases: *Re R* and *Re W*

Despite the arguably liberal focus of the House of Lords in *Gillick*, and the agreement within the academic community that a competent child has a right to choose whether or not to undergo medical treatment, subsequent case law has evidenced what has been named the 'retreat from *Gillick*'.[38] This 'retreat' began with *Re R*, where the courts were faced with a 15 year old girl seeking to defy medical advice and refuse anti-psychotic drugs.[39] The court concluded that R was not competent to decide for herself, yet went on to advise generally on the status of competent minors seeking to refuse treatment. In doing so, Lord Donaldson attempted to add a gloss to *Gillick.* He professed that even in the case of a minor with undeniable competence, the court retained the ability to overrule a refusal of medical treatment.[40] He denied the implication of many academics and judges alike that *Gillick* competence granted the same weight to decisions to consent and refuse treatment. As a torrent of criticism poured over this judgment from the academic community, Lord Donaldson took the opportunity to alter his limitation on *Gillick* in a similar subsequent case.

[37] *An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam).
[38] Taylor (n 2).
[39] *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11.
[40] ibid 26.

Re W once more concerned a mature minor, this time 16 years of age.[41] She was refusing treatment relating to anorexia nervosa. Rather than revoke his paternalistic gloss on *Gillick*, Lord Donaldson and his fellow judges merely limited the circumstances in which a child who satisfies *Gillick* is denied a decisive voice over their own treatment. Here, it is stated that the court may override the decisions of a competent minor if that decision would have life-threatening, or permanently damaging consequences.[42] This not only confirmed a limitation of the rights granted to a minor who satisfies the *Gillick* test, but also extended this logic to young adults who attract the statutory protection of the FLRA due to the minor's age within this case.

Issues with reconciling these Court of Appeal cases with the House of Lord's decision in *Gillick* shall be explored. As a result, it shall be argued that these cases are questionable at best as binding legal authorities and even less convincing where Lord Donaldson's reasoning is concerned. This could mean that the application of the retreat cases within the lower courts has been in error.

Conflict with *Gillick*

This section shall attempt to demonstrate an innate lack of coherence between the *Re R* and *W* judgments and the judicially superior House of Lords decision in *Gillick*. Firstly, the legitimacy of Lord Donaldson's suggestions for concurrent powers to consent shall be examined critically, ultimately concluding there to be a lack of verification for this line of argument in the context of the *Gillick* judgment. Secondly, the general principles underlying both judgments shall be explored, and their inherent contradictions exposed. Finally, the subsequent section shall address the legal status

[41] *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64.
[42] ibid 88 (Balcolmbe LJ) and 82 (Lord Donaldson).

of Lord Donaldson's comments. Ultimately, it shall be concluded that these cases may have been falsely taken as binding authorities.

Lord Donaldson is insistent within both *Re R* and *Re W* that *Gillick* does not preclude the existence of 'concurrent powers' of consent in minors with competence and those with parental responsibility. He does so by utilising the words within Lord Scarman's judgment very narrowly indeed. Lord Scarman states that parental powers 'to determine whether or not' their child has treatment 'terminates' upon the attainment of *Gillick* competence.[43] At face value, most have interpreted this to mean that the child's rights take over the parental rights, allowing the child to be the 'sole controller' of their own body once they have competence.[44] Nevertheless, Lord Donaldson disagreed.

In an attempt to preserve paternalistic control over minors, he employs what can be seen as a form of linguistic manipulation to allow Lord Scarman's speech to support his own somewhat contradictory conclusion. Lord Donaldson states that *Gillick* competence only deprives parents of their right to *determine* their child's fate regarding medical treatment. He distinguishes this from a right to consent to treatment, a more limited right, through use of the 'keyholder' analogy.[45] He suggests that before a child attains competence, their parents hold the key to their consent to allow a doctor to perform treatment. Once competence is attained, the parents lose the *sole* right to determine their child's treatment, as the child gains their own key. As such, a parent loses the power to *veto* consent given by their child as a keyholder, whilst retaining their own power to consent in the face of a refusal by the child.[46] Lord Donaldson

[43] *Gillick* (n 1) 188-9.
[44] Lilian Edwards, 'The Right to Consent and the Right to Refuse; More Problems with Minors and Medical Consent' (1993) 1 *Juridical Review* 52, 60.
[45] *Re R* (n 39) 22-23.
[46] ibid.

preserved this idea of concurrent powers within *Re W,* altering his metaphor to that of a 'flak jacket' to prevent a child with competence 'lock[ing]' the door to treatment as well as 'unlock[ing]' it.[47] Nevertheless, *W* went even further, applying this logic to those who fall within the protection of the FLRA, meaning that even those over the age of 16 could not have complete control of their own bodies if refusing treatment.

Some feel that this conclusion is a legal possibility, in other words that Lord Donaldson's interpretation of Lord Scarman's judgment is a potentially legitimate one. Whilst not agreeing whole-heartedly with the decision in *Re W,* one such argument comes from Stephen Gilmore and Jonathan Herring. They argue that concurrent powers could be possible due to differing standards of competence for different 'types' of refusal.[48] They distinguish refusing consent to a certain treatment, which requires the same level of understanding as consent, and refusal of *all* treatment. For example, if a child is recommended to have a specific type of treatment to alleviate their condition, and understands entirely what that procedure entails as well as its consequences, then they would have the competence to consent or refuse consent. However, if that same child refuses not only the proposed treatment, but states that they wish to have no treatment at all, then despite having the ability to understand the issues regarding the *proposed* treatment, that child could still lack the competence to refuse *all* treatment if they did not understand the consequences of the latter decision.[49] In this scenario, if refusing *all* treatment without the competence to do so, the parents could provide the consent to the original treatment as the child would lack full competence. In some scenarios, the refusal of one treatment and the refusal of all

[47] *Re W* (n 41) 76 and 78.
[48] Stephen Gilmore and Jonathan Herring, 'Children's refusal of medical treatment: could *Re W* be distinguished?' (2011) 41 *Family Law* 715, 716-7.
[49] Stephen Gilmore and Jonathan Herring, '"No" is the hardest word: consent and children's autonomy' (2011) *Child and Family Law Quarterly* 3, 7.

treatments could be the same thing, as one treatment may be all which is possible to save the child.[50] The authors argue that whilst concurrent powers may exist where a child has the competence to merely refuse consent for specific treatments, as they could concurrently lack the competence to refusal all treatment,[51] once a child attains the higher standards required to refuse *all* treatment, alternative parental powers of override cease and the child becomes the arbiter of their own fate.[52]

Although their reasoning is commendable and logical, even Gilmore and Herring's limited support cannot justify the broadest reading of Lord Donaldson's judgment. Namely, that no limit to the extent of concurrent powers exists, no matter what level of competence the child can demonstrate. Lord Donaldson does not suggest any level of competence which could ever lead to absolute autonomy for minors, taking his judgment beyond the realms of justification using Herring and Gilmore's arguments. As expressed by Lilian Edwards, Lord Donaldson's interpretation is 'somewhat forced'.[53] *Gillick* evidently intended to grant mature minors control over their own medical treatment, and as discussed above Lord Scarman's language hints heavily at parental rights ceasing once competence is achieved as discussed above. Even Lord Donaldson himself admits his interpretation may be incorrect.[54] Although some have attempted to logically justify the potential for concurrent powers, Lord Donaldson's arguments are ultimately unconvincing.

A further argument employed by Lord Donaldson to justify his gloss to *Gillick* is that without the ability for parents or the court to give consent where a minor refuses

[50] ibid.
[51] ibid 8.
[52] ibid 15.
[53] Edwards (n 44) 58.
[54] *Re W* (n 41) 76.

treatment, doctors would be presented with an 'intolerable dilemma'.[55] But what is this 'dilemma'? According to Lord Donaldson, this is the threat of civil and criminal charges if he/she wrongly concludes a child's competence to decide.[56] Nevertheless, this argument is also unconvincing. This 'dilemma' was, at the time, equally applicable to the assessment of competence for those over the age of majority.[57] Doctors ran the same risk of committing a crime and a tort when deciding to override the decisions of potentially incompetent adults; nevertheless, this is a risk which the law regards as tolerable in light of competing interests relating to respect for autonomy. When placed into context, Lord Donaldson's logic was inherently flawed and consequently, the basis for his judgments in the retreat cases is further discredited.

Finally, and arguably most significantly, there is an inherent disconnect between the underlying rationales of the *Gillick* decision and the retreat cases. Whilst *Gillick* has been heralded as a progressive step for children's liberation and rights, *Re R* and *Re W* are undeniably paternalistic. Kennedy describes the restriction of competent children's rights as '[driving] a coach and horses through *Gillick*'.[58] In other words, the progress made for children's rights to self-determination in the recognition of their intelligence and maturity is retracted entirely by denying minors the ability to refuse medical treatment without the potential for paternalistic interference. Lord Donaldson introduced a 'radical departure' from *Gillick,*[59] in that he created asymmetry between the competence to consent to and refuse treatment. This has 'marginalised' the

[55] *Re R* (n 39) 24.
[56] ibid.
[57] Elizabeth Lawson, 'Are *Gillick* Rights Under Threat?' (1991) 80 *Childright* 17, 19; note the influence post-2005 of MCA, s5 which prevents liability where the doctor reasonably believed the patient had competence.
[58] Ian Kennedy, 'Consent to Treatment: The Capable Person' in Clare Dyer (ed), *Doctors, Patients and the Law* (Blackwell Scientific Publications 1992) 60.
[59] Anne Morris, '*Gillick*, 20 years on: arrested development or growing pains?' (2005) 21(3) *Professional Negligence* 158, 162.

protection of mature minors at law, with one right being supported over the other.[60] As discussed in the context of *Gillick*, the right to consent without a converse ability to refuse leaves no real choice at all. As such, the law in this area is now overwhelmed by 'virtually unbridled paternalism'.[61]

Additionally, a further contradiction with *Gillick* arises. *Gillick* denies reliance on anything but the child's intelligence and maturity within its legal test.[62] However, Lord Donaldson links the assessment of a child's competence with the consequences of their decision and their age through the allowance of paternalistic intervention in life or death scenarios. This is inherently incompatible with *Gillick*'s functional test. Basing the law on outcome and age means that competence has no real meaning within capacity law.[63] If a child can be overruled no matter their degree of competence at law, then this invalidates *Gillick* as a meaningful authority. If true, then *Re R* and *Re W* present 'a rare legal phenomenon indeed': the Court of Appeal effectively overruling a decision of the House of Lords.[64] Nevertheless, as has been demonstrated, Lord Donaldson's reasoning is far from water-tight. To have such cataclysmic consequences as to invalidate a superior and long-standing judicial authority, arguably the 'retreat' cases would require much stronger legal reasoning.

The *Re R* and *Re W* litigations have sent this area of law into disarray. As a result, providing legal advice for minors with any degree of accuracy is incredibly difficult.[65] Lord Donaldson's judgments mean that it is uncertain whether a minor could *ever* be

[60] Hagger (n 32) 29.
[61] Andrew Bainham, 'Liberal Paternalism in the Courts' (2006) 65(2) *Cambridge Law Journal* 285, 287.
[62] Michael Freeman, 'Rethinking *Gillick*' (2005) 13 *International Journal of Children's Rights* 201, 212; *Gillick* (n 1) 188 (Lord Scarman).
[63] ibid 211.
[64] Kennedy (n 58) 60.
[65] Jane Fortin, *Children's Rights and the Developing Law* (Second Edition, Lexis Nexis Butterworth 2003) 71.

intelligent enough to obtain full autonomous control. They are left in the dark regarding their rights to refuse medical treatment. As shall be argued in further chapters, these cases are not only puzzling in themselves, but the judiciary's approach to their application –or lack of– causes further concern for young people's rights.

Precedent or pretender? Issues with *Re R* and *Re W*

Re R and *Re W* have been taken as binding authorities in subsequent years.[66] Nevertheless, it shall be demonstrated that this conclusion is at the very least questionable. It is suggested that neither R nor W were unequivocally held to be competent by the Court of Appeal. As such, Lord Donaldson's comments limiting the force of *Gillick* competence for minors were merely obiter statements, technically holding no decisive weight for future courts. If true, this means that *Gillick* should remain the authority on this issue. Consequently, as stated previously, it is generally accepted that if a child satisfies the *Gillick* test they gain the right to consent or refuse treatment without interference. This would mean that the law in this area has been wrongly decided since the early 1990s, and the 'retreat from *Gillick*' can be reversed if a suitable case was to arise.

In terms of *Re R*, it is evident that the comments of Lord Donaldson regarding the override of decisions made with competence were obiter. The child was unequivocally stated to incapable of satisfying the *Gillick* test due to fluctuating mental capabilities as a result of her psychosis. As such, the real question comes with the subsequent case of *Re W*. Here, the result is less certain. W suffered from anorexia nervosa. Although Lord Donaldson shows some lenience towards Thorpe J's previous judgment,[67] he also speaks of W's condition in a manner which questions his commitment to

[66] For example, see *NHS v P* (n 37).
[67] *Re W* (n 41) 76.

supporting the previous court's conclusion on the child's competence. Lord Donaldson fails to make a definitive statement on the girl's competence, as do the other judges. As such, this issue is open to debate. Although some feel that W was seen as competent by the Court of Appeal in order to take comments within *Re R* on minor's rights to refuse beyond being obiter,[68] it is argued that the judgment's tone is much more inherently paternalistic. Although likely to be eager to fortify his previous dicta within *Re R*, Lord Donaldson appears unable to resist the paternalistic urge to deny acknowledgement of the minor's competence. He expresses doubts about Thorpe J's conclusion that W had 'sufficient understanding' to satisfy *Gillick* due to the nature of anorexia as an illness in his eyes being 'capable of destroying the ability to make an informed choice.'[69] Consequently, although agreeing with the previous court's conclusion that treatment could be ordered without the child's consent, his agreement on the issue of competence is less obvious. If W was, as is believed, seen to be incompetent, this once more leaves Lord Donaldson's comments regarding the court's ability to overrule a refusal made by a competent child as merely obiter dicta.[70] As a result, these cases could arguably present no real threat to *Gillick*, as the case was decided in the House of Lords, a higher court. Nevertheless, it would appear that the judiciary has not adopted this view within subsequent case law, applying *Re R* and *Re W* as binding precedent despite issues of inherent contention with *Gillick*. Consequently, the idea that the retreat cases could be easily deemed obiter and overruled is perhaps a little too simplistic. The judiciary appear have treated the ability of the courts and parents to override a decision made with competence as binding ratio

[68] Priscilla Alderson and Jonathan Montgomery, *Health Care Choices: Making Decisions with Children* (IPPR 1996) 36.
[69] *Re W* (n 41) 80-1.
[70] Edwards (n 44) 63.

for the past two decades.[71] As such, the idea that the judgment would be viewed otherwise now is highly unlikely.

Even if W was ultimately deemed competent, it is still arguable that this case was wrongly decided. It is very much possible that the case ignores a relevant area of law: mental health legislation. Rather than tokenistic mention of such law, with Donaldson stating that W '[p]robably' did not fall within the Mental Health Act 1983 (hereinafter MHA), arguably this avenue for intervention should have been more seriously considered. Lawson professes that W's case was in fact the perfect example of where the MHA should be invoked.[72] This Act allows for minors with mental health related illnesses to be treated without consent, even if they can be seen to have competence. Consequently, through use of the MHA Lord Donaldson could have acknowledged her competence, showing support for mature minors' rights and abilities, yet still he would not have left a vulnerable child alone to make life-threatening decisions. It is also seen that the MHA provides further safeguards specifically designed for those with mental health problems.[73] Nevertheless, counsel on both sides refused to present this argument to the court, rendering its formal discussion impossible. Even so, this exclusion shows how such ignorance of potentially relevant legal avenues could in fact hinder minors' protection. This is yet another way in which these authorities can, and should, be questioned.

It shall be demonstrated within subsequent chapters that, even if a valid authority, *Re W* should not continue to govern the future of children's rights to autonomy in the medical sphere. The current confusion left by Lord Donaldson's judgments is

[71] For example, see *NHS v P* (n 37).
[72] Lawson (n 57) 20.
[73] Carole Smith, 'Children's Rights: Judicial Ambivalence and Social Resistance' (1997) 11 *International Journal of Law, Policy and the Family* 103, 122.

unacceptable. Minors deserve some degree of legal certainty regarding the test which will determine their fate, and the standards to be achieved to attain control of their bodies. Currently, this lies in disarray.

Conclusions on the Current Law

This chapter has aimed to provide an overview of the current law governing minor's rights to control their own medical treatment. *Gillick* provided a step forward for children's rights and autonomy. The idea that *Gillick* only allows a right to consent, and not to refuse, has been discredited as irrational and ill-founded. Additionally, the threshold of 'intelligence and understanding' from Lord Scarman's judgment have been identified as the more generally applicable standards: high, but potentially attainable for suitably mature adolescents. Although vaguely formulated, the *Gillick* test allows for a precious level of flexibility required by this area of law. Medical procedures are so diverse and ever-changing that a rigid, inflexible standard of competence would be entirely unsuitable. Although this fluid nature leaves the test open to exploitation, evidenced within the *Re R* and *Re W* judgments, the flexibility of *Gillick* could be used to adapt medical law to keep up with a society increasingly embracing children's rights and autonomy more generally.

It has been argued that *Gillick*'s message of child liberation has been questionably tainted by *Re R* and *Re W*. It has been proven to be a distinct possibility that these cases are wrongly seen as binding precedent, which may erroneously displace the validity of a *Gillick* competent minor's decision. Not only are the most controversial aspects of these cases very arguably obiter in nature, the decisions contradict the rationale and judgements of a superior court in *Gillick*. Nevertheless, it appears that despite these issues, the courts are upholding *Re R* and *Re W* as binding authorities. As such, Chapter III will seek to examine and review the use, or lack of use, of the

principles set out by the retreat cases in subsequent refusal cases. It shall be argued that the judges are reluctant to employ these 'authorities', perhaps due to their dubious nature, and instead have distorted and moulded the *Gillick* test beyond recognition in order to maintain a less controversial paternalistic hold on mature minors.

Chapter III: Refusals and Paternalism: A Misuse of *Gillick*?

As addressed in the previous chapter, the law on adolescent refusal is far from clear cut. The weight granted to *Gillick* competence is uncertain when faced with minors who wish to make life-changing medical decisions.[1] To attempt to clarify the judiciary's stance in this regard, the case law on adolescent refusals of treatment shall be examined within this chapter. Although limited in scope, the case law shows a worrying trend. The courts tend to avoid the principles within *Re W*, however, this has not translated into empowerment for mature, intelligent minors who wish to refuse. Instead, the judiciary appear to have grasped at any chance to label the child incompetent, making their denial of the child's determinative capacity possible without use of Lord Donaldson's controversial judgment.[2] It shall be argued that the decisions in these cases have been poorly reasoned, with the *Gillick* test being applied in a tokenistic manner or even ignored.[3] Judicial avoidance of *Re W*'s direct application within refusal cases has resulted in confusion regarding minors' rights to refuse and the relevant tests for competence. The dubious tactics employed by the judiciary in such cases shall be evidenced through the case law.

Although some feel that the outcomes of these cases, and their aim in preserving life can be viewed as morally commendable regarding competent minors,[4] this thesis aims to challenge this view. The right to consent without a concurrent right to refuse leaves no real choice at all for children.[5] Although any form of clarity would be welcomed in this area, even if this means that minors have no ability to refuse treatment until they

[1] Richard Huxtable, '*Re M (Medical Treatment: Consent)*- Time to remove the 'flax jacket'?' (2000) 12(1) *Child and Family Law Quarterly* 83, 85.
[2] Lynn Hagger, *The Child as Vulnerable Patient: Protection and Empowerment* (Ashgate 2009) 30.
[3] For example, see *Re P (Medical Treatment: Best Interests)* [2003] EWHC 2327 (Fam).
[4] Jane Fortin, *Children's Rights and the Developing Law* (Second Edition, LexisNexis Butterworth 2003) 25.
[5] Huxtable (n 1) 84.

reach the age of majority,[6] it shall be concluded that the most appropriate way forward would be to respect the decisions of those who manage to attain *Gillick* competence. In other words, capacity to determine one's own medical treatment, whatever the consequence, should flow from the attainment of competence under the law.

Examining the Case Law: Competence and Convenience

Very few cases reach the courts regarding mature minors who are refusing life-saving medical treatment.[7] This is feasibly because most dissenting children change their minds and consent to treatment as a result of discussions with family and/or medical professionals, or perhaps due to eventual acquiescence regarding the refusal on behalf of the doctors. As an example of the latter scenario, Hannah Jones at 13 was allowed to refuse a heart transplant required due to her battle with leukaemia.[8] Following some debate with her doctors, her decision to refuse was accepted without judicial challenge. Although Hannah eventually changed her mind and chose to have the life-saving procedure, she was allowed to be the arbiter of her own fate without the involvement of the judiciary. Nevertheless, where such cases are brought to the courts, the outcome tends to be very different to that seen within Hannah's case. When serious cases are presented to the court and a child's life hangs in the balance, there has only been one outcome: the refusal of the child is overridden. Although the judiciary's desire for such an outcome is understandable, this chapter shall cast doubt on the authenticity of the courts' assessment of competence in such cases. Rather than accept a minor's competence and maturity by granting capacity, the judiciary have been evasive or

[6] ibid 88.
[7] Emma Cave, *Young People Who Refuse Life Sustaining Treatment* (Nuffield Foundation, University of Leeds 2011-2013) 3.
[8] Robert Verkaik, 'Girl, 13, wins right to refuse heart transplant' *The Independent* (London, 11 November 2008) <www.independent.co.uk/life-style/health-and-families/health-news/girl-13-wins-right-to-refuse-heart-transplant-1009569.html> accessed 30 January 2017.

manipulative regarding the application of the *Gillick* test where the child's potential competence could have interfered with their desire to override the refusal. Despite having the power to override even a competent minor's refusal, the judiciary have in all but one instance avoided the direct use of this controversial principle from *Re W*.[9] As such, the true motivations of the court shall be discussed, suggesting that the judiciary have struggled to overcome paternalistic impulses in refusal cases, leading to outcome-based decisions rather than meaningful employment of the legal test for competence.[10]

Re M: Ignoring the *Gillick* Test

Amongst the most controversial cases on the subject of adolescent refusal is *Re M*.[11] Here, somewhat similarly to Hannah's situation, a 15-year-old girl refused a heart transplant needed to save her life. The doctors involved sought a declaration to proceed with treatment without her consent. Despite the judge in question recognising M's intelligence and maturity when asked about the proposed treatment, her refusal was overridden.[12] Johnson J's decision was made, remarkably, without a single mention of *Gillick*. As such, there was no assessment of M's competence at all. Instead, Johnson J based his override of her decision on the suggestion that M had been 'overwhelmed' by the decision with which she was faced because, unlike Hannah who had been ill for a long period of time, M's health deteriorated suddenly and without warning.[13] Although a potentially valid reason to challenge M's competence had *Gillick* been used, Johnson J provides no further explanation or evidence for his decision and otherwise applauds M's intelligence and maturity.[14] Rather than relying on the legal

[9] *An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam).
[10] Michael Freeman, 'Rethinking *Gillick*' (2005) 13 *International Journal of Children's Rights* 201, 212.
[11] *Re M (Medical Treatment: Consent)* [1999] 2 FLR 1097.
[12] ibid 1100 (Johnson J).
[13] ibid 1100.
[14] ibid 1097.

test for competence and applying this to M, Johnson J chose to base his decision to deny determinative capacity to M based on speculative opinions about her state of mind.

Despite the judge's implications to the contrary, M could have potentially satisfied *Gillick* on the facts presented within the case. She justifies her decision to refuse the transplant with insightful reasoning. M states that although she understands that she would die without the transplant, and this was not something she wished for.[15] Nevertheless, she expressed that she did not wish to have a lifetime of drugs following the procedure. She also stated that she would rather have lived her 15 years with her own heart, than live with the heart of another.[16] Therefore, M can be seen to demonstrate an understanding not only of the procedure of the transplant, but also the aftercare in the form of drug therapy. Looking back to the *Gillick* test, its requires the minor to demonstrate 'sufficient intelligence and understanding' of the procedure proposed.[17] Even if interpreted so as to encompass a broad understanding of the consequences of the refusal, M could potentially satisfy this test. She understood that her death was an inevitable consequence of her refusal. In fact, some, such as Michael Freeman, feel that M was certainly competent in the *Gillick* sense.[18]

Nonetheless, this is not a foregone conclusion. Johnson J could have reached the same decision –to override her refusal– whilst still employing the relevant legal test for competence. As mentioned above, M had been suddenly stricken with a very serious illness, differentiating her from an experienced patient such as Hannah Jones.[19] As

[15] ibid 1100.
[16] ibid.
[17] *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112, 113-114.
[18] Freeman (n 10) 210.
[19] Sheila AM McLean, 'Whose Decision is it Anyway?' *The BMJ.com* (14 November 2008) <http://blogs.bmj.com/bmj/2008/11/14/sheila-mclean-whose-decision-is-it-anyway/> accessed 21 June 2017.

such, Johnson J's assertion that she may have been overwhelmed and rendered unable to make a competent decision despite her intelligence is feasible. Nevertheless, due to Johnson J's lack of assessment of M's competence and abilities, discussion M's potential to satisfy *Gillick* is restricted to mere speculation. Consequently, the obfuscation of the law and ignorance of *Gillick* can be seen to be an even more questionable step taken by a court desperate to find reason for intervention.

The reasoning within M's case shows a reluctance within the judiciary to engage with minors' competence. This thesis aims to suggest that this avoidance is linked to a reluctance to directly apply the more controversial aspects of Lord Donaldson's judgment in *Re W*. Namely, this would be the override of a competent, mature minor seeking to refuse treatment rather than overriding an incompetent minor. Rather than having to confront the potential of M's competence and *then* overrule her refusal, the judge chose to ignore the legal test entirely. This is because the override of a competently made decision is a much more controversial way to overrule a minor's refusal, as it interferes far more significantly with the autonomy rights of competent individuals.[20] It is suggested that the court in this case chose to ignore *Gillick* so as to allow for a more convenient, meaning less controversial, override of the child's autonomy.

Ignoring *Gillick* in refusal cases such as M's does the law no favours. Although the judiciary may be attempting to save a minor's life, without doubt an admirable objective, this does more harm than good for legal certainty. This case further confuses the rights of minors to refuse treatment, and the relevant tests which apply when they seek to do so. *Re M* appears to show that *Gillick* is no longer a factor which needs to

[20] McFarlane J, 'Mental capacity: one standard for all ages' [2011] *Family Law* 479, 483.

be considered where a minor's refusal is concerned. After all, following the retreat cases, *Gillick* competence is no longer a determinative factor when it comes to granting capacity for minors. Nevertheless, *Re W* itself still holds competence as a relevant issue to consider when determining whether the court or a parent should be allowed to override a minor's choice to refuse treatment. As such, the relevance of *Gillick* is entirely confounded due to the judiciary's apparent desperation to avoid engaging with minors' competence. This confusion is further exasperated when further retreat cases which *do* in fact cite and focus upon the child's ability to satisfy *Gillick* are considered. In fact, further manipulation and confusion arises from such cases due to their application and interpretation of the requirements for competence.

Re E and *Re L*: Manipulating *Gillick*

As opposed to ignoring *Gillick* in its entirety, as seen in *Re M*, some refusal cases do in fact utilise the test. However, it shall be shown that judicial manipulation of this flexible common law test has occurred within refusal cases involving mature, intelligent minors in order to favour the court's intervention through findings of incompetence. Once more, the case law exhibits evidence of judicial avoidance of the controversial power to override competent minors through misuse of the *Gillick* test.

The manipulation of *Gillick*'s requirements can most poignantly be seen in *Re E*[21] and *Re L*.[22] Both cases involved mature minors, E a 15-year-old male and L a 14-year-old female, who sought to refuse life-saving blood transfusions as a result of their Jehovah's Witness faith. Both were fervently committed to their religion, L, for example, had taken out a 'no blood' card two years prior to the incident which left her in need of an urgent blood transfusion.[23] Despite both minors expressing their

[21] *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.
[22] *Re L (Medical Treatment: Gillick Competence)* [1998] 2 FLR 810.
[23] ibid 811 (Sir Stephen Brown).

absolute commitment to refusing blood and the judges agreeing that both demonstrated a mature, intelligent understanding of the fatal consequences of their decision, they were deemed *Gillick* incompetent. Nevertheless, despite taking consideration of the *Gillick* test within each judgment, it is suggested that the decisions in these cases were never truly based upon competence. Instead, this thesis shall aim to show that in cases where a child attempts to refuse life-saving treatment, it is the fatal outcome of refusal which is the focus of the court. The judiciary show favour in findings of incompetence, which justify their paternalistic intervention regarding refusals more readily than cases involving competent minors as discussed within the context of *Re M*. This outcome-based approach has led to the manipulation of the *Gillick* test and legal requirements for competence, fostering confusion within this area of law.

The judges rejected the idea that E and L had *Gillick* competence based upon the minors' lack of understanding of the *nature* of their deaths should they refuse the transfusions. [24] Although this appears to fall within *Gillick*'s requirements of 'sufficient understanding', there is more to this conclusion than meets the eye. In fact, E and L had never been provided with the information surrounding the nature of their deaths. It was thought too grisly and sombre a topic to be forced to discuss with the minors.[25] As such, they had no chance to achieve competence at all. In essence, the judiciary had pre-determined E and L's status as incompetent minors due to their failure to properly investigate why information so crucial to the determination of competence was withheld. Their competence was assessed before they had all the

[24] ibid 813; *Re E* (n 21) 391.
[25] ibid.

requisite information required to make a valid decision at law.[26] This choice shall be questioned.

It shall be suggested that the judiciary have in these circumstances manipulated not only the requirements of understanding under *Gillick*, but have conflated two of the requirements for a legally valid consent or refusal regarding treatment. Firstly, the outcome in both cases appears to have been based on a lack of communication with the patient, rather than the child's competence.[27] Nevertheless, this lack of information should not have been an issue for competence at all. This is because competence relates to the child's *ability* to understand relevant factors and consequences involved with their decision, not their *actual* understanding.[28] As such, the courts should have focused on the minors' intelligence and maturity regarding the levels of understanding that would be required in order to make the decision at hand. In this sense, denying the minors in these cases competence based on their lack of access to specific information regarding the decision suggests that the judges were requiring the minors to show *actual* understanding, misinterpreting –perhaps intentionally– the meaning of competence.[29]

Additionally, the denial of competence in *Re E* and *Re L* was based on their lack of understanding of the *nature* of their deaths, which sets the bar for competence at an incredibly high standard. Already, *Gillick* goes beyond the levels of understanding required by adults. The adult test requires only a demonstration of the ability to

[26] Emma Cave, 'Maximisation of Minors' Capacity' (2011) 23(4) *Child and Family Law Quarterly* 431, 434.
[27] Andrew Grubb, 'Refusal of Treatment (Child): Competence' (1999) 7(1) *Medical Law Review* 58, 60.
[28] Emma Cave, 'Goodbye *Gillick*? Identifying and resolving problems with the concept of child competence' (2014) 34(1) *Legal Studies* 103, 106.
[29] Andrew Bainham, 'The Judge and the Competent Minor' (1992) 108 *Law Quarterly Review* 194, 200.

understand the procedure in question.[30] In fact, case law has shown that the threshold is at times rather low. For example, regarding consent to and refusal of contraception, an adult need only understand the immediate consequences of not using contraceptives, rather than the long-term consequences such as childbirth and motherhood.[31] Adults also enjoy a presumption of capacity, further lowering the burden on those seeking to make their own medical decisions.[32] Conversely, minors must understand issues such as the social and familial consequences of pregnancy in order to be considered competent and have a chance at the determinative capacity which is the general default position for adults.[33]

Yet, even with this higher standard of competence, the judges in *Re E* and *Re L* went even further. By requiring that the children involved understand not only that they would die as a result of their refusal, but the specific details of the nature of that death, it is argued that this goes far beyond any realistically attainable standard for minors. In fact, Hagger and Bainham have expressed the opinion that most adults would struggle to satisfy such competency standards.[34] As such, the high benchmark for understanding applied to E and L can once more be seen as an effort by the judges to ensure the outcome they desired, namely the conclusion that the child lacked competence and could thus be easily overridden in their refusal of life-saving treatment. These cases evidence a manipulation of the flexibility within the *Gillick* test to the court's paternalistic advantage, acting as a barrier to competence and subsequent capacity for mature minors.[35]

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[30] Mental Capacity Act 2005, s3.
[31] *Re A (Capacity: Refusal of Contraception)* [2010] EWHC 1549 (Fam).
[32] Mental Capacity Act 2005, s1(2).
[33] *Gillick* (n 17) 189 (Lord Scarman).
[34] Hagger, *Vulnerable Patient* (n 2) 31; Bainham (n 29) 200.
[35] Emma Cave, 'Adolescent consent and confidentiality in the UK' (2009) 16(4) *European Journal of Health Law* 309, 316.

The requirement of actual understanding, and the high standards required under the guise of the *Gillick* test played perfectly to the judiciary's favour in these cases. They wished to permit treatment for the children due to the fatal consequences of allowing the minors determinative capacity. In fact, this is a trend more generally within refusal cases where a life is at stake, shown perfectly within Ward J's judgment in *Re E*, where her states that the court should be 'very slow to allow an infant to martyr himself'.[36] Although the sentiment is understandable, the undertone of the judgment is very much protective, rather than suggestive of empowerment. Ward J even uses the term 'infant', despite the case relating to a child of 15. This implies, once more, that the judiciary are inherently predisposed to view children as in need of protection, incapable of making important decisions such as the refusal of medical treatment without adult supervision and guidance. It is suggested that the manipulation of the requirements for understanding was a tactic employed within these cases in order to allow for the simpler, less controversial override of the minors' wishes.[37] As mentioned before, judges have attempted, where possible, to avoid directly applying the override power allotted within *Re W* to competent minors. Instead, this thesis aims to demonstrate evidence within refusal cases of dubious judicial tactics seeking to allow at times questionable findings of incompetence, in turn avoiding the difficult judicial decision to overrule a competent, mature minor through use of a contested and controversial legal authority.

The judiciary not only appear to have applied a standard far higher than that implied within *Gillick*, but in requiring actual understanding from the children involved the judiciary's manipulation of the law may have created legal issues which stretch

[36] *Re E* (n 21) 394.
[37] Hagger, *Vulnerable Patient* (n 2) 30.

beyond the *Gillick* test. It shall be argued that the judges in these cases conflate the formal requirements of a legally valid consent or refusal regarding proposed treatment. A legally valid decision requires three things: capacity on the behalf of the individual, sufficient information for the decision to be based upon and, finally, for the decision to be a voluntary one for the patient.[38] These cases evidence a conflation of the former two categories, namely capacity and sufficient information. If a minor is seen to have competence, then they would be able to understand all relevant information regardless of whether or not they have actually been presented with such information. In other words, a lack of information should never deny a minor competence, as competence does not require actual understanding. Once proved competent, the patient should be granted all the information required in order for him/her to properly exercise that competence. As such, if the minors *could* have understood the information relating to the nature of their deaths, the judges should have ordered that information be presented to them, the outcome being that the minors should have been granted the capacity to decide their fate without judicial intervention. Therefore, the denial of competence based on a lack of information can be seen as a conflation of the requirements of mental competence and the requirement of sufficient information. This is yet another way in which the judiciary's intervention in potentially competent minors' decisions has led to a lack of clarity within the law. The court's focus on the fatal outcome should they not intervene has led to the conflation, manipulation, and confusion not only of the requirements of *Gillick*, but of the overarching requirements of a legally valid decision regarding medical treatment more broadly.

[38] Shaun D Pattinson, *Medical Law and Ethics* (Fourth Edition, Sweet and Maxwell 2014) 105; Jonathan Herring, *Medical Law and Ethics* (Oxford University Press 2006) 88-89.

The above discussion of the *Re E* and *Re L* litigations supports this thesis' suspicion that the judiciary appear to be driven by the outcome of the decision –that the child would die without intervention– rather than basing their decision on an assessment of the child's competence. As such, the *Gillick* test, heralded as a success for children's rights and autonomy, can be seen to be manipulated within *Re E* and *Re L* in order to allow for an easier override of the potentially competent minors' refusals.[39] This approach could push the court's paternalistic protection beyond those who genuinely require it. If truly competent, a minor should not be dealt with paternalistically, but should instead be empowered to take control of their own decisions. As shown above, *Gillick* sets a higher standard than that required by adults. Hence, surely such intelligent and mature minors should be recognised as having real, meaningful rights when it comes to their own medical treatment. Nevertheless, it has been shown that the judiciary are willing to go to extreme lengths, ignoring and indeed manipulating the current law in order to avoid this conclusion.

It can be seen from the above case analysis that the *Gillick* test is applied in a rather inconsistent manner within refusal cases. The courts have tended to avoid direct application of the *Re R* and *Re W* principles, preferring to find 'convenient' and at times 'artificial' findings of incompetence to justify ignorance of the child's often intelligent and justifiable views.[40] The courts seem to base their decisions on the patient's status as a minor, rather than their intellectual abilities and competence, a premise which can be questioned as a justified reason to steadfastly overrule autonomous medical decisions. This chapter shall go on to question the focus of the

[39] Margaret Brazier and Caroline Bridge, 'Coercion or Caring: Analysing adolescent autonomy' (1996) 16 *Legal Studies* 84, 109; Anne Morris, '*Gillick*, 20 years on: arrested development or growing pains?' (2005) 21(3) *Professional Negligence* 158, 158.
[40] Huxtable (n 1) 86-87.

judiciary on the age of majority as a gateway to competent thinking, as well as the questionable application of *Gillick* in an area of law where competence appears to have no impact. If a child can never competently refuse treatment, it shall be argued that to continue to assess competence is to obfuscate minor's rights and lead to uncertainty in the law. Ultimately, minors need clarity regarding their legal rights.

Unsustainable Legal Fallacies: Arguments for Change

As has been demonstrated by a close examination of the case law, the courts have repeatedly avoided the hard questions presented by the *Re W* dicta. Whilst the underlying motive of protecting children from harm, suffering and death is understandable, the avoidant tactics and dubious reasoning used by the judiciary are less defensible.[41] Not only does the reasoning take advantage of the *Gillick* test, twisting its requirements to match the court's desired outcome, it leaves the rights of minors to refuse entirely unclear. Legal clarity and lack of arbitrariness within the law are central principles of the rule of law, which ought to guide the common law and the judiciary.[42] Currently, as explored above, it would appear that the judiciary are ruling under their own moral discretion, rather than using the *Gillick* test and other authorities available to them, leading to decisions of an arbitrary nature. This, according to Bingham, is the 'antithesis of the rule of law'.[43] If the truth is that a minor, regardless of their intelligence and maturity, can never legally refuse treatment it is questionable why the courts continue to assess competence at all. As analysis of the case law suggests, competency assessments, when employed at all, appears to have no weight on the outcome of judicial decisions in this area. Consideration of the need for legal clarity under the rule of law seems to have been neglected within this area. Instead,

[41] Lynn Hagger, 'Some implications of the Human Rights Act 1998 for the medical treatment of children' (2003) 6 *Medical Law International* 25, 25.
[42] Tom Bingham, *The Rule of Law* (Penguin Books 2011) 48.
[43] ibid.

the judiciary appear driven by the need to protect children from decisions they see as unwise and unfavourable, causing confusion regarding the rights of mature minors.

The lack of consideration of competence can once more be seen in *Re P*.[44] Here, a Jehovah's Witness very close to turning 17 sought to refuse blood transfusions which would potentially be needed to treat a pre-existing medical condition should his condition deteriorate.[45] Despite acknowledging that P's beliefs were 'established' and committed, Johnson J thought the treatment was in his best interests, and granted a declaration overriding his refusal.[46] This conclusion was reached, as with M's case, without any reference to *Gillick*.[47] There was also no mention of the FLRA, nor his rights under the European Convention on Human Rights (hereinafter ECHR).[48] In a very short judgement, Johnson states that despite being 'reluctant' to do so, he feels the treatment would best suit P's interests due to the judiciary's duty to 'preserve' minors until they reach the age of majority.[49] For P, the lack of engagement with the relevant legal tests for competence meant that his intellect and maturity had no impact on his right to self-determination. P could not have known what was required of him to have his decision respected, as the only legal tests available to him, *Gillick* and the MCA test via section 8 FLRA, were ignored entirely. As such, the refusal cases show a lack of respect for legal clarity in relation to children's rights and the rule of law, as minors cannot be sure of the prerequisites for, or even the existence of, their right to refuse treatment. Instead of using the available legal tests, Johnson J uses the child's age as a justification for his paternalistic conclusion. This case provides further

[44] *Re P* (n 3).
[45] ibid.
[46] ibid [10] and [12] (Mr Justice Johnson).
[47] ibid [12].
[48] ECHR rights are relevant due to the application of the Human Rights Act 1998.
[49] *Re P* (n 3) [9].

evidence for the assertion that the patient's status as a minor, rather than his or her competence, is the decisive factor for the courts.

The focus on a perceived judicial duty to 'preserve' minors until they reach 18 as a reason to deny competence and determinative capacity flies in the face of the *Gillick* test. There is no requirement that age should play a factor in achieving competence and as such, Johnson J's reasoning goes even further than purely ignoring *Gillick.* It entirely contradicts the test by basing the decision on the outcome –that a child would die as a result of the refusal– and age-based status rather than focusing on the competence of that child.[50] This focus on age over ability has the potential to egregiously harm principles of autonomy, harm which can be demonstrated through the fate of the minor from the aforementioned *Re E*. Despite having lost the right to competently refuse blood transfusions at 15, it was later revealed that E had consistently refused further treatment until he finally reached the age of 18. As he had reached the age of majority, his competent decision was then accepted and he died shortly afterwards.[51] Despite the judiciary using the age of majority as a hallmark of autonomous decision making and freedom within cases such as *Re P*, it is argued that E's case demonstrates the fallacies involved with basing competence and capacity upon this milestone birthday. Through his consistent and fervent refusal of blood products, it can be seen that E's religious convictions and opinions towards his forced treatment had not changed in the years which followed his court case. Additionally, it would be ludicrous to say that E's competence was extraordinarily improved upon the morning of his 18th birthday.[52] The focus on 'preserving' children until they reach the

[50] Freeman (n 10) 212.
[51] *Re P* (n 3), [8] (Mr Justice Johnson).
[52] Sara Fovargue and Suzanne Ost, 'Does the theoretical framework change the legal end result for mature minors refusing medical treatment or creating self-generated pornography?' (2013) 13(1) *Medical Law International* 6, 16.

age of majority can therefore be viewed as an unnecessarily protective judicial stance. Competence was not at the forefront of Johnson J's mind in *Re P,* the case's potential outcome –P's death– was. It is argued that more weight ought to be granted to the concept of evolving capabilities, meaning that strict, chronological age is not a sufficient indicator of experience and intellect, a concept which is inherent in the *Gillick* test itself.[53] Once a child has demonstrated the high levels of understanding required by *Gillick*, it would be unnecessarily paternalistic and condescending to deem such highly intelligent children as vulnerable and in need of judicial protection.[54]

It appears that the judiciary tend to view minors, no matter how intelligent or mature, as inherently helpless and in need of protection.[55] As such, it is argued that competence currently holds no real weight regarding minors' refusals, and rather these cases have become purely outcome-based.[56] It is time to challenge the legal fallacy of the 'magic [18th] birthday' and acknowledge that some children can demonstrate sufficient intelligence and deserve decision-making capacity before this age.[57] To say that a competent child is vulnerable is an incoherent statement, as they must demonstrate high levels of intellect to attain this lucrative status.[58] Additionally, to avoid this controversial area of law and falsely label intelligent children as incompetent, or even mentally impaired, is to discredit and demean minors in a way which strikes at their dignity and self-worth.[59]

[53] Gerison Lansdown, *The Evolving Capacities of the Child* (UNICEF 2005) 50.
[54] David Archard, *Children: Rights and Childhood* (Third Edition, Routledge 2015) 243.
[55] ibid.
[56] Freeman (n 10) 211.
[57] Priscilla Alderson, *Children's Consent to Surgery* (Open University Press, 1993) 44.
[58] Pip Trowse, 'Refusal of Medical Treatment- A Child's Prerogative?' (2010) 10 *Queensland University of Technology Law and Justice Journal* 191, 211.
[59] Charlotte McCafferty, 'Won't Consent? Can't Consent! Refusal of Medical Treatment' (1999) *Family Law* 335, 336.

Overruling Competent Minors: Case Closed?

It is evident that the law is in need of clarification. The courts continue to assert the fact that even competent children can be overruled when it comes to the refusal of life-saving treatment. Although this chapter has so far focused on cases where dubious tactics have allowed for questionable findings of incompetence, this is not always possible when confronted with an unquestionably competent child. In *NHS v P*, such a case arose.[60]

The court assessed the competence of a 17-year-old girl who required ongoing treatment for a drug overdose in case she subsequently refused.[61] Although the minor was deemed to satisfy the adult test under the MCA,[62] the judge stated that a declaration in favour of the hospital proceeding with treatment was possible through Lord Donaldson's judgment within *Re W*.[63] Unfortunately, this case appears to reinforce *Re W* as precedent on the right to refuse–or lack of–for minors, potentially marking the end of the road for minors' autonomy within this area.

Nevertheless, this need not be the case. *NHS v P* was only decided within the High Court, meaning that challenge of the Court of Appeal's decision in a lower court was not possible, or would at least have been highly unorthodox. Additionally, the minor was not actively refusing at the time of the court's decision,[64] therefore this case does not parallel with the immediately apparent contention faced within the other refusal cases discussed within this chapter. Hence, despite the reaffirmation of *Re W* within this case, the lack of attention towards this issue from higher courts means that *NHS v P* by no means marks the end of the road for this area of law and cannot be seen as

[60] *NHS v P* (n 9).
[61] ibid [6] (Baker J).
[62] The MCA test was applicable through section 8 FLRA, as P was17 years old.
[63] *NHS v P* (n 9).
[64] ibid [6] (Baker J).

clarifying the legal position of minors beyond doubt. These arguments shall be further developed within Chapter IV. Ultimately, this case does not dispel the argument that the current approach of the judiciary to *Gillick* competence and the retreat cases remains entirely inconsistent.[65] The need for clarity has never been more apparent.

A Need for Clarity

As has been demonstrated within this chapter, the case law paints an inconsistent picture when it comes to the assessment of *Gillick* competence and the application of the *Re W* principles. Generally, the courts have shied away direct engagement with *Re W*, preferring to find –at times dubious– reasons to brand the minor involved as incompetent in order to allow treatment to be carried out. As such, minors' rights to capacity once they have proven competence when seeking to refuse medical treatment have been incoherently communicated within case law. It shall be argued that this must change to ensure that minors can be certain of their rights.

One possible resolution to this problem would be to unequivocally deny the right to refusal for even competent minors.[66] This would allow for the judiciary to follow their paternalistic motives without using and abusing the *Gillick* competence test as a shroud for outcome-based analysis.[67] This is an approach has been supported by some academics, as it allows for the protection of young people and prevents them from making mistakes which could impact their future.[68] Although this appears to be the stance which the courts may take considering the recent decision in *NHS v P*, it is

[65] ibid 88.
[66] ibid.
[67] Brazier and Bridge (n 39) 109.
[68] For example, see Jane Fortin, 'Children's rights- flattering to deceive?' (2014) 26(1) *Child and Family Law Quarterly* 51, 60 and Laine Friedman Ross, 'Arguments Against Health Care Autonomy for Minors' (1995) *Bioethics Forum* 22, 24-25.

argued that this conclusion should be avoided, instead advocating for the empowerment of competent minors.

This thesis aims to challenge the appropriateness of denying competent minors the right to refuse treatment. Rather than labelling children as inherently vulnerable individuals who require protection, it would be more progressive for the courts to allow them the right to refuse treatment, no matter the consequence, once they have proven that they have competence. It has been argued already that the right to consent means nothing without a concurrent right of refusal.[69] To allow a patient to accept treatment, but not reject it, flies in the face of what is required by principles of autonomy.[70] This is a view supported by Harris, who sees the asymmetry between respect for competent consents and refusals as 'palpable nonsense'.[71] As such, the idea that the inconsistency in this area could be cured by the complete removal of a right to refuse medical treatment causes yet more controversy and inconsistency. To remove refusal as an option would leave children with no choice at all, leaving them as passive agents until they reach the age of majority. This would not be suitable considering pro-patient advances regarding autonomy and human rights, as will be discussed in more depth within Chapter IV.

It is unfair to continue to treat *Gillick* as a 'lesser' form of competence,[72] especially when the high standards required by *Gillick* are considered. Whereas adults enjoy the right to consent or to refuse if competent to decide, as well as a presumption of this competence, minors must prove their competence to a higher standard, yet even then

[69] Huxtable (n 1) 84.
[70] Rachel Taylor, 'Reversing the retreat from *Gillick*? *R (Axon) v Secretary of State for Health*' [2007] *Child and Family Law Quarterly* 81, 83.
[71] John Harris, 'Consent and End of Life Decisions' (2003) 29 *Journal of Medical Ethics* 10, 12.
[72] Trowse (n 58) 211.

are not guaranteed the capacity to decide.[73] Due to the high bar set by *Gillick*, minors who seek to refuse treatment would not easily be deemed competent nor their decisions accepted on a whim. As such, concerns over the need to protect children from the harm which can come from refusals can be somewhat quelled under the reassurance that only the most intelligent and mature children could hope to satisfy *Gillick*'s requirements. When coupled with the incoherence of allowing what can be seen as a half-right to children, it is argued that the only logical outcome would be to respect the decisions of competent children. Competence should generally lead to the capacity to decide, no matter what decision the child chooses to make.

Although the correct path for this area of law is a topic likely to always split academic opinion, what is certain is that we need an authoritative decision from the judiciary. Ideally, a suitable case to truly test the judiciary regarding their competing commitments to paternalism and patient autonomy would arise in the near future.[74] Such a case could become the ultimate arbiter for children's rights regarding medical consent law. Without a case being heard at the Court of Appeal or Supreme Court, the judiciary will remain bound by the questionable authorities of *Re R* and *Re W.*[75] Following chapter will aim to further examine the inconsistencies surrounding respect for autonomy in medical consent law between adults and minors through an exploration of human rights law. The outcome will show that the controversial and paternalistic principles within *Re R* and *Re W* are in need of urgent reconsideration. The best way forward would be to respect mature, intelligent minors who can

[73] McFarlane J (n 20) 484; Pattinson (n 38) 163.
[74] Cave, *Young People* (n 7) 3.
[75] Gillian Douglas, 'Medical Treatment' [2014] *Family Law* 1249, 1250; Gillian Douglas, 'Medical Treatment' [1999] *Family Law* 753, 753.

demonstrate competence and to allow them to make their own decisions, even if the judiciary see them as mistakes.[76]

[76] John Eekelaar, 'The Emergence of Children's Rights (1986) 6(2) *Oxford Journal of Legal Studies* 161, 182.

Chapter IV: The Future for Child Autonomy

In comparison to adults, children have a much higher hurdle to overcome to exercise autonomy regarding their own medical treatment. Not only do they have to prove their mental competence, but the *Gillick* test has been shown to require a far deeper notion of understanding regarding the medical procedure involved than under the MCA.[1] Despite this, judges have still shown reluctance to grant competence and subsequent capacity to intelligent and mature minors seeking to refuse medical treatment.[2] Although the *Re R* and *Re W* cases legally permit the override of a competent minor's refusal of treatment,[3] it has nevertheless been demonstrated that the judiciary has developed a dubious tendency to label intelligent minors as incompetent based on tokenistic, or even non-existent, examinations of competence.[4] Consequently, minors' abilities are being undermined by this lack of engagement with their competence, as well as limiting their legal rights to autonomy.

This chapter will aim to question the continuation of this judicial approach. This thesis shall suggest that Lord Donaldson's judgments in the retreat cases are now legally questionable based not only on the issues explore within Chapter II, but on broader progress in recent years in terms of human rights and autonomy. It will demonstrate that the current lacuna in progress for children's rights in this area of law is no longer appropriate, and that the legal principles affecting mature minors' autonomy rights require modernisation. Respect for human rights and autonomy has progressed rapidly

[1] David Archard, *Children: Rights and Childhood* (Third Edition, Routledge 2015) 119; *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112.
[2] For example, *Re M (A Child) (Refusal of Medical Treatment)* [1999] 2 FLR 1097.
[3] *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11; *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64.
[4] *Re P (Medical Treatment: Best Interests)* [2003] EWHC 2327 (Fam).

in the two decades since the conclusion of the retreat cases.[5] Evidence to support this shift shall be drawn from legislative and common law developments, as well as international influences such as the European Convention on Human Rights and the United Nations Convention on the Rights of the Child. These sources suggest a general legal retreat away from overriding paternalism in favour of priority for individual autonomy.[6] This chapter shall conclude by suggesting that it is time that we stop underestimating and demeaning children with preconceived notions of incompetence and vulnerability. Instead, we should be embracing their status as rights holders and individuals capable of making their own decisions, even if adults view them as mistakes, upon satisfaction of the *Gillick* test.[7]

The Increased Prominence of Human Rights and the Road to Autonomy Since *Re R*

A lot has changed since the early 1990s. The United Kingdom has experienced a change in the foundation of the law, placing human rights firmly at the centre of judicial consideration.[8] *Re R* and *Re W* were decided in the infant years of the UK's ratification of the UNCRC and preceded the domestic incorporation of the ECHR through the HRA. It is argued that these documents have altered the legal landscape so fundamentally that the pre-HRA authorities on the refusal of medical treatment by minors are in need of urgent reassessment.[9]

[5] Emma Cave, 'Maximisation of Minors' Capacity' (2011) 23(4) *Child and Family Law Quarterly* 431, 440.
[6] Lynn Hagger, *The Child as Vulnerable Patient: Protection and Empowerment* (Ashgate 2009) 15.
[7] John Eekelaar, 'The Emergence of Children's Rights (1986) 6(2) *Oxford Journal of Legal Studies* 161, 182.
[8] Jane Fortin, 'Rights brought home for children' (1999) 62 *Modern Law Review* 350, 351.
[9] Emma Cave, *Young People Who Refuse Life Sustaining Treatment* (Nuffield Foundation, University of Leeds 2011-2013) 3.

The UN Convention of the Rights of the Child

The *Re R* and *W* litigations were heard very shortly after the ratification of the UNCRC by the United Kingdom.[10] As such, the Convention's impact on domestic law had not yet been realised. It shall be argued that the UNCRC's inclusion of not only protective rights, but participatory rights for children can provide grounds upon which to question the principles within *Re R* and *Re W* in favour of higher regard for competence and autonomy. The CRC for the first time created an international Convention specifically designed to further the needs and rights of children as a unique and individual group. It recognised the status of children as rights holders.[11] This in itself was a great step forward for the empowerment of children as individuals with 'their own identities', rather than objects of adult control and protection. [12] Nevertheless, adults, including the judiciary, are reluctant to give up their power over children.[13] Although protective measures have been embraced domestically, there is a continued resistance to the empowerment of children.[14] This is evidenced within the refusal cases, as well as the continued application, or at least the lack of condemnation, of the retreat cases. It is argued that by favouring paternalism and protection, effectively ignoring meaningful participatory rights in the field of adolescent refusals, the UK could be seen to be in breach of its international obligations under this Convention.

[10] The UNCRC was signed by the United Kingdom in 1990, ratified in 1991 and came into force in 1992.
[11] UN Committee on the Rights of the Child, 'General Comment 4: Adolescent health and development in the context of the Convention on the Rights of the Child' (2003) UN Doc CRC/GC/2003/4, [6].
[12] Archard (n 1) 117.
[13] Geraldine Van Bueren, 'Children's Rights: Balancing Traditional Values and Cultural Plurality' in Gillian Douglas and Leslie Sebba (eds), *Children's Rights and Traditional Values* (Ashgate 1998) 19.
[14] Gerison Lansdown, *The Evolving Capacities of the Child* (UNICEF 2005) 32.

The most important provision for children's autonomy comes within Article 12 CRC. The Article reads:

> States Parties shall assure to the child who is *capable of forming his or her own views* the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. (emphasis added)[15]

This article enshrines the dual motives of the Convention not only to protect children, but to empower them.[16] Within General Comment 12, the Committee of the Rights of the Child stated that participatory rights are of 'fundamental' value to the Convention.[17] The Committee also emphasised the role of evolving capabilities, which encompasses the fact that minors do not attain intellectual maturity at a certain age, but develop more gradually, regarding the weight to be attributed to Article 12 rights.[18] *Gillick*, despite being decided prior to the UK's ratification of the CRC, serves as an example of a test which incorporates this concept into domestic law.[19] It relies not on age as an indicator of ability to attain competence, but the child's maturity and intelligence.[20] Despite this potential within the law for the empowerment of competent minors, the retreat cases placed limits on a competent child's ability to refuse.[21] Consequently, as was proven within the previous chapter, the judiciary have been reluctant to truly embrace the empowerment of mature minors, struggling to release competent children from their protective wing.[22]

[15] UNCRC, Article 12(1) (emphasis added).
[16] Michael Freeman, 'The Future of Children's Rights' (2000) 14 *Children and Society* 277, 277.
[17] UN Committee on the Rights of the Child, 'General Comment 12: The Right of the Child to be Heard' (1 July 2009) UN Doc CRC/C/GC/12, [2].
[18] ibid [31].
[19] Archard, (n 1) 117.
[20] *Gillick* (n 1) 188 (Lord Scarman).
[21] *Re R* (n 3); *Re W* (n 3).
[22] Van Bueren (n 13) 22.

Although children's views are often heard within court cases, this involvement is often more 'tokenistic' than empowering.[23] For example, the children's views were heard and discussed within *Re M*.[24] However, such views have never been allowed to have determinative impact within refusal cases. As Laura Lundy has eloquently argued, the rights within Article 12 are meaningless unless children not only have a voice, but can communicate their opinions in a way which can lead to actual impact and recognition.[25] This view is echoed by the Committee on the Rights of the Child, which stated that merely listening to the child is insufficient; once a child has demonstrated their competence to understand a situation, they must be granted greater responsibility for their decisions.[26] States have an obligation to assess the competence of children before denying them meaningful participation in their decision.[27] This is something which has been neglected by the judiciary either through merely tokenistic examination, or even ignorance, of the *Gillick* competence test in refusal cases.[28] As such, the current law may well be incompatible with international obligations on this basis.

The *Gillick* test, although by no means a perfect test, does focus upon evolving competence for minors, rather than age-based standards and over-bearing paternalism. As such, it is suggested that should the retreat cases be removed, *Gillick* could secure the empowerment intended for them by this pioneering Convention.[29] This thesis

[23] Claire Cassidy, 'Implementing the Convention on the Rights of the Child in the UK: A Problem of Political Will' in Clark Butler (ed), *Child Rights: The Movement, International Law and Opposition* (Purdue University Press 2012) 165.
[24] *Re M* (n 2).
[25] Laura Lundy, ''Voice' is not enough: Conceptualising Article 12 of the United Nations Convention on the Rights of the Child' (2007) 33(6) *British Educational Research Journal* 927, 931-33.
[26] General Comment 12 (n 17) [85].
[27] ibid [30].
[28] For examples, see the discussion of refusal cases within Chapter III.
[29] Further discussion of the potential routes for reform in this area of law shall be addressed within Chapter V.

argues that the prominence and continued application of the retreat cases, as well as the manipulation and lack of application of the *Gillick* test in refusal cases, require urgent reconsideration and condemnation respectively. Due to the ever-increasing prominence of the CRC and its strengthening of participatory rights, the law must be updated in order to eradicate contradiction with the Convention's principles. Accordingly, it is time that the paternalistic standards derived from *Re R* and *Re W* were reassessed and the authorities themselves overruled.

The Human Rights Act 1998

Another key development since *Re R* and *W* was the incorporation of the ECHR into domestic law through the enactment of the HRA 1998. As a result, judges must interpret legislation in a rights-compatible manner and must also apply Convention rights within their daily judicial duties due to their status as a public authority.[30] As such, human rights principles now permeate the law in a more considerable way than was the case when Lord Donaldson made his judgments within the retreat cases. It has been emphasised that children have just as much entitlement to the rights contained within the ECHR as their adult counterparts, with Article 8 being of particular importance to minors.[31] As such, children are rights holders in need of empowerment, rather than passive objects to be protected by the judiciary.[32] In relation to consent law, this could have substantial impact should *Re R* and *Re W* be reconsidered. Should a refusal case be heard today, it would be almost 'inconceivable' for the courts to

[30] HRA, s6(3)(a).
[31] European Union Agency for Fundamental Rights and Council of Europe, *Handbook on European law relating to the rights of the child* (Belgium, 2015) 23. <www.echr.coe.int/Documents/Handbook_rights_child_ENG.PDF> accessed 31 October 2016.
[32] ibid 17.

ignore the weight to be granted to the rights of patients under Article 8 ECHR due to their duties under the HRA.[33]

This has proven somewhat true, as the 2014 case of *NHS v P* incorporated Convention rights into its decision.[34] Nevertheless, although P was seen to have competence, she was still denied determinative capacity based on the *Re W* judgment. Baker J even states that he has 'no hesitation' in authorising the treatment. He does mention that the minor's Article 8 rights under the Convention were relevant, however quickly discredits the right's weight due to its qualified nature, as well as the competing balance from the right to life under Article 2. As such, even with the influence of the ECHR, it appears that minors' autonomy rights are still being denied by the judiciary. Nevertheless, despite the hindrance this case appears to present to the potential impact of human rights law on minors' refusal rights, this thesis challenges its significance as a barrier to progress. In other words, this case need not mark the end of the road for minors' autonomy rights.

Firstly, *NHS v P* was heard in the High Court, whereas *Re W* was heard in the superior Court of Appeal.[35] Consequently, Baker J was bound to apply the logic of this judicially superior, albeit antiquated, case. Even if this logic fails, the *NHS v P* case presented a much less controversial decision to the judge as it first appears. The minor in question had already given her consent to begin treatment for her overdose.[36] The judge was making a pre-emptive decision as to whether the doctors may continue the treatment if the girl subsequently refused the following required doses.[37] Thus, it is arguable that a truly hard case in this area, one where the child is vehemently refusing

[33] McFarlane J, 'Mental capacity: one standard for all ages' [2011] *Family Law* 479, 483.
[34] *An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam).
[35] *Re W* (n 3).
[36] *NHS v P* (n 34) [6].
[37] ibid.

all treatment and fully satisfies the *Gillick* test at the time of judgment is yet to be seen. When the change in judicial attitude both internationally and domestically –which shall be explored in depth below– is considered, *NHS v P* may not be indicative of the potential approach of the judiciary more broadly towards the weight to be given to Article 8 rights for refusing minors. As such, it is arguable that if a true refusal case came before the Court of Appeal, or indeed the Supreme Court, the judiciary may be more inclined to give proper weight to minors' Article 8 rights, as well as the fundamental right of self-determination for competent individuals.

With regards to adults' rights under Article 8, *Pretty v United Kingdom* proved that medical law ought to give great weight to individual autonomy.[38] Here, it was stated that Article 8 unequivocally contains a right to self-determination.[39] Although the interference with the applicant's rights was found to be justified under Article 8(2), this case demonstrates an increased commitment to adult autonomy within the human rights and medical spheres.[40] There is also evidence of increased respect for autonomy domestically within some aspects of the *Nicklinson* judgment.[41] Here, a majority of the Supreme Court held that it would be possible to deem the law criminalising assisted suicide to be incompatible with Article 8 ECHR.[42] Despite the fact that a declaration was not made, this case demonstrates that the autonomy given to competent individuals is of the upmost importance to the highest court within the United Kingdom. The reason the judiciary were concerned about making any meaningful alteration to the law was that it would have interfered with Parliamentary

[38] App No (2346/02) (2002) 35 EHRR 1 [61].
[39] ibid.
[40] Jane Fortin, 'Children's rights- flattering to deceive?' (2014) 26(1) *Child and Family Law Quarterly* 51, 60.
[41] *R (on the application of Nicklinson) v Ministry of Justice* [2014] UKSC 38.
[42] ibid [111] (Lord Neuberger).

matters, as the issue was at the time under consideration by the Houses in the form of a Bill.[43] Therefore, as the issue is no longer active within Parliament, this judgment hints that the likely priority would go to Article 8 rights regarding end of life decisions if a similar case arose in the future.[44] Even when considering controversial life and death issues, the judiciary continue to emphasise the importance of self-determination. As such, it is argued that a similar priority for autonomy be applied in cases of refusal involving minors, which, as previous chapters evidence, is currently lacking greatly. After all, children have been explicitly accepted as being entitled to the same Convention rights as adults, with Article 8 being identified as amongst the most relevant for minors.[45]

The emphasis of both domestic and international bodies on the priority to be granted to personal autonomy for competent individuals demonstrates the archaic nature of the overwhelming paternalism supported in the retreat and refusal cases. Jurisprudence on the ECHR's fundamental right of self-determination has prompted a shift in judicial attitude towards the status of children as rights holders. The judiciary have demonstrated an increasing tendency to refer to children's rights to participation in matters concerning them, rather than taking a purely welfare-based approach. Hence, this provides further evidence for the potential overrule of the retreat cases, and the embrace of competent minors' rights to autonomy.

Firstly, in *Mabon v Mabon* Thorpe LJ showed a commitment to ensuring the fulfilment of international human rights obligations relating to children's participation in court proceedings concerning their daily lives.[46] This case involved children aged

[43] ibid [190] (Lord Mance).
[44] ibid, see for example the judgments of Lord Neuberger and dissenting judgments of Lady Hale and Lord Kerr.
[45] European Union Agency (n 31) 23.
[46] [2005] EWCA Civ 634.

17, 15 and 13 arguing for their right to choose who represented them in family proceedings. Their appeal was granted, and the court's reasoning for their success focused heavily on the 'keener appreciation of the autonomy of the child and the child's consequential right to participate' evident in the 21st century.[47] Citing Article 12 CRC and Article 8 ECHR, *Mabon* urged judges to ensure that their focus is on the understanding on the minor involved. Thorpe LJ went so far as to say that where 'articulate teenagers' are concerned, the right to participation 'outweighs' paternalism and welfare concerns.[48] Consequently, Thorpe LJ's dicta can be seen to evidence a shift in judicial opinion away from inherently paternalistic motivations towards the protection of autonomy rights where a child has proven that they deserve such responsibility over their own decisions.

Secondly, *R (Axon) v Secretary of State for Health* provided further evidence of a judicial shift towards the primacy of autonomy.[49] Here, the decision in *Gillick* was affirmed as 'good law' post-HRA, and a similar thread of children's rights and autonomy dominated the judgement.[50] Drawing upon the dicta of Thorpe LJ as well as the aforementioned international human rights instruments, Silber J stated that any subsequent retreat from *Gillick* would be 'wrong' in light of the 'general movement' towards supporting and respecting children's rights to autonomy over their futures.[51] This once more suggests that the sort of retreat seen within *Re R* and *Re W* is currently frowned upon within judicial dicta and that the courts are, in light of human rights progress, inclined to favour empowerment over protection for mature, competent minors.

[47] ibid [26] (Thorpe LJ).
[48] ibid [28] (Thorpe LJ).
[49] [2006] EWHC 37 (Admin).
[50] ibid [93] (Silber J).
[51] ibid [115] (Silber J).

The reasoning within these two post-HRA cases is vehemently opposed to the paternalistic, welfare-focused reasoning evident within the refusal and retreat cases. Respect for autonomy has been continually denied for mature minors in favour of paternalism, justified by *Re R* and *W*. Nevertheless, the reasoning in *Mabon* and *Axon* could provide a welcome modernisation in the law.[52] They show an emphasis on the importance of participation and autonomy, even when faced with welfare concerns, which starkly contrasts that seen within the refusal cases explored in the previous chapter. Following the dicta in these more modern cases, as well as the general shift of judicial and legal attitude towards autonomy and children's rights, it appears possible that if a suitable refusal case was heard by the Court of Appeal or Supreme Court today, the pendulum would finally and definitively swing away from intrusive paternalism regarding competent minors.

Nevertheless, despite the continuing prominence of autonomy and paternalism falling 'out of favour' as a result,[53] *Re R* and *Re W* remain leading authorities regarding minors' refusals of medical treatment. Progress in this morally difficult area appears to be stunted as reluctance to allow competent children to make life-changing decisions endures. This attitude is arguably inappropriate and outdated when the UNCRC, HRA and judicial shifts in favour of child autonomy are considered. This chapter shall go on to scrutinise why the judiciary, and the political branches, are so reluctant to grant the same autonomy to competent minors as is given to adults. It aims to dispel some of the fears about recognising the fundamental right to self-

[52] Rachel Taylor, 'Reversing the retreat from *Gillick*? *R (Axon) v Secretary of State for Health*' [2007] *Child and Family Law Quarterly* 81, 94.
[53] Hagger (n 6) 46.

determination to such children and suggests that the time is ripe for meaningful progress to be made for minors wishing to refuse medical treatment.

Children and the Refusal of Medical Treatment: A Lack of Progress for Autonomy

Despite the progress made generally in increasing the prominence of human rights and autonomy, it appears that there is still some reluctance in letting go of the paternalistic paradigm when it comes to competent minors.[54] In 2014, as mentioned previously, *An NHS Foundation Hospital v P* unfortunately demonstrated that despite the progress examined within this chapter for autonomy in general, even for the increased recognition of children's rights shown in *Axon* and *Mabon*, there remains a lacunae in progress for children's rights and autonomy within the field of medical refusals.[55] Some of the reasons behind this continued reluctance shall be examined in an attempt to dispel fears about granting competent children determinative capacity.

It is a natural instinct to seek to protect children. Society has labelled children as 'cute, lovable creatures, but above all, weak, vulnerable and dependent' according to Archard, leading to a tendency to view them as objects in need of protection rather than individuals and rights holders deserving of empowerment.[56] There is a strong paradigm that minors are less intellectually able than those over the age of majority, warranting less weight to be given to their decisions and a more protective stance by the judiciary.[57] This presumption has infiltrated the core of medical consent law regarding children, evidenced most obviously within the *Re R* and *Re W* judgments.

[54] Richard Huxtable, '*Re M (Medical Treatment: Consent)*- Time to remove the 'flax jacket'?' (2000) 12(1) *Child and Family Law Quarterly* 83, 83.
[55] Jane Fortin, 'Children's Rights: Are the Courts Now Taking Them More Seriously?' (2004) 15 *King's College Law Journal* 253, 271.
[56] Archard (n 1) 243.
[57] Lansdown (n 14) 27.

Critics of autonomy rights for children such as Lainie Friedman Ross have expressed the view that children lack the life experience to make life-changing decisions about issues such as medical treatment.[58] She feels that they lack the competence to make such decisions, as they cannot draw from past experience to judge the outcome or the likely effects of refusal. Such beliefs about children's competence have led to the reluctance to grant autonomy even to mature minors evidenced within the case law. Nevertheless, this view is somewhat narrow minded towards children's abilities.

Lynn Hagger is a strong advocate for children's rights to autonomy and respect.[59] She has emphasised the fact that children have mental abilities far beyond those we accredit them with.[60] Although it is accepted that not all children will have the same mental abilities as adults, of course very young children will lack the independence adults can be expected to have and some children are indeed immature, Ross's view appears to connect experience purely to age. This thesis argues that this is an unduly restrictive view, and is not always conducive to reality.[61] Children, especially those with chronic or recurrent conditions, may be very 'experienced patients' with a deep knowledge and understanding of medical matters.[62] Such minors would know far more than the average adult and their competence regarding related matters would be far more difficult to deny than an individual who had never set foot inside a hospital. Consequently, Ross's argument that children invariably lack competence and therefore should never be granted capacity to refuse treatment becomes somewhat unconvincing. UNICEF have echoed this concern, warning against the application of

[58] Lainie Friedman Ross, *Children, Families and Health Care Decision Making* (Oxford University Press 1998) 61.
[59] See her book on the issue, Hagger (n 6).
[60] ibid 22.
[61] Richard Daniel, 'Mature Minors and Consent to Treatment: Time for Change' [2009] *International Family Law* 233, 233.
[62] Hagger (n 6) 235-36.

'blanket assumptions' regarding children.[63] Experience is something accrued without discrimination of age, and to assume that minors lack the ability to make such decisions is to ignore plain evidence to the contrary.[64] Such attitudes also fail to account for the concept of evolving capabilities, which has been shown to be central to the CRC's principle of empowerment.[65] Consequently, the argument that *all* children should be prevented from refusing treatment due to a lack of experience or ability is a fallacy based on sweeping generalisations, and is less than persuasive.

Another justification for the lack of progress for competent minor's autonomy lies in the weight to be granted to parental rights. The ECHR has been seen to encompass children's interests. However, many rights, including Article 8 under paragraph 2, allow for interferences to be justified with reference to the rights of others. Supporters of paternalism argue that parents are fundamental to a child's creation of important familial relationships and general development, and as such children's rights ought to be tempered with parental approval.[66] Support for this argument has been apparently evidenced even within the European Court of Human Rights' jurisprudence in *Nielsen v Denmark*.[67] Here, a child of 12 kept against his will on a psychiatric ward through his mother's choice failed to show his Article 5 right to liberty had been engaged, let alone breached.[68] The Strasbourg court held that at this age it is normal for a parent to be the one to make such decisions on their child's behalf.[69] The lack of weight given

[63] Lansdown (n 14) xiv.
[64] ibid x.
[65] ibid 3.
[66] Friedman Ross, *Heath Care Decision Making* (n 58) 3-4.
[67] App No (10929/84) (1989) 11 EHRR 175.
[68] ibid.
[69] ibid [72].

to the child's rights and wishes in this case lends support the arguments that parental input and override powers are legitimate despite the HRA.[70]

Nevertheless, the arguments from parental rights are far from water-tight. As explored above, the ECHR provides rights to both adults and children alike without discrimination.[71] As such, to presumptively favour the rights of parents over the rights of children is contrary to the intentions of the Convention and demeans the status of children as rights holders.[72] In addition, *Nielsen* is a dubious authority decided over two decades ago.[73] The Convention is described as a 'living instrument' which develops along with social changes and progress.[74] As such, evidence examined in the previous section hold strong weight in suggesting that the Strasbourg court may view children's rights in a more favourable light if a case regarding a minor's autonomy were heard today.[75] Furthermore, within the *Nielsen* judgement itself it was alluded that had the child been older, his mother's interference would not have been justifiable and the boy's decision should have had much more gravity.[76]

In addition, *Gillick* itself professed that parental rights terminate upon their child achieving competence.[77] It is also important to note, as Ian Kennedy has asserted in light of the tragic litigation regarding Charlie Gard, parents have not rights, but *duties*

[70] Laine Friedman Ross, 'Arguments Against Health Care Autonomy for Minors' (1995) *Bioethics Forum* 22, 24.
[71] ECHR Article 14; Lansdown (n 14).
[72] General Comment 4 (n 11) [6].
[73] Austen Garwood-Gowers, 'Time for Competent Minors to Have the Same Right of Self Determination as Competent Adults with Respect to Medical Intervention?' in Austen Garwood-Gowers, John Tingle and Tom Lewis (eds), *Healthcare Law: The Impact of the Human Rights Act 1998* (Cavendish Publishing 2001) 237.
[74] *Tyrer v United Kingdom* App No (A/26) (1979-80) 2 EHRR 1, [31].
[75] Garwood-Gowers (n 73) 237.
[76] *Nielsen* (n 67) [72].
[77] *Gillick* (n 1) 113-14.

regarding their children in the context of medical treatment.[78] In other words, parents must act within the child's best interests, and have no right to intervene with their child's decisions simply due to disagreement. As such, it is argued that once a minor has proven competence, which in itself is an incredibly difficult task, then the child should be seen to be able to determine their own best interests. The parents are no longer needed to step in and protect their child, as competence proves an ability to think independently with intelligence and understanding. To allow interference with a competently made decision is to impose standards of objective rationality on minors, meaning that they could not decide unless it is what the courts, or parents deem to be the 'correct' decision.[79] Even Friedman Ross, a strong proponent of near-unrestricted parental rights, agrees that only accepting a decision if the adults involved agree with it makes a 'farce' of true autonomy.[80] As such, arguments which allude to parental rights as superior to that of competent children's autonomy rights carry much less weight than they are often accredited with.

As such, this chapter has aimed to demonstrate that *Re R* and *Re W* become even more tenuous authorities when subjected to rights-based scrutiny. The idea that a child's rights have no certainty in their legal weight, or even existence, can be seen to insufficiently address the United Kingdom's international obligations. [81] Consequently, the continued denial of autonomy for competent minors cannot

[78] Ian Kennedy, 'Despite Charlie Gard's tragic story, we must respect the process of our courts' The Guardian (London, 24 July 2017) <www.theguardian.com/commentisfree/2017/jul/24/charlie-gard-tragic-respect-courts> accessed 27 July 2017.
[79] Anthony Perera, 'Can I Decide Please? The State of Children's Consent in the UK' (2008) 15 *European Journal of Health Law* 411, 419.
[80] Friedman Ross, *Heath Care Decision Making* (n 58) 66.
[81] Jane Fortin, 'Accommodating children's rights in a post Human Rights Act era' (2006) 69(3) *Modern Law Review* 299, 306.

continue to be based on arguments from parental authority, as developments both domestically and internationally contradict this conclusion.

Perhaps the most forceful argument driving the judiciary's reluctance to grant children determinative capacity comes from a strong moral pull against allowing children to refuse potentially life-saving treatment.[82] Even academics such as Jane Fortin, who are otherwise strong supporters of children's rights and autonomy, struggle to accept that minors may have the right to refuse treatment knowing that this will lead to serious harm or even death.[83] It is an uncomfortable thought, to ask a judge to support the death or pain of a child even if that child is mature and competently chooses this path for themselves. Because of this discomfort, judges have disregarded the wishes of mature minors, replacing respect for autonomy with artificial findings of incompetence to shroud their paternalistic motives for overriding refusals.[84]

The judiciary feel a very strong obligation to ensure that children attain the age of majority.[85] Upon turning 18, a person obtains almost unrestricted autonomy to refuse treatment without question as to their motives or rationality.[86] Judges have justified the continued validity of the approach in *Re W* with reference to their obligation to ensure a minor survives to be granted these rights and decide for themselves.[87] In other words, they appear to reject the ability of competent minors to refuse, so that they may preserve their future autonomy.[88]

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[82] ibid 323.
[83] Fortin, 'Flattering to deceive?' (n 40) 60.
[84] Huxtable (n 54); additionally, see discussion within Chapter III.
[85] *Re P* (n 4) [6] (Johnson J).
[86] *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95, 102 (Lord Donaldson); exceptions lie within, for example, the Mental Health Act 1983.
[87] *Re P* (n 4) [6] (Johnson J).
[88] Richard B Miller, *Children, Ethics and Modern Medicine* (Indiana University Press 2003) 43.

This is a view also shared by Friedman Ross, who promotes the idea that recognising children's autonomy rights would ignore their long-term interests and ability to exercise autonomy in later life.[89] As such, she is 'unwilling' to accept decisions by minors which would be regarded as unsavoury, even if they are competent, as the long-term interests of the child require protection even if at the expense of what she calls 'short-term autonomy'.[90] She does not feel that the achievement of competence is enough to warrant respect for minors' autonomy; children, in her view, must be thought of as developing persons, undeserving of full autonomous respect until they reach adulthood.[91] The idea of protecting even competent children by restricting their autonomy is a popular one amongst those who support *Re W* and *Re R*. However, this thesis takes the opinion that their logic may be flawed. Although a noble and admirable motive, to protect children from death and harm, the methods employed by the judiciary which have prevented mature minors exercising autonomy ought to be questioned.[92] It shall be demonstrated that *competent* minors are not fragile, vulnerable creatures, but rather intelligent individuals deserving of respect, whatever the consequence.

Gillick requires understanding far beyond that required within the MCA. For example, in *Re E* the child was expected to not only understand the broad consequence of his refusal, but the concept and finality of death along with the agonising nature of this demise.[93] This is an incredibly deep level of understanding most adults would fail to satisfy.[94] Yet, upon attaining this incredibly high standard, minors are not granted the

[89] Friedman Ross, 'Arguments Against' (n 70) 24.
[90] Friedman Ross, *Heath Care Decision Making* (n 58) 61.
[91] ibid 10.
[92] Jane Fortin, *Children's Rights and the Developing Law* (Second Edition, Lexis Nexis Butterworth 2003) 25.
[93] *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386, 391 (Ward J).
[94] Archard (n 1) 119.

same freedom as competent adults due to the prominence of paternalism within the retreat cases. As such, the judiciary currently heavily underestimate children, infantilising them to justify paternalistic instincts in refusal cases.[95] As the threshold in *Gillick* is so high, and has been interpreted to be even higher within certain refusal cases,[96] it is logical that if a child satisfies this test they cannot validly be labelled as vulnerable, and have instead earnt the right to respect for their autonomous decision.[97] The status of competence ought to mean something, and we ought to respect competent decisions by minors in the same way as adults.[98]

The future autonomy arguments are also fragile when the age of majority itself is examined. The age of 18 brings with it no magical force. It is most likely that a child of 17 and a half years and one of 18 are entirely similar in their cognitive abilities, beliefs and understanding.[99] Yet, the law grants the latter the freedom to decide autonomously what medical treatment their body shall be subject to, and denies the former any such right. This concept of competence is entirely false. For example, the minor in *Re E* was forced to endure years of blood transfusions, leaving him feeling as though he had betrayed his faith and his God. As explained within Chapter II, just three years later upon turning 18, the boy was allowed to refuse the continuation of his treatment and died.[100] His beliefs and understandings of his situation had not changed. Nevertheless, due to the paternalistic actions of the judiciary based on their conceptions of his future autonomy, E died feeling 'violated'.[101] Even more

[95] ibid 243.
[96] See discussion of *Re E* (n 93) within Chapter III.
[97] Pip Trowse, 'Refusal of Medical Treatment- A Child's Prerogative?' (2010) 10 *Queensland University of Technology Law and Justice Journal* 191, 211.
[98] Cave, 'Maximisation' (n 5) 432.
[99] Andrew Grubb, 'Refusal of Treatment (Child): Competence', (1999) 7 *Medical Law Review* 58, 60.
[100] Revealed in *Re P* (n 4) [8].
[101] Michael Freeman, 'Rethinking *Gillick*' (2005) 13 *International Journal of Children's Rights* 201, 209.

demeaning is the fact that many arguably competent children have endured being wrongly perceived to be mentally inferior to meet the judiciary's paternalistic drives.[102]

The arguments from 'future autonomy' fail to account for the staggering impact forced treatment can have on the patients involved. Invasion of a person's bodily integrity should not be justified with reference to the fact that they might one day change their mind, or regret that decision.[103] If this logic were applied more broadly, no one would ever be able to make a drastic life decision. The conception that judges know what is best for a child's future goals and should deny autonomy on this basis is therefore misguided and unfair to competent children.[104] In refusing to acknowledge that children can have the same intellectual abilities as adults, we continue to demean and infantilise them unnecessarily. When such affronts to the dignity of the children involved are concerned, denying competent minors the capacity to refuse becomes harder to support.

As has been demonstrated, the reluctance to engage with children's autonomy rights to refuse medical treatment has been backed by questionable logic. It has been shown that arguments centred around the vulnerability of children are largely ill-founded when applied to mature, competent minors. As such, the judiciary's general lack of engagement with capacity for competent minors can no longer be justified. It is time that mature minors were given the rights they deserve having proven their competence, even if this could lead to difficult outcomes.

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[102] Charlotte McCafferty, 'Won't Consent? Can't Consent! Refusal of Medical Treatment' (1999) *Family Law* 335, 336.
[103] Victoria Chico and Lynn Hagger, 'The Mental Capacity Act 2005 and mature minors: A missed opportunity?' (2011) 33(2) *Journal of Social Welfare and Family Law* 157, 164.
[104] Hagger (n 6) 33.

The Way Forward: Respecting Competent Minors

The reluctance on behalf of the judiciary and the political branches to grant minors the ability to refuse treatment is understandable. Often, the cases discussed by this thesis involve a child facing life-or-death circumstances. This is an undeniably difficult issue, and strikes at the sensitivity of protective and paternal instincts regarding children.[105] It is far easier for judges to find minors incompetent, rather than to acknowledge their paternalistic agendas and explicitly override a mature minor's competently made decision. In turn this has led to a plethora of bad law in this area, and the unwarranted infantilisation of mature minors. This chapter has aimed to demonstrate that this approach cannot continue. Not only do the dubious findings of incompetence within refusal cases demean children, the lack of embrace for children's competence and subsequent capacity is very arguably incompatible with the UK's human rights obligations.

The following chapter shall examine the potential routes available for reform of this area of law, as well their likelihood of becoming reality. Despite support for children's rights within the law both domestically and internationally, there remains resistance to embracing minors' rights within this area. Children are struggling to 'redefine themselves as competent beings' as Katherine Hunt Federle has described it.[106] As such, Chapter V shall not only address the potential for legal reform, but the need for social changes regarding how we perceive children.

[105] Fortin, 'Flattering to deceive?' (n 40) 60.
[106] Katherine Hunt Federle, 'Rights Flow Downhill' (1994) 2 *International Journal of Children's Rights* 343, 344.

Chapter V: Protecting the Vulnerable and Empowering the Capable: Thoughts on How to Change the Law

This chapter aims to suggest ways in which the law could be altered in order to bring this area of law in line with human rights obligations and general principles of autonomy. It has been concluded that the law cannot remain in its current state of uncertainty. Equally, it has been concluded that to eradicate minors' rights to refuse entirely would be inappropriate and illogical. As such, the question to address here is *how* those who are able to make a difference should go about clarifying minor's rights to refuse life-saving medical treatment. This chapter shall explore the likelihood and suitability of judicial and parliamentary methods of altering the existing law. The potential extension of the adult test, the MCA, to patients of all ages will also be assessed. It shall be argued that although some aspects of this statutory regime could be beneficial if applied to minors, the full extension of the MCA to under 16s would not be the best reform option. Ultimately, it shall be suggested that although change and reinforcement would be required at law in order to formally support the rights of minors with competence, what we may require before such reform can succeed is further social challenge to the current dichotomy between childhood and adulthood. Only once society accepts that children can be just as capable of making independent decisions as those over the age of majority can we fully expect legal changes to have real impact on patients.[1] It is suggested that the judiciary could play their part in reinforcing and encouraging this social change through incremental reform.

[1] Eva Brems, 'Children's Rights and Universality' in Jan CM Willems (ed), *Developmental and Autonomy Rights of Children: Empowering Children, Caregivers and Communities* (Second Edition, Intersentia 2007) 25.

Judicial Change

The first and most obvious method of change for this area would be to allow the judiciary to remedy the confusion left by its own methods through the common law. The *Gillick* test was a product of judicial creation, as was the unfortunate retreat from *Gillick*. As such, it would make sense for the judiciary to be the ones to further develop and update the law surrounding minors' refusal rights. But how should the courts go about such a task? And how likely are the judiciary to uphold the rights of minors if a suitable case was to arise?

As mentioned within Chapter II, it is certainly arguable that Lord Donaldson's dicta within *Re W* remains just that, obiter dicta, due to the uncertainty around W's competence.[2] As such, subsequent courts would not be bound to follow his judgment regarding the strength and weight allotted to a refusal made with *Gillick* competence. In this sense, it may be as simple as to state that Lord Donaldson's limitations on granting capacity to competent minors are no longer applicable. If the judiciary were to embrace this option, this should ensure that a lack of competence would be the only justification for paternalistic interventions where a minor refuses treatment. This option would remove barriers to the acceptance of *Gillick*'s liberal nature, terminating powers to override a decision made with competence to both consent *and* refuse.[3] This would ensure that the concepts of evolving competencies and individual autonomy were firmly at the forefront of this area of law in a way which the retreat cases currently prevent. Nevertheless, this is perhaps a little optimistic. To do so would be to eradicate 20 years of Lord Donaldson's judgment being treated as binding by the

[2] Lilian Edwards, 'The Right to Consent and the Right to Refuse; More Problems with Minors and Medical Consent' (1993) 1 *Juridical Review* 52, 63.
[3] John Eekelaar, 'The Emergence of Children's Rights (1986) 6(2) *Oxford Journal of Legal Studies* 161, 181.

judiciary. Such long-standing commitment to the retreat cases is unlikely to be thrown away quite so flippantly. In fact, the judgment has had direct application as recently as 2014.[4] As such, a more nuanced approach may be necessary.

Another way in which the judiciary could alter the existing law without desecrating the long-standing retreat cases quite so aggressively would be to adjust the law through the HRA. As this piece of ground-breaking legislation was not enacted until after the conclusion of *Re R* and *Re W*, it is possible that should a suitable case arise, the common law could be altered and developed in a more rights-oriented manner through the court's powers and obligations granted within the HRA. This is especially poignant as an option for reform when the damning nature of right-based scrutiny in this area of law seen within Chapter IV is considered.

The HRA could assist reform through various sections. Firstly, the courts have the interpretive obligation under section 3 HRA at their disposal. This section requires the judiciary to develop the law compatibly with the ECHR when deciding cases which engage Convention rights. In this sense, a case involving a minor vehemently refusing life-saving treatment would engage the right to private life under Article 8, which has been determined to include the right to autonomy.[5] The Convention has as much applicability to children as to adults,[6] as discussed within the previous chapter. Additionally, Article 14 prohibits discrimination when applying Convention rights, which would include discriminatory treatment based on age. As the retreat cases precede the HRA, it would be necessary to consider the rights under the ECHR when deciding a refusal case. The articles mentioned would lend the courts the scope they

[4] *An NHS Foundation Hospital v P* [2014] EWHC 1650 (Fam).
[5] *Pretty v United Kingdom* App No (2346/02) (2002) 35 EHRR 1 [61].
[6] European Union Agency for Fundamental Rights and Council of Europe, *Handbook on European law relating to the rights of the child* (Belgium, 2015) 23. <www.echr.coe.int/Documents/Handbook_rights_child_ENG.PDF> accessed 31 October 2016.

would need to adjust the common law and allow for minors to refuse treatment once they can prove competence. As mentioned within Chapter IV, the current common law is very arguably incompatible with these rights and therefore would fall within the scope of the section 3 obligation.[7] Similarly, the courts are bound to act compatibly with the convention due to their status as a public authority under section 6(3)(a) HRA, opening another avenue for change via the judiciary.[8] In these ways, the courts could intertwine *Gillick* with Article 8 rights in order to ensure that protection for minors' autonomy becomes the focal point of medical consent law not only for adults, but for all.

The HRA could hence be used to de facto overrule, or at least adjust the paternalistic force of, the retreat cases through rights-based reinterpretation. Although it has been suggested by Pattinson that the provisions within the HRA should allow even the lower courts to depart from precedent where incompatibility with the ECHR arises, this path has yet to be embraced by the courts themselves.[9] As such, the task of reform is more likely to succeed if left to the higher courts. Through reinterpretation of the retreat cases, the courts could amend the common law and give the same weight to refusals made with competence as is seen for consent. Using these methods, the higher courts could use a subsequent, suitable mature minor's refusal as a catalyst for real change within the law. Such a case could ensure that autonomy, rather than paternalism, becomes the dominant principle of minors' medical consent law. In other words, the law could finally eradicate the unsustainable asymmetry between capable minors' consent and refusals, bringing the law for adults and minors together more cohesively.

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[7] Jane Fortin, 'Rights brought home for children' (1999) 62 *Modern Law Review* 350, 352.
[8] Jane Fortin, 'Accommodating children's rights in a post Human Rights Act era' (2006) 69(3) *Modern Law Review* 299, 306.
[9] Shaun D Pattinson, 'The Human Rights Act and the doctrine of precedent' (2015) 35 (1*) Legal Studies* 142, 147 and 157.

Nevertheless, even if the HRA is not engaged, the common law itself can provide a means for reform. Sir James Munby professes that the common law has a 'remarkable ability to adapt in dramatic ways' to changing tides.[10] It has often allowed for the evolution of law in order to keep up with general shifts in society's opinions on issues such as autonomy rights. One example within the context of adults can be seen in the caesarean section litigations.[11] For adults, competence means an 'absolute right to choose' whether to consent or refuse treatment regardless of the decision's rationality or consequence.[12] However, in the early 1990s, Lord Donaldson suggested that the right of a competent adult to refuse may be compromised where the life of an unborn baby is also at risk.[13] As a result of this dicta, subsequent cases deprived otherwise arguably legally competent women of their freedom of choice, a right which was so vehemently defended within the same paragraph of the judgment.[14]

However, over time the judiciary swung their favour from paternalistic intervention based on the protection of mother and child to one focused on the fundamental right of self-determination owed to all with the competence to make decisions for themselves. This view was evidenced in *Re MB* by Butler Sloss LJ, who emphasised that an adult with competence, even if pregnant, had the absolute right to refuse treatment regardless of the consequences.[15] This position was confirmed in *St George's Heathcare NHS Trust v* S, bringing an end to Lord Donaldson's autonomy-limiting dicta five years after its introduction.[16] As such, although no case has yet

[10] Sir James Munby, 'Protecting the Rights of Vulnerable and Incapacitous Adults- The Role of the Courts: An Example of Judicial Law Making' (2014) 26(1) *Child and Family Law Quarterly* 64, 77.
[11] Rebecca Bailey-Harris, 'Pregnancy, autonomy and the refusal of medical treatment' (1998) 114 *Law Quarterly Review* 550.
[12] *Re T (Adult: Refusal of Medical Treatment)* [1993] Fam 95, 102 (Lord Donaldson).
[13] ibid.
[14] *Re S (Adult: Refusal of Treatment)* [1993] Fam 123.
[15] *Re MB (Refusal of Treatment)* [1997] 2 FLR 426.
[16] [1998] 3 WLR 936, 950.

been heard where a competent woman's refusal of a caesarean section has been unequivocally accepted, this line of cases demonstrates the ability of the common law to develop with time. Consequently, the same logic can, and should, be applied to competent, mature minors seeking to refuse life-changing medical treatment.

In fact, the solution to the judiciary's misuse of *Gillick* may be less ground-breaking than first thought. This is because the solution may in fact already exist in the form of the court's inherent jurisdiction. This power has been subject to judicial development in recent times due to its extension regarding 'vulnerable adults' who nonetheless have competence under the relevant tests.[17] Originally, the inherent jurisdiction had no place where an adult was seen to satisfy the test for competence.[18] However, this proved troublesome for some vulnerable adults. The MCA test can, at times, leave individuals who cannot truly make an autonomous decision with the status of competence and therefore legal capacity.[19] Herring states that the MCA does not allow for assessment of the genuineness of personal beliefs which underpin the patient's decision.[20] Consequently, some may be granted capacity without full requisite competence, encompassing mental abilities as well as free and autonomous thought. For example, the inherent jurisdiction has been applied to adults who were competent under the relevant tests, yet had proven unable to make their own autonomous decision as a result of strong familial influence and even abusive coercion.[21] Such adults are sound of mind, suffering no impairment or disturbance of the mind or brain.[22] Nevertheless, factors which go beyond the MCA's requirements may still influence

[17] Shaun D Pattinson, *Medical Law and Ethics* (Fifth Edition, Sweet and Maxwell 2017) 143 (forthcoming).
[18] *Re C (Adult: Refusal of Treatment)* [1994] 1 All ER 819.
[19] Jonathan Herring, *Vulnerable Adults and the Law* (Oxford University Press 2016) 54.
[20] ibid 57.
[21] *Re L (Vulnerable Adults with Capacity: Court's Jurisdiction)* [2012] EWCA Civ 253; *Re T* (n 12)
[22] Pattinson, *Medical Law and Ethics* (n 17) 143.

such individuals' abilities to act in a truly autonomous manner.[23] It would be damaging and potentially dangerous to grant capacity to a patient incapable of autonomous thought.[24] Such an individual, lacking in independent thought and conscience, would not be competent enough to truly assess their situation and make the right decision regarding their own interests. To remove protection from such a patient would be an injustice in itself, leaving them vulnerable to harm. Consequently, the inherent jurisdiction has developed as a 'safety net' of sorts for vulnerable adults, granting those without true autonomy the protection they require whilst ensuring that well-rounded competence and freedom of choice remain the focal points of capacity law.

In terms of this power's application to minors, nothing is required in the way of expanding the scope of the inherent jurisdiction. The courts already have an unlimited reach when it comes minors. As such, if the judiciary were to overrule the retreat cases and allow competent minors the same rights to consent and refuse treatment as are currently allotted to capable adults, it would not shut the door to protection. The inherent jurisdiction could act as a similar safety net for those minors who may satisfy the legal tests, but are nonetheless affected by undue influence or other extraneous factors which may impede their ability to make a truly autonomous decision. This would ensure that competent minors would be granted capacity, but only if their competence encompassed autonomous capabilities. Hence, the judiciary would still be able to prevent those who lack autonomy from making decisions they ought not to be in control of.

[23] Jonathan Herring and Jesse Wall, 'Autonomy, Capacity and Vulnerable Adults: Filling the Gaps in the Mental Capacity Act' (2015) 35(4) *Legal Studies* 698, 699-700.
[24] Herring (n 19) 54.

Rather than misusing, ignoring, or manipulating the *Gillick* test, the inherent jurisdiction could be used to allow the judiciary to embrace competent minors' capacity. This power could offer a more limited form of paternalistic intervention than is currently permitted through the retreat cases. The retreat cases allow for intervention with a competent decision if the courts feel it would be the best decision for that child. As has been seen, this often means that intervention occurs due to the judiciary's disagreement with the child's decision. Conversely, the inherent jurisdiction's use within competent adults' cases has been limited to those who can be seen to lack autonomous thought in some form. Whilst ensuring that the law would be focused on the child's competence, the inherent jurisdiction would allow a degree of 'flexibility' for the judiciary where the competent child lacks full autonomy.[25] This flexibility ensures that the attainment of competence by minors would remain of primary importance, yet this status would not prevent paternalistic interferences with mature minors' decisions where that child truly requires protection.

Hence, it has been demonstrated that the common law could ameliorate its own misgivings by remedying the archaic paternalism inherent within the retreat cases by embracing the rights of competent minors to determine their own medical treatment. Nevertheless, these suggestions would all be for naught without assessing the likelihood of such techniques being employed by the judiciary. Consequently, this chapter moves on to consider its second question: how eager are the courts when it comes to increasing minors' refusal rights? Unfortunately, as with most issues within this area of law, the answer is somewhat unclear.

[25] Herring and Wall (n 23) 718.

The Likelihood of Judicial Change

Although the judiciary would be the most obvious choice when it comes to amending the law on minors' refusal rights due to its roots in the common law, it is uncertain how likely the courts are to embrace this task. Although some evidence of a judicial shift towards autonomy has been seen in the *Axon* and *Mabon* cases,[26] the courts have proven themselves reluctant to embrace minors' competence and subsequent determinative capacity where the consequences are life-threatening.[27]

An NHS Foundation Hospital v P demonstrates this reluctance perfectly.[28] Here, the High Court was presented with the very scenario academics had been waiting for: a mature minor whose competence could not be –and was not– denied who required life-saving medical treatment. Many had professed that should such a case arise, due to progress regarding children's rights discussed within Chapter IV, the judiciary would find it difficult to ignore autonomy rights for competent, mature minors, leading to a challenge to the retreat cases.[29] Nevertheless, this did not occur. Instead, the High Court upheld Lord Donaldson's dicta, stating that even once competence is unquestionable, a mature minor cannot have a determinative say in whether or not they receive life-saving medical treatment. This case confirms suspicions that the judiciary are somewhat hypocritical when it comes to children's rights. When faced with life-or-death choices, the underlying paternalism inherent within this area of law cannot help but rear its head despite progress made within medical law, and the law more

[26] *R (Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin) [115] (Silber J); *Mabon v Mabon* [2005] EWCA Civ 634, 28 (Thorpe LJ); discussed within Chapter IV.
[27] Jane Fortin 'The *Gillick* Decision- Not Just a High-Water Mark' in Stephen Gilmore, Jonathan Herring and Rebecca Probert (eds) *Landmark Cases in Family Law* (Hart Publications 2011) 212.
[28] *NHS v P* (n 4).
[29] Rachel Taylor, 'Reversing the retreat from *Gillick*? *R(Axon) v Secretary of State for Health*' [2007] *Child and Family Law Quarterly* 81, 85; Victoria Chico and Lynn Hagger, 'The Mental Capacity Act 2005 and Mature Minors: A Missed Opportunity?' (2011) 33(2) *Journal of Social Welfare and Family Law* 157, 158.

generally, in embracing autonomy as its central principle.[30] As such, the likelihood of judicial alteration to the common law in a way which would increase autonomy rights for mature minors appears slim.

Not only does *NHS v P* dampen the glimmer of hope for judicial amendment of the common law, the judiciary have been less than willing to fully embrace even *adults*' rights to autonomy within the context of end of life decisions. As such, this may further reduce the chances that the judiciary would welcome an opportunity to amend the law to guarantee minors' rights to refuse life-saving treatment. Evidence of this reluctance can be seen within *R (on the application of Nicklinson) v Ministry of Justice*.[31] Here, the Supreme Court was faced with claimants seeking to challenge the law on assisted suicide. The claimants sought to end their lives due to their respective debilitating conditions, but would be or were unable to do so alone. As such, they required assistance in order to end their lives.[32] Currently an illegal practice, those who would assist the claimants would potentially face criminal charges. It was argued that section 2 of the Suicide Act 1961 breached Article 8 ECHR due to the inability of the mentally capable claimants to choose to end their lives simply because this would require positive action by another.[33] Nevertheless, although a majority of the judges felt this case *could* have resulted in a section 4 declaration of incompatibility under the HRA, this step was not taken.[34] The judges, with the exception of Lady Hale and Lord Kerr, dissenting,[35] chose to defer the issue to Parliament. It was felt that the issue of legalising assisted suicide was one of such sensitivity and importance that it would be

[30] Alastair Bissett-Johnson and Pamela Ferguson, 'Consent to Medical Treatment by Older Children in English and Scottish Law' (1995-1996) 12 *Journal of Contemporary Health Law and Policy* 449, 455-56.
[31] [2014] UKSC 38.
[32] ibid [3]-[10] (Lord Neuberger).
[33] Suicide Act 1961, s2; ibid [5].
[34] *Nicklinson* (n 31) [113] (Lord Neuberger).
[35] ibid [300] and [326].

inappropriate for its determination through the common law. This type of deference is relatively common in the context of emotionally-charged, delicate issues which would have broad societal consequences.[36] As such, it can be predicted that if the judiciary are so reluctant to intervene that they refuse even to grant a section 4 declaration, which holds no binding weight, that they would be equally unwilling to allow minors the ability to refuse treatment which would result in their deaths. The *Nicklinson* litigation is just one example of judicial deference and reluctance to embrace change when it comes to life-and-death decisions.[37] As such, the potential for change through the judiciary looks less and less likely.

Nevertheless, hope is not lost. As mentioned within Chapter IV, the *Nicklinson* judges were particularly reluctant to force Parliament's hand on the issue due to concurrent discussion of a Bill which sought to amend the relevant Act's ban on assisted suicide.[38] No such interference with Parliamentary intent would be required regarding the reform of the retreat cases and law on minors' rights to refuse. The law in this area is founded largely in the common law, or the retreat cases at least are of judicial origin. As such, the override of these cases within the judiciary would be an entirely suitable reform method, avoiding the controversies which led to such a timid judicial approach within *Nicklinson*. Additionally, as mentioned within the previous chapter, some of the dicta within *Nicklinson* can provide evidence of the Supreme Court's commitment to upholding autonomy as a central principle for medical law. Nevertheless, until a refusal case comes before the higher courts, the true motivations of the courts in their reluctance to embrace minors' autonomy can only be speculated. As mentioned

[36] *International Transport Roth GmbH and others v Secretary of State for the Home Department* [2002] EWCA Civ 158; [2003] QB 728, [87] (Laws LJ).
[37] Bisset-Johnson and Ferguson (n 30) 455-56.
[38] *Nicklinson* (n 31) [190] (Lord Mance); Assisted Dying Bill, HL Bill (2016-17) 1 <www.publications.parliament.uk/pa/bills/lbill/2016-2017/0042/17042.pdf> accessed 10 July 2017.

previously, the recent *NHS v P* case was heard only by the High Court. It may be that the lack of progress for minors is due to reluctance to interfere with precedent. In this case, hope is not lost for minors' rights to refuse should the Court of Appeal or Supreme Court hear a suitable case.

Although some hope may remain for minors' refusal rights in terms of the override of the retreat cases, arguably the courts would be reluctant to eradicate *all* powers to protect even competent minors.[39] A more restricted, autonomy-focused residual power to replace the retreat cases' paternalism could exist within the inherent jurisdiction, as previously discussed. Nevertheless, in terms of the likelihood of the inherent jurisdiction being employed as a tool for promoting autonomy, as has been seen for adult patients, this is also sadly uncertain.

As has been demonstrated throughout this thesis, the judiciary are less than enthusiastic about granting competent minors capacity which would be equivalent to that of competent adults. Therefore, it is perhaps unlikely that the inherent jurisdiction would be applied quite so positively for minors should the retreat cases be overruled. The courts have proven that when left to their own devices they are willing to prioritise paternalism over autonomy where minors are involved, especially in life-and-death scenarios.[40] The same would be possible with the inherent jurisdiction. Rather than using this power to maximise competence and promote autonomy, the judiciary may repeat their mistakes regarding manipulation of their powers in the same way as within the refusal cases. As seen within Chapter III, the courts are keen to grasp at the chance to overrule intelligent and potentially competent minors. As such, the inherent jurisdiction, whilst having the potential to offer a solution which not only empowers

[39] Jane Fortin, 'The *Gillick* decision' (n 27) 221.
[40] Andrew Bainham, 'Can we protect children and protect their rights?' (2002) 32(4) *Family Law* 245.

but protects children, could be used in a negatively paternalistic manner.[41] The inherent jurisdiction could go the same way as the *Gillick* test, with the courts exploiting its flexibility to intervene with capable minors who do not require protection, but who rather make a decision which sits uncomfortably with paternalistic ideals. As such, it is suggested that a judicial solution to the confusion within the law could only plausibly work if the courts were truly willing to promote competence and capacity for competent minors.

Legislative Change

As an alternative to the common law, reform for minors' rights to refuse treatment could instead mirror the adult position. In other words, a legislative scheme could be devised to replace, or codify, the current legal test for minors and set out in clear statutory form their rights once such competence is achieved. This could come from extending the existing adult scheme, the MCA, to under 16s.[42] The possibility of legislative change which would embrace the rights of capable, mature minors shall now be explored and assessed as to its suitability and likelihood.

Extension of the Mental Capacity Act 2005

The MCA currently provides the test for competence regarding those over the age of 16. It is comprised of a two-part test, along with general principles in section 1. The most notable aspects of the MCA shall be outlined in terms of how they would alter the legal position of minors in order to modernise the current law and prioritise autonomy.

[41] Robin Mackenzie and John Watts, 'Is childhood a disability? Using Mental Capacity Tribunals and the Deprivation of Liberty Safeguards to shield children's capacity to consent to and refuse medical treatment' (2014) 19(2) *Tizard Learning Disability Review* 96, 104.
[42] The scheme is already relevant to 16-17 year olds as a result of s8 FLRA.

First is the presumption of capacity.[43] Unless evidence is available and apparent to rebut this, adults, and those between the ages of 16 and 17 due to the impact of the FLRA, are presumed to have the competence and hence the capacity to make their own medical decisions. This contrasts the current situation for minors, who must prove they have *Gillick* competence before even being considered to have the capacity to consent or refuse for themselves.[44] Some feel that allowing this presumption to apply to minors would help to counteract the inherent stigma many have against minors' abilities to obtain and exercise their competence.[45] Rather than the child bearing the considerable onus of convincing a reluctant judiciary that they deserve to be granted capacity, the burden would fall upon the medical professional or judge to show evidence of that child's incompetence. This would, in theory, ensure that a child's decision making capacity could only be overridden if there were real and serious concerns about their abilities to make the decision required. This could help to counteract the dubious judicial reasoning seen within Chapter III currently employed within refusal cases. Premonitions about minors being 'overwhelmed' by[46] or underappreciative of the consequences of[47] their decision would have to be backed up with facts in order to rebut a presumption of capacity, which could ensure a greater respect and priority for minors' autonomy rights.

Nevertheless, this thesis shall suggest that applying the presumption of capacity to under 16s may do more harm than good. As shall be explained below, the MCA test sets a much lower standard than is seen within *Gillick*. As such, the presumption of

[43] MCA s1(2).
[44] *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112.
[45] Priscilla Alderson and Jonathan Montgomery, *Health Care Choices: Making Decisions with Children* (IPPR 1996) 64.
[46] *Re M (Medical Treatment: Consent)* [1999] 2 FLR 1097.
[47] *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.

capacity would allow cases of borderline competence to fall in favour giving that child decision making capacity. This may mean that children who are in need of protection, in other words those who lack competence and do not have true autonomous capabilities, are given control over serious medical decisions. Additionally, children are usually more likely to be subject to familial influence, as they are more likely to be living with and dependent on their parents or guardians, as opposed to adults who tend to live separately.[48] As such, this higher potential for influence may increase the chances that a child is not acting autonomously. Consequently, a child's autonomous decision-making capabilities should be assessed, rather than assumed. As Herring has stated, to deny capacity to someone who has competence is abhorrent, but it is perhaps even more abhorrent to force capacity upon an incompetent individual who cannot make that decision with full autonomy.[49] As such, although the benefits of the MCA's presumption may be apparent in theory, the reality is that some protection for minors must be preserved to ensure that capacity is granted only to truly competent patients.

Another distinction with the current common law governing minors is that the MCA requires that 'all practicable steps' must be taken to ensure that an individual could attempt to make their decision for themselves if capable of doing so.[50] This would mean that a person who is on the borderline of competence but is refusing treatment due to a fear of needles, or perhaps religious pressure from family, would have to be spoken to and assessed as to their competence without the stressor present. This would mean, for example, removing needles from sight, or speaking to the patient without

[48] Johan Christiaan Bester, Martin Smith and Cynthia Griggins, 'A Jehovah's Witness Adolescent in the Labor and Delivery Unit: Should Patient and Parental Refusals of Blood Transfusions for Adolescents to be Honored?' (2017) 7(1) *Narrative Inquiry in Bioethics* 97, 101.
[49] Herring (n 19) 54.
[50] MCA s1(3).

the family's intervention.[51] This principle also requires communication of the relevant information needed in order to exercise competence to the patient if they could be capable of understanding. This duty does not formally exist for minors, which is a great hindrance for those attempting to assert their right to refuse treatment.[52] Although, as Cave states, there may be some evidence of a duty to attempt to 'maximise' minors' competencies,[53] to extend the MCA to under 16s would ensure that they do not miss out on the opportunity to exercise autonomy.

If extended to minors under the age of 16, doctors, other medical professionals and judges would have a formal, legal duty to ensure that a mature, intelligent minor has all the tools they require in order to exercise their competence. As such, the problematic reasoning explored in Chapter III within cases such as *Re E* and *Re L*,[54] would not occur. Here, it shall be recalled that the minors were stated to lack competence due to their lack of understanding of the nature of their deaths, something which they were never told. Under the MCA, section 1(3) would require that information to be provided, in order to ensure that if the patients are capable of making the decision for themselves, such ability would be prioritised over paternalistic intervention. Once more, it can be seen that the extension of the MCA could provide a solution to some of the more dubious judicial tactics which have been employed to stunt progress for minors' refusal rights.

Another change would, of course, be to the relevant test to assess competence. The MCA requires a two-part test to be applied for adults who are suspected of lacking

[51] Examples drawn from: *Re MB* (n 15); *Re T* (n 12).
[52] Emma Cave and Zenon Stavrinides, *Medical practitioners, Adolescents and Informed Consent Project Final Report* (April 2013, University of Leeds) 17.
[53] Emma Cave, 'Maximisation of Minors' Capacity' (2011) 23(4) *Child and Family Law Quarterly* 431, 447.
[54] As discussed within Chapter III.

competence. The first is that the inability to decide must be caused by 'an impairment of, or a disturbance in the functioning of, the mind or brain.'[55] Secondly, this impairment must render the patient unable to retain, understand and use the information relevant to their decision.[56] Whilst the latter requirement is arguably similar to the *Gillick* test, with both requiring an understanding of the procedure, section 2 lowers the bar from the current common law. Requiring an 'impairment' or 'disturbance' of the mind or brain would make it much harder for judges to find incompetence utilising this test in minors' refusal cases. Although such disturbances can be temporary and need not relate to a permanent condition,[57] immaturity would likely not be enough to satisfy this test. As such, minors would have a much easier time proving competence than under the strict *Gillick* standard.

Nevertheless, there is fear amongst the academic community that extending the MCA test to minors would set the bar for competence far too low.[58] Under the MCA, some feel that most, or at least many more, minors would be seen to be competent where they would fail the *Gillick* test.[59] This is because the test does not consider 'richer notion[s] of autonomy', meaning factors which could affect competence which go beyond mental impairment.[60] This may include familial influence, the sincerity of the beliefs which motivate the decision and so on. Still, this need not mark the MCA as entirely ill-suited as a reform option for minors. Although the MCA takes a fairly narrow view of competence, and does not consider factors beyond an 'impairment' of

[55] MCA s2(1).
[56] MCA s3(1).
[57] MCA s2(2).
[58] Cave and Stavrinides (n 52) 43.
[59] ibid.
[60] Herring and Wall (n 23) 704.

the mind which may in fact impair a minor's decision-making abilities,[61] as has been stated, the inherent jurisdiction could fill these 'gaps' in protection. After all, although by no means a perfect test, extending the MCA to patients of all ages would ensure that we have clarity for minors, one standard for all without compromising on protecting those who truly need it.[62] Nevertheless, once the likelihood of parliamentary change has been assessed, the suitability of this reform option shall be questioned.

The Likelihood of Parliamentary Change

A clear, statutory scheme would allow for a more straightforward picture when it comes to minors' rights to refuse treatment. There would also be no need to wait for a suitable case to arise in order to change the law, in contrast to common law reform. Nevertheless, whilst legislative change may provide greater potential for certainty within this area of law, once more the likelihood of such reform must be assessed. Legislative change must, of course, have the support of Parliament. Judging from the treatment, or perhaps avoidance, of similar issues political will to change the law in this area is lacking.

To return to the example of assisted suicide, Parliamentary consideration of this controversial issue for competent individuals may shed light on the likelihood of success for minors' refusal rights. The judges in *Nicklinson* refused to pressure Parliament to reconsider the law on assisted suicide due to its concurrent consideration of a Bill which would allow 'competent adults who are terminally ill to be provided at their request with specified assistance to end their own life'.[63] Despite autonomy being

[61] Emma Cave, 'Protecting Patients from Their Bad Decisions: Rebalancing Rights, Relationships and Risk' (2017) *Medical Law Review* 1, 16; Emma Cave, 'Goodbye *Gillick*? Identifying and resolving problems with the concept of child competence' (2014) 34(1) *Legal Studies* 103, 120.
[62] Cave and Stavrinides (n 52) 44.
[63] *Nicklinson* (n 31) [190] (Lord Mance); Assisted Dying Bill (n 38).

heralded as the central principle of medical law when it comes to competent adults, Parliament has shown no further interest in amending or repealing the Suicide Act's penalties regarding assisted suicide.[64] If the legislature are unwilling to embrace autonomy for capable *adults* where life-threatening issues arise,[65] it is likely that capable minors have an even bleaker chance when it comes to meaningful reform for their rights to refuse such treatment.

Minors generally have a more protectionist stance lingering over their legal rights, due to the involvement and relevance of issues such as parental rights. According to Montgomery and Alderson, this legislative protectionism can be evidenced within the lack of decisive weight given to children's views within the Children Act 1989. They feel that this shows the lack of political will to grant minors true, meaningful power over their own decisions.[66] Additionally, society at large still attaches a great deal of vulnerability to childhood,[67] which would once more limit the possibility of legislative change. Political pressures mean that public support of minors' rights to refuse treatment may be intrinsically linked to the likelihood of politicians backing such reforms. As such, until more progress is seen for the end of life autonomy of adults, or public support for minors' rights improves, it is unlikely similar autonomy will be granted to minors seeking to refuse life-saving treatment.

Even if the legislative branches were more willing to engage with minors' autonomy rights, it is uncertain that extending the MCA would make much difference for refusing minors. If the presumption of capacity was extended to minors, as discussed above, it *could* mean a greater respect for minors as capable and intelligent individuals.

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[64] Sheila AM McLean, *Autonomy, Consent and the Law* (Routledge Cavendish 2010) 122.
[65] Andrew Bainham, 'Liberal Paternalism in the Courts' (2006) 65(2) *Cambridge Law Journal* 285, 287.
[66] Alderson and Montgomery (n 45) 33.
[67] David Archard, *Children: Rights and Childhood* (Third edition, Routledge 2015) 111.

Nevertheless, as discussed within Chapter III, the judiciary have managed to find ways to 'disprove' competence even where they have the overt power to overrule competent minors. There is no evidence to show that the same tactics would not be employed against minors should the MCA be extended to children in order to rebut the presumption of capacity and allow paternalistic intervention. As such, legislative change is very much intertwined with judicial willingness to embrace the independent rights of minors. If judges wish to find ways to allow their intervention, they have proven on many occasions that they have a plethora of tactics and reasoning in order to do so. Once more, it seems that a shift in attitude towards childhood and minors may be the underlying issue which has prevented reform within this area. Consequently, it would once more appear that although the legislative tools to embrace minors' rights to refuse are within reach for Parliament, the likelihood of such steps being taken is less than promising.

Due to the potential lack of protection for borderline incompetent minors discussed above, it is argued that the extension of the MCA in its entirety to those under the age of 16 would not be the best option for reform. The presumption of capacity has been shown to be a potential pitfall if applied to minors. Additionally, the test for competence would arguably be too easily satisfied even if the presumption was limited to over 16s. Even if the MCA was applied to under 16s, the opposite issue could also arise. The judiciary could manipulate case facts to overcome the lower standards and presumptions enshrined within the MCA. Due to their pivotal role in the potential for applying and prioritising minors' rights, this thesis suggests that despite a poor track record within refusal cases, the judiciary are best suited to lead the way for reform in this area. The hope is that they can embrace this challenge with a focus on human rights, rather than excessive paternalism.

Social Change- A Preliminary Necessity?

A recurring theme throughout this chapter when considering avenues for reform is the absence of will to grant competent minors the right to make their own decisions without interference. Although the tools required to allow competent minors the same rights as adults already exist, nothing has been done to change the law in this area for over two decades. As such, it is suggested that in order for capable minors' rights to refuse to be respected and hold real weight, what is needed first is for society to embrace minors' abilities as equal to that of adults.

Currently, the courts and parents retain a significant amount of control of a minors' health care decisions until they reach 18. Overruling the retreat cases would require adults to allow mature minors independence which goes beyond the boundaries of their supervision and control– a limit on their powers. Judging from the lack of progress in this area, adults are at present 'unwilling' to relinquish their control and protection over minors.[68] In this sense, the duty adults currently feel towards protecting children, regardless of the child's competence, from what is perceived to be harmful must be challenged. Not all mature minors are in need of protection. If a minor is capable of understanding and accepting the consequences of their refusal, is able to satisfy the relevant legal test and is unaffected by significant alternate influences, adults should not be permitted to intervene. Yet, they continue to do so, or at least leave the door open which allows them to do so.[69]

They do so because they disagree with the minors' decisions. For adult patients, agreement with the patient's choice is irrelevant, what is important is their

[68] Carole Smith, 'Children's Rights: Judicial Ambivalence and Social Resistance' (1997) 11 *International Journal of Law, Policy and the Family* 103, 133.
[69] The continued relevance of the retreat cases for example.

competence. Nevertheless, we still appear to assess the rationality of a minor's decision to refuse against our own perception of the 'correct' decision. This asymmetry is evidenced within Lord Donaldson's dicta in *Re R*.[70] Here, he states that allowing a competent minor to refuse without interference would present an 'intolerable dilemma' for doctors.[71] In this, he meant the 'dilemma' of potentially facing charges if they were to treat despite the refusal. This highlights the inherent difference in approaches to adults and children. Despite the same risks of prosecution with adult patients at the time,[72] no such 'dilemma' was seen by Lord Donaldson where a competent adult refuses treatment despite the same risks of prosecution.[73] If an adult refuses treatment, the doctor must obey despite any urges to protect the patient from harm and/or death, and do so without question unless aggravating factors call the decision's validity into question. Nevertheless, this logic is not applied to minors, as society views them as inherently *requiring* such protection despite their levels of maturity or intelligence. This can be traced to the stereotyping of children as illogical beings, and adults as older and therefore wiser.[74] Society assumes that children who refuse life-saving treatment are wrong and that the judges, doctors, or parents are correct; the latter are seen to be more logical and capable due to their advantage in terms of age. These generalisations must be challenged in order for any real progress to be made in the field of children's rights and medical consent law.

Although some progress for minors' rights can be seen within the *Axon* and *Mabon* cases, discussed within the previous chapter, there is still a long road ahead. As seen

[70] *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11.
[71] ibid 24 (Lord Donaldson).
[72] As mentioned within Chapter II, note the impact of s5 MCA which provides some protection to doctors who misinterpret competence.
[73] Elizabeth Lawson, 'Are *Gillick* Rights Under Threat?' (1991) 80 *Childright* 17, 19.
[74] Priscilla Alderson, 'Competent Children? Minors' Consent to Health Care Treatment and Research' (2007) 65 *Social Science and Medicine* 2272, 2276.

even amongst academics who otherwise support autonomy, there is still a reluctance to embrace minors' rights if they make a choice which sits uncomfortably with their paternalistic urges.[75] As a society, we still separate childhood and adulthood in terms of ability. Childhood is generally perceived as a time of inherent vulnerability and dependence on adults, of illogical thinking and immaturity.[76] Although true for some, especially very young children, to apply this dichotomy without nuance to mature minors is somewhat unrealistic.

Not all children are unwise, especially those who have the misfortune of suffering chronic or long-term medical conditions.[77] Such children, Lynn Hagger advocates, would know far more than most adults about their condition, and would possess the ability to understand and consider the positives and negatives of relevant proposed treatment.[78] Equally, many adults cannot be said to be wise, independent nor capable. Consequently, the status and attached stereotypes of 'childhood', as Herring, Probert and Gilmore profess, are no more than 'socially constructed' generalisations.[79] The idea of maturity and 'adulthood' being bestowed upon an individual when they turn 18 is entirely unrealistic.[80] Nevertheless, the incessant, instinctual call of paternalism is proving hard to resist despite evidence that children are intellectually capable of far more than society appears willing to give them credit for.[81]

[75] For example, see: Jane Fortin, 'Children's rights- flattering to deceive?' (2014) 26(1) *Child and Family Law Quarterly* 51, 60.
[76] Alderson, (n 74) 2276.
[77] Lynn Hagger, *The Child as Vulnerable Patient: Protection and Empowerment* (Ashgate 2009) 23.
[78] Alderson (n 74) 2276-78.
[79] Jonathan Herring, Rebecca Probert and Stephen Gilmore, *Great Debates in Family Law* (Second Edition, Palgrave Macmillan 2015) 60.
[80] Andrew Grubb, 'Refusal of Treatment (Child): Competence *Re L (Medical Treatment: Gillick Competency)*', (1999) 7 *Medical Law Review* 58, 60.
[81] Hagger (n 77) 22.

Social prejudices against those legally considered to be children act as a barrier to the sort of progress sought for minors within this thesis.[82] As such, it is suggested that we need to tear down these barriers before the reform suggestions above have any chance of radically improving minors' legal rights. Even if serious changes were made imminently, arguably their practical impact could be dampened without a gradual embrace of minors' abilities and autonomy. As stated by Brems, even if changes are made within the formal legal system, children will find it hard to exercise their rights if social customs and stereotypes still oppose or contradict such rights.[83] Competence is much less likely to be found and accepted if social paradigms still preconceive minors as incapable of true independence until they reach the age of majority. Therefore, this chapter shall conclude by suggesting ways in which this social change could be brought about.

How to Prompt Social Change

Although the need for change in social attitudes has been argued within this section, it is important to note that progress has been, and is still being, made.[84] As seen within the previous chapter, progress for children's rights has come a long way since the introduction of the UNCRC. Additionally, social change can arguably be seen within out-of-court refusal cases. Children have been allowed to refuse life-saving treatment outside of the judicial setting. Two such cases involved minors named Hannah Jones and Joshua McAuley. Jones was 13, and sought to refuse a heart transplant after treatment for leukaemia.[85] Similarly to M's case, she did not wish to live with a life of drugs and preferred to die by her own choice.[86] McAuley, aged 15, refused blood

[82] Archard (n 67) 111.
[83] Brems (n 1).
[84] Mr Justice Cobb, '"Seen but not heard?"' [2015] *Family Law* 144, 144.
[85] Patrick Barkham, 'Hannah's choice' *The Guardian* (12 November 2008) <www.theguardian.com/society/2008/nov/12/health-child-protection> accessed 10 July 2017.
[86] —, 'Transplant refusal girl Hannah Jones backs donors' *BBC News* (20 August 2013) <www.bbc.co.uk/news/uk-england-hereford-worcester-23770583> accessed 10 July 2017.

transfusion after suffering injuries during a car crash. In connection with the *Re E* and *L* cases, he refused treatment due to his Jehovah's Witness faith.[87] However, neither of these minors had to go to court to assert their refusal rights.

The doctors in each case, although at first reluctant, appreciated that the decisions were made with competence and full appreciation of the consequences. Both refusals were accepted without the need for judicial interference. When compared to similar court cases, it can be inferred that the judiciary would not have been as willing to accept the minors' refusals. Whilst Jones later accepted a transplant and survived, McAuley's decision to remain committed to his faith was accepted and lead to his death. Although Joshua's is a sad tale, his and Hannah's choices evidence some degree of ground-level acceptance of the potential for minors to demonstrate competence to make their own decisions, no matter the consequences.[88] The underlying message is that although we may disagree with the decisions of capable minors, the choice is ultimately theirs to make.[89] Paternalistic impulses were quelled, and autonomy prioritised in these cases, providing some hope for the future of children's rights in this area.

It is important to remember that the number of cases which reach the courts is small. The majority of minors refusing treatment will have their discrepancy resolved outside of the court setting. The people making decisions about whether to grant capacity and accept refusals on a daily basis will be medical professionals, not Parliament or the

[87] Laura Roberts, 'Teenage Jehovah's Witness refuses blood transfusion and dies' *The Telegraph* (18 May 2010) <www.telegraph.co.uk/news/health/news/7734480/Teenage-Jehovahs-Witness-refuses-blood-transfusion-and-dies.html> accessed 10 July 2017.
[88] Mary Welstead and Susan Edwards, *Family Law* (Fourth Edition, Oxford University Press 2013) 343.
[89] Sheila AM McLean, 'Whose Decision is it Anyway?' *The BMJ.com* (14 November 2008) <http://blogs.bmj.com/bmj/2008/11/14/sheila-mclean-whose-decision-is-it-anyway/> accessed 21 June 2017.

judiciary. This is why this thesis aims to show that social acceptance of minors' autonomy is likely to have a much bigger impact than legal change alone. Nevertheless, although ground-level decisions will have the most impact, this does not mean that the judiciary has no role to play in the social change which is recommended within this thesis. In fact, they may be the best route for the facilitation of further progress for the amelioration of minors' rights and independence.

The judiciary have the advantage of incremental reform. A fully-fledged, swift overhaul of adults' control leaving minors with complete autonomy, although favourable objectively, may not work without pre-existing social acceptance of such abilities and rights for children. As such, the judiciary could bring in piecemeal reforms which would more delicately introduce greater rights for minors, whilst chipping away at overly paternalistic measures over time. Evidence of the judiciary's ability to impact and reflect social attitudes are seen within *Axon* and *Mabon*.[90] The law has slowly shifted its focus away from medical paternalism towards the autonomy and empowerment of competent patients. Even now, medical law has changed its prominent principle from that of 'doctor knows best' to absolute priority for patient autonomy, expected not only within the law but within society.[91] Nevertheless, minors are still somewhat excluded from this progress. It is suggested that although social change may take time, the judiciary can assist by not only reinforcing the existing progress discussed above, but in increasing the momentum for reform. This chapter

[90] Ananda Hall, 'Children's Rights, Parents' Wishes and the State: The Medical Treatment of Children' [2006] *Family Law* 317, 322.
[91] JJ Chin, 'Doctor-patient Relationship: from Medical Paternalism to Enhanced Autonomy' (2002) 43(3) *Singapore Medical Journal* 152, 152; Janet E Smith, 'The Pre-eminence of Autonomy in Bioethics' in David S Oderberg and Jacqueline A Laing (eds), *Human Lives: Critical Essays on Consequentialist Bioethics* (Palgrave 1997) 183.

shall move on to suggest just how the courts could help assist progress for minors' autonomy rights.

Firstly, rather than extending the MCA to minors, the judiciary could take inspiration from this Act in order to promote autonomy. If a child can be seen to have competence, a duty equivalent to that seen within section 1(3) of the MCA would greatly empower competent children. This would prevent the denial of competence based on missing information, and would also ensure that those with competence can more easily assert that ability in relation to medical decisions. This could be a positive, incremental step in embracing the minors' understanding of information relevant to medical procedures, which would in turn challenge social stigma against minors having such intelligence and abilities.

The law could also be developed in relation to parental rights over their competent, mature children. The law has already adjusted the language of parental rights to one of 'parental responsibility'.[92] This was intended, or so perceived by Andrew Bainham in 1988, to make society rethink the 'parental role' from one of absolute control to one of responsibility for the child's benefit.[93] However, the courts could go even further by emphasising that parents should be seen to have *duties* towards their children within the medical context, rather than powers.[94] A positive first step in this sense could be to follow the lead of New South Wales. Although utilising the same *Gillick* test, in a Commission report New South Wales has professed an intention to remove the rights of parents to veto a child's competently made decision even if that decision involves

[92] Children Act 1989, s2 and s3.
[93] Andrew Bainham, *Children, Parents and the Law* (Sweet and Maxwell 1988) 60-1.
[94] Ian Kennedy, 'Despite Charlie Gard's tragic story, we must respect the process of our courts' *The Guardian* (London, 24 July 2017) <www.theguardian.com/commentisfree/2017/jul/24/charlie-gard-tragic-respect-courts> accessed 31 July 2017.

the refusal of consent.[95] As such, this could be a positive first step in order to reflect and encourage changing attitudes towards children's rights and ameliorate broader social progress. Although removing parental powers of override within this context may still be met with resistance, this should not stop the judiciary from paying real regard to human rights as they are bound to do. As Van Bove has stated, 'the empowerment of the vulnerable […] often meets the resistance of the defenders of the *status quo*'.[96]

The courts would in this instance retain some degree of control of competent minors within their own powers, but make a positive and long overdue step towards the effectual override of the *Re W* principles. In fact, Cave has stated that the reasoning within cases such as *Axon* 'might in future lead the courts in England and Wales to a similar conclusion' as seen within New South Wales.[97] Such reform on behalf of the judiciary would ensure that parental duties remain just that, duties, rather than overtly controlling powers which inhibit a competent child's autonomy. This would ensure a retreat to the intention of *Gillick* as is interpreted by this thesis, or at least the interpretation of *Gillick* which would come when human rights obligations are considered– that the achievement of *Gillick* competence should prevent parental override of the child's decision.

This thesis would prefer that the courts removed all interference with the competently made decisions of a child outright, no matter the consequences. The only power of

[95] New South Wales Law Reform Commission, *Young People and Consent to Heathcare* (Report 119, October 2008) [5.44] <www.lawreform.justice.nsw.gov.au/Documents/report_119.pdf> accessed 17 July 2017.
[96] Theo Van Bove, 'Children's Rights are Human Rights' in Jan CM Willems (ed), *Developmental and Autonomy Rights of Children: Empowering Children, Caregivers and Communities* (Second Edition, Intersentia 2007) 3.
[97] Emma Cave, 'Adolescent consent and confidentiality in the UK' (2009) 16(4) *European Journal of Health Law* 309, 319.

paternalistic intervention which should remain is the inherent jurisdiction, required only to protect those without true autonomy. Paternalistic interference with competent decisions should not extend beyond this limited context. This should be the judiciary's end goal. Nevertheless, it is somewhat unrealistic to expect the courts to give up not only parental control of competent minors, but to limit their own powers in one all-encompassing reform. As such, this thesis has attempted to suggest some more limited reform options with could encompass the first steps taken towards the complete empowerment of competent and mature minors. The courts cannot continue to ignore their duties regarding children's rights. They have duties both domestically and internationally to ensure that the United Kingdom complies with its human rights obligations. To continue to avoid reformation of this area of law is to ameliorate decades of injustice for mature minors. Clarity is long overdue, and the judiciary may be the only ones able to not only reflect society's changing attitudes, but to lead the way to further meaningful change. It will be a long road towards complete empowerment and autonomy for competent minors, but the judiciary ought to ensure that we are at least on the right path.

Chapter VI: Conclusion

This thesis has aimed to prove that the law on minors' refusals of life-saving medical treatment is at present in an entirely unsatisfactory state. Children cannot be sure of their rights, as it is unclear whether there is a scenario where they could ever be granted capacity, regardless of their intellectual maturity or their competence. It has been argued that to eradicate the ability for mature minors to refuse to consent to treatment would leave only an empty right to consent. To have but one choice, the alternative being that another will consent on their behalf, is unacceptable. Indeed, to call such a decision a choice would be a farce. Heywood agrees with such a conclusion, stating that to prevent all refusals by minors merely due to their age would not embrace the 'active role' the law ought to take in the protection of individual rights.[1] Quite the opposite, it would diminish and undermine children's rights. As such, it has been demonstrated that the law is in need of clarification. However, that clarification should not come in the form of further limiting minors' rights to refuse.

The first step which has been suggested by the previous chapter would be to eradicate the ability for parental intervention with their child's competently made decision. It was demonstrated within Chapter II that the *Gillick* case was most likely intended as a qualification on parental rights.[2] This was evidenced within Lord Scarman's judgment as well as the statements made by Lord Fraser. Despite some potential opposition from academics such as Stephen Gilmore regarding the liberal agenda of

[1] Rob Heywood, 'The Right of Terminally Ill Teenagers to make End-of-Life Decisions' (2009) 77(1) *Medico-Legal Journal* 30, 31.
[2] Andrew Bainham, *Children, Parents and the Law* (Sweet and Maxwell 1988) 49.

the *Gillick* judgments,[3] it is argued that even if the case was not as liberally inclined as it has subsequently been interpreted to be upon its conclusion in 1985, this would not prevent a more modern interpretation being taken currently. As was shown within Chapter IV, much has changed regarding the UK's legal landscape since the early 1990s, and even more so since *Gillick*. Human rights, and children's rights, have become much more prevalent regarding the law's focus. As such, many legal issues decided before these changes occurred will be in need of reconsideration and a modern update. As stated within the *Gillick* judgment itself, the law ignores progress and change 'at its peril'.[4] The current judiciary would be equally foolish to ignore the increased prominence of autonomy rights and human rights highlighted within Chapter IV. In light of the inclusion of autonomy rights within Article 8 ECHR,[5] as well as increased emphasis given to children's evolving capabilities within recent judicial dicta in *Axon* and *Mabon*,[6] it is concluded that to allow parental override of the child's competent decision would be unjustifiable and incompatible with human rights obligations. Consequently, the suggestion that the qualification of parental rights should be one of the first steps towards embracing autonomy for minors is seen to be a very suitable option for reform.

Nevertheless, the failings of the law in empowering competent minors is certainly not limited to the scope of parental responsibility. The courts have also held on to their vast powers to override competent children despite the human rights obligations they are tasked with upholding. This thesis has sought to remind the judiciary that they are

[3] Stephen Gilmore, 'The Limits of Parental Responsibility' in Rebecca Probert, Stephen Gilmore and Jonathan Herring (eds), *Responsible Parents and Parental Responsibility* (Hart Publishing 2009) 64 and 75.
[4] *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112, 183 (Lord Scarman).
[5] *Pretty v United Kingdom*, App No (2346/02) (2002) 35 EHRR 1, [61].
[6] *R (Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin), [130] (Silber J); *Mabon v Mabon* [2005] EWCA Civ 634, [28] (Thorpe LJ).

for many a facilitator of rights, tasked not only with protecting the vulnerable but empowering the capable as well. The case law at present shows an unwavering concentration on the former protective role, and a neglect for the empowerment of mature and competent minors. At times, this concentration on paternalism over autonomy has led to dubious and manipulative use or, even more strikingly, ignorance of the relevant law as was evidenced within Chapter III. In fact, this manipulation of the law has been shown to have the potential to do more harm than good. Not only do the judicial tactics explored by this thesis cause unbridled confusion in the requirements for competence and the possibility for minors' capacity, but they demean intelligent, mature individuals by tenuously labelling them as incompetent or mentally impaired.[7]

It has been argued that due to the high standards set by the law, the current protective stance is unnecessary for autonomous, competent children who wish to refuse treatment based on their sincere beliefs and wishes. To interfere with the decisions of minors who are competent and autonomous takes the courts into the realms of excessive paternalism. Rather than focusing on the outcome if intervention was to be withheld, the law should instead shift its focus to 'competent, autonomous choice' rather than 'presumptuous ideals'.[8] The fact that the judge or parent feels that the child is making the 'wrong' decision should not be enough to justify the override of that child's autonomous choice. To impose another's concept of the 'correct' choice on a competent individual would ignore their individual wishes and beliefs, which is something that ought to be respected with the achievement of competence.

[7] Charlotte McCafferty, 'Won't Consent? Can't Consent! Refusal of Medical Treatment' (1999) *Family Law* 335, 336.
[8] Heywood (n 1) 33.

The judiciary have inherently good intentions behind their manipulation of the law, wishing to preserve the life of the minor involved. Nevertheless, this area of law is a prime example of 'do-gooders' doing 'unwanted good'.[9] The child's decision may come from vehemently held religious beliefs, which the judiciary cannot understand as outweighing the value of life.[10] Nevertheless, if competent to do so, the child should be able to base their refusal on whatever genuinely held beliefs they possess. To overrule their beliefs, particularly religious beliefs, can be incredibly distressing and emotionally scarring for the child, and as such unwarranted interference with a competent decision can do more harm than the perceived good.[11] As McLean has stated, if competently made, the choice, although 'uncomfortable' to think that a child could die, is that child's decision and theirs alone.[12]

The retreat cases have been almost exclusively avoided in their most controversial sense, that is, in their authorisation of the override of a competent minor's choice to refuse life-saving treatment. Chapter III demonstrated the lengths the judiciary have gone to in order to avoid such application of the *Re W* judgment. Consequently, it has been argued that the retreat cases ought to be overruled or reinterpreted under the HRA imminently. Chapter II evidenced the questionable nature of Lord Donaldson's reasoning to begin with, and Chapter III demonstrated that even the judiciary are wary to apply these controversial judgments when incompetence can be argued, however tenuously, as an alternative. Chapter IV additionally questioned the continued application of the retreat cases, as they are most likely incompatible with the UK's

[9] Julian Savulescu, 'The Trouble with Do-Gooders: the Example of Suicide' (1997) 23 *Journal of Medical Ethics* 108, 108.
[10] As was the case in *Re E (A Minor) (Wardship: Medical Treatment)* [1993] 1 FLR 386.
[11] Michael Freeman, 'Rethinking *Gillick*' (2005) 13 *International Journal of Children's Rights* 201, 209.
[12] Sheila AM McLean, 'Whose Decision is it Anyway?' *The BMJ.com* (14 November 2008) <http://blogs.bmj.com/bmj/2008/11/14/sheila-mclean-whose-decision-is-it-anyway/> accessed 21 June 2017.

human rights obligations. As such, this thesis finds it difficult to come to any other conclusion than to dispel of these troublesome and excessively paternalistic authorities.

Additionally, this thesis has aimed to show that to overrule the retreat cases would not leave mature minors without protection. The potential for refinement of the court's inherent jurisdiction in a similar way which has been seen for vulnerable adults may provide the safety net of protection needed to prompt the judiciary to abandon the retreat cases. Even if competent, the inherent jurisdiction would ensure that only those capable of truly autonomous choice are granted capacity. As such, the worries which seem to fuel the judiciary's attempts to manipulate *Gillick* and secure the minor's incompetence have been unnecessary. Instead, the judiciary could embrace the child's competence, and instead look towards the child's autonomous capabilities to assess whether it is justified to intervene with the decision. Only if the child cannot exercise their competence in an autonomous manner should intervention be permitted. Competent decisions should not be capable of being overridden as a default option. Rather, this should be the exception to the rule. Competence regarding a decision to refuse treatment should, generally, lead to capacity for mature minors.

Nevertheless, it has been established that the largest hurdle to overcome in order for meaningful reform to occur for mature minors is the social stigma which currently applies to those below the age of majority. As addressed within Chapter V, the idea that minors should be able to exercise the same rights as adults if competent has been difficult to accept. This stigma against minors being capable of competent choice without adult interference has led to legal confusion surrounding minors' refusal rights. As stated above, the judiciary must remember that their role is not purely protectionist, but encompasses the empowerment of those who deserve autonomy. As

such, it has been suggested that the judiciary may be the most suited to the task of addressing and reforming social attitudes towards childhood, breaking down barriers for mature minors and facilitating their rights. This would, eventually, ideally result in the abandonment of the retreat cases.

This thesis has aimed to prove that a child's minority should never be enough to justify the override of a competently made decision.[13] Competence, if teamed with an ability to act autonomously, should lead to the acceptance of capacity for the individual, regardless of age. The dichotomy between childhood and adulthood regarding autonomous and cognitive abilities is largely ill-founded and must be challenged in the context of medical treatment. The current approach of the judiciary in their falsification of, and even disregard for, the *Gillick* test cannot continue. The overrule of the retreat cases is long overdue, and it is time that autonomy was solidly established as the central concept for medical consent law, regardless of age.

[13] Caroline Bridge, 'Religious Beliefs and Teenage Refusal of Medical Treatment' (1999) 62 *Modern Law Review* 585, 589.

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