

Minors' Capacity to Refuse Treatment: A Reply to Gilmore and Herring

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ABSTRACT

Re R and *Re W* allow a parent to consent to treatment a competent minor refuses, but the cases have not been tested post-Human Rights Act 1998. Gilmore and Herring offer a means by which they might be distinguished or sidelined. They interpret *Gillick* to say that in order to consent a minor need only have a full understanding of the particular treatment. They argue that the minors in *Re R* and *Re W* were refusing *all* treatment which requires a separate assessment of capacity— an assessment which was not made. We fear that this distinction would not be workable in clinical practice and argue that their interpretation of *Gillick* is flawed. From a clinician's point of view, competence cannot always be judged in relation to a specific treatment, but instead must relate to the decision. We show that a decision can incorporate more than one treatment, and more than one decision might be made about one treatment. A minor's understanding of a specific treatment is not always sufficient to demonstrate competence to make a decision. The result is that whilst there might be situations when a parent and a minor both have the power to consent to a particular treatment, they will not share concurrent powers in relation to the same decision. Consequently a

challenge to *Re R* and *Re W*, if forthcoming, would need to take a different form. We emphasise the necessity to minimise the dichotomy between legal consent and how consent works in medical practice.

INTRODUCTION

Though the decisions in *Re R (A Minor) (Wardship: Consent to Medical Treatment)*¹ and *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)*² are nearly 20 years old, they remain leading authorities. They result in a much criticised³ asymmetry between consent and refusals. A minor might be competent to consent but cannot necessarily refuse treatment. In Scotland, though there has not been a case specifically on the issue it is likely that the right to accept treatment encompasses a right to refuse it.⁴ In Ireland, a draft Health (Children and Consent to Health Care Treatment) Bill was published in 2011. In England and Wales, a test case is possible given that Department of Health guidance in 2009 advises doctors to approach the courts because the law has not been tested post Human Rights Act 1998.⁵ Article 8 of the European Convention on Human Rights protects the right to respect for private and family life.⁶ Increased significance of children's rights in the European Court of

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¹ [1991] 4 All ER 177. Hereafter *Re R*.

² [1992] 4 All ER 627. Hereafter *Re W*.

³ See S Gilmore, J Herring, 'No' is the Hardest Word: Consent and Children's Autonomy (2011) 23 Child and Family Law Quarterly 3.

⁴ S Elliston, *The Best Interests of the Child in Healthcare* (Routledge Cavendish, 2007) p 112.

⁵ Department of Health, *Reference Guide to Consent for Examination or Treatment*, 2nd ed (2009) Ch 3, para 15. 'The courts have, in the past, also found that parents can consent to their competent child being treated even where the child/young person is refusing treatment. However, there is no post-Human Rights Act 1998 authority for this proposition, and it would therefore be prudent to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child.'

⁶ Though see JK Mason, GT Laurie, *Mason and McCall Smith's Law and Medical Ethics*, (8th Edn. OUP, 2011), p 74 who argue that: 'The English courts have made a concerted effort to demonstrate their desire to find the balance in these cases and there is little in the jurisprudence of the European Court of Human Rights that would lead them to upset that delicate equilibrium.'

Human Rights will translate to greater emphasis on individual autonomy.⁷ Indeed, Gilmore and Herring's reappraisal of *Re R* and *Re W* is justified by reference to evolving conceptions of and responses to 'children's autonomy interests'.⁸

There are various explanations for the asymmetry between consent and refusals. One is that, whilst consent is likely to be in the minor's best interests, a refusal may not be and therefore there are valid reasons for overruling a competent refusal.⁹ This aspect of the debate is beyond the remit of this paper. Another is that different levels of competence may apply to each. Gilmore and Herring offer one potential explanation for why this might be so and why it might be justifiable. In order to structure our engagement with their analysis of the cases and suggestions for distinguishing between refusal to consent and refusal of treatment, it is useful to summarise their main points.

I. A BRIEF SUMMARY OF GILMORE AND HERRING'S MAIN POINTS

Gilmore and Herring revisit *Re R* and *Re W* and offer a partial defence for Lord Donaldson's view that power to consent can be held by a parent and child at the same time. In so doing, they suggest that the criticisms of his judgments may stem from a failure to distinguish between what the law requires of a minor to be able to give effective consent to treatment on the one hand and on the other hand, to act autonomously in refusing treatment. There are problems with this distinction which we will return to later. Their argument rests on formulating different conceptions of 'no consent', suggesting that it is unhelpful to regard refusal of all treatment as simply the opposite of consent. These conceptions include a refusal

⁷ See *R (Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin) and R Taylor, 'Reversing the Retreat from Gillick? *R (Axon) v Secretary of State for Health*' (2007) 19(1) *Child and Family Law Quarterly* 81 arguing that *Axon* might lead to a challenge of *Re R* and *Re W*.

⁸ Gilmore and Herring, above, n 3, 6.

⁹ See for example N Lowe, S Juss, 'Medical Treatment – Pragmatism and the Search for Principle' (1993) 56 *Modern Law Review* 865.

of a *particular* treatment as distinct from a refusal of *all* treatment. According to their first conception, when the minor refuses a particular treatment, it may be appropriate to treat the refusal of consent as merely the opposite of consent and to assume that the level of capacity required is the same. The second conception, they argue, involves the minor making ‘a conscious decision to incur the consequences of a total failure to treat’.¹⁰ Gilmore and Herring illustrate their distinction with an example:

Imagine a 15-year-old girl who suffers from heart failure and is offered a heart transplant. She might ‘not consent’ in either of the ways we have identified. She might say ‘I don’t want the heart transplant offered’ (a rejection of the proposed treatment). The girl might, however, add ‘but I might consent to other treatment for my condition’. As this illustrates, a refusal of consent to a particular proposal does not necessarily imply refusal of all treatment. By contrast, illustrating our second category, the child might say ‘I don’t want a heart transplant and, in fact, I don’t want any treatment. I understand the consequences: leave me alone to die’.¹¹

They do accept that in some instances there will only be one course of treatment available to the minor, so either decision will lead to the same end. In these types of cases the usefulness of their distinction breaks down, as the minor faced with consent to or refusal of the only life-saving treatment available will have to turn her mind to all the consequences associated with their second conception of ‘no consent’. However, they suggest that according to their definitions, refusal of consent to a particular treatment or other and refusal of all treatment *sometimes* require different levels of capacity.

¹⁰ Gilmore and Herring, above, n 3, 7.

¹¹ Ibid. 8.

Their point here is illuminating as they elucidate the ways in which a minor is required to turn her mind ‘in very different directions’ where there is a refusal of consent to all treatment as opposed to situations when there is more than one treatment available.¹² Thus, in the case of a minor refusing a particular treatment, she will only need to consider whether or not to consent to the proposed treatment. When the case involves the refusal of all treatment, the question is rather whether or not the minor has the capacity to understand the full consequences of a refusal of all treatment. They argue that an assessment that a minor has capacity to consent to or refuse a particular treatment should not readily lead to a conclusion that a minor also has the capacity to refuse all treatment, because the range of factors involved are different and more complex in the latter instance and the minor may not have addressed the significant matters.¹³ Additionally, Gilmore and Herring suggest that the doctor may only have told the minor about the proposed treatment and that therefore she would be uninformed about the full range of options and also of the consequences of refusing all treatment.¹⁴

Such an interpretation of the law leads Gilmore and Herring to accept Lord Donaldson’s proposition that parents and minors can provide ‘concurrent consent’,¹⁵ insofar as the minor and parent might share power to consent to treatment if the minor is competent to consent to or refuse a specific treatment but lacks the capacity required to refuse all treatment. However they do not agree that parents or the court should have the power to veto a competent refusal; they do not support Lord Donaldson’s *obiter* assertions that the court or the young person’s

¹² Ibid.

¹³ We return to this point later in the paper as we suggest that there are inherent problems with their analysis.

¹⁴ This approach raises questions about professional and ethical practices which we address later when discussing the duty of health care professionals to inform adolescents about their treatment options.

¹⁵ A definition we challenge later in the paper.

parents might consent even if the minor makes a competent refusal.¹⁶ Once the higher hurdle of capacity has been leaped by the adolescent, their decision should be respected.¹⁷

Later in their paper, Gilmore and Herring justify the retention of concurrent parental powers of consent by drawing upon three theoretical concepts of autonomy. They suggest that there is a distinction between strong and weak autonomy which should be attributed with varying degrees of respect. Those decisions which are ‘richly autonomous’ should be respected; they are ‘made with a full understanding of the consequences’. Those which are constructed as weakly autonomous, as a ‘whim or casual preference’ are also worthy of respect but they do not, according to Gilmore and Herring, deserve the same level of respect. In legal terms, the suggestion is that a weak notion of autonomy is insufficient to amount to a legally effective refusal of treatment.¹⁸ Acknowledging the individualistic nature of the discussion of autonomy and capacity, Gilmore and Herring continue by expounding a relational approach to autonomy which is more contextual in that it stresses the relational nature of decision-making. Their point is that both parents and children have interests in the treatment choices and that all the professionals involved should listen closely to what is being said by all the parties. However, as will be discussed later in the paper, there are problems with the way Gilmore and Herring conceptualise autonomy in terms of weak or strong autonomy and (in our view mistakenly) leaving ‘ideal desire autonomy’ out of the analysis. As we make clear later, it is our view that constructing autonomy in the rather dualistic fashion of strong/weak in the context of life threatening medical conditions is somewhat unreal, as it is unlikely that

¹⁶ *Re W* at [84] per Lord Donaldson: ‘No minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court.’

¹⁷ Gilmore and Herring, above n 3, 25: ‘Where the child does have the capacity to refuse all treatment then he or she should be treated in the same way as adults’. This implies that neither parents nor the courts should overrule a competent refusal. Elsewhere more limited rights are advocated. See p 15: ‘If the child does have the capacity to refuse all treatment then *her parents* should not be able to override her refusal’. (Our italics).

¹⁸ *Ibid*, 21-22.

adolescents will approach treatment refusal in a casual fashion. Additionally, the discussion of relational rights and strong autonomy sit uncomfortably together.

II. GIVING CONSENT VS REFUSING TREATMENT

There is some ambiguity as to whether Gilmore and Herring are drawing a distinction between consenting and refusing, as well as between consenting / refusing particular treatment and refusing all treatment. The first part of the paper makes a clear distinction between different conceptions of 'no consent'. The 15 year old girl in their example has different powers depending on whether she 'not consents' by rejecting the treatment, or by refusing all treatment. They suggest that parents and minors potentially have concurrent powers to consent in two circumstances; (1) when the minor refuses all treatment;¹⁹ and (2) when she refuses to make a decision.²⁰ The implication is that a minor capable of consenting will also be capable of refusing the specific treatment, provided that refusal does not constitute a refusal of all treatment:

It does not necessarily follow from the fact that a child has capacity to consent (and corresponding capacity to decline consent) to certain specific treatment that he or she will have capacity to refuse all treatment. ... So a child may have the capacity to consent to treatment X, but not to refuse all treatment. ... [I]t is possible *in the circumstances identified* above for parent and child to hold powers of consent concurrently and it may be important for them to do so.²¹

¹⁹ Ibid, 7.

²⁰ Ibid, 8.

²¹ Ibid, 8.

Confusingly, the distinction between different kinds of ‘no’ is absent from the penultimate section, in which they provide ‘ethical support for distinguishing between consent and refusal’. Nevertheless, we presume (in particular from their emphatic ‘*in the circumstances identified above*’ in the above quotation) that they do not advocate a general distinction between consent and refusals;²² but that their ‘ethical support for the distinction between consent and refusal’ refers to only one sort of refusal– the refusal of all treatment.

As noted above, they argue that, according to the case law, there is potentially a difference in the capacity required to consent to and refuse particular treatment, and the capacity required to refuse all treatment. We have three problems with this conception. First we disagree with their interpretation of the understanding required of a competent minor in *Gillick*. Second, we argue that Gilmore and Herring place too little prominence on the minor’s understanding of what will happen if a minor exercises the ‘corresponding capacity to decline consent’.²³ Third, whilst we agree that a retrospective analysis of a minor’s decision might sometimes indicate that a minor lacked capacity to make the decision, we do not agree that a treatment-centred conception of competence is appropriate or even feasible in practice.

A. Understanding

Gilmore and Herring question whether *Gillick v. West Norfolk and Wisbech Area Health Authority*²⁴ requires a minor to fully understand the effects of a refusal of all treatment in order to consent to it and conclude, rightly we think, that it does not. Where we differ is in relation to the general proposition they build from this - that an understanding of the implications of a refusal of consent is only needed if the minor refuses treatment. We will

²² As is implied in the final third of the paper which examines the ‘ethical support for distinguishing between consent and refusal’. See Gilmore and Herring, above, n 3, 19-25.

²³ *Ibid*, 8.

²⁴ [1986] AC 112.

show that there are cases where a minor will lack the competence to consent unless she understands the implications of refusal. We do not accept their formulation of the understanding required in *Gillick*. They argue that it requires ‘merely an understanding of that which is proposed by way of treatment’.²⁵ On this conception, in order to be considered competent to consent, the 15 year old in their example needs only to understand the treatment being proposed, rather than the alternatives to it and the risks of not having one treatment when compared with another.

Lord Fraser does indeed require that the minor is capable of ‘understanding what is proposed’.²⁶ This might involve a mere technical understanding, for example where an incision will be made, what will be removed, how long it will hurt. Alternatively, it might involve a deeper understanding such as why treatment is necessary; why it is better than the alternatives; and what health benefits will follow. We submit that the *dicta* in *Gillick* leans towards the second interpretation. Lord Scarman requires the minor to ‘understand fully what is proposed’²⁷ and Lord Fraser lists the moral and emotional aspects of contraception and abortion which must be fully understood in addition to the technical aspects of the proposed treatments.²⁸ Gilmore and Herring list these criteria to demonstrate that minors would not automatically be required to consider a refusal of treatment in order to be found competent to consent. We will later explain our partial agreement with this statement to the extent that in some contexts (including the *Gillick* context), capacity is not dependent on understanding the implications of refusing all treatment. We readily accept that a broad understanding of the treatment was all that was required in *Gillick*. *Gillick* concerned minor patients seeking sexual advice and treatment from the doctor in a situation where the minor ‘is very likely to

²⁵ Gilmore and Herring, above, n 3, p 10.

²⁶ [1986] AC 112, [169].

²⁷ [1986] AC 112, [253].

²⁸ [1986] AC 112, [189D].

begin or to continue having sexual intercourse with or without contraceptive treatment'.²⁹ Refusal was not a relevant consideration in this case and consequently the Law Lords could not be expected to contemplate it as part of the test for understanding.

What we believe Lord Fraser's criteria to demonstrate is that wider contextual issues are relevant to the consideration of the minor's understanding. In the context of sexual advice and treatment, competence does not flow from a mere clinical understanding of which contraceptive device provides the best protection against pregnancy, but also requires a deeper understanding of factors such as 'the emotional impact of pregnancy'. If the same level and depth of understanding is applied in an altogether different context (say, for example, a minor who is considering risky but potentially life-saving surgery), the emotional understanding might well incorporate an understanding of the relative advantages and disadvantages of no treatment at all. Gilmore and Herring construe Lord Fraser's requirement that the minor understand what is proposed as relating purely to treatment, because this is what it related to in *Gillick*. We argue that the examples of deeper, emotional understanding provided by Lord Fraser point to a more context-laden definition of understanding.

B. Understanding the Effects of Declining Consent

Gilmore and Herring rely on the distinction between rejection of proposed treatment and refusal of [all] treatment to mount a partial defence of *Re R* and *Re W*. To use their example of the 15 year old girl, she might be capable of consenting (or declining to consent) to particular treatment but not necessarily be capable of refusing all treatment, in which case there will be concurrent powers to consent to treatment.

²⁹ [1986] AC 112, [174] per Lord Fraser.

Alasdair Maclean accepts ‘the essential asymmetry between consent to treatment and refusal of treatment’.³⁰ Maclean distinguishes between giving and declining consent on the one hand, and vetoing treatment on the other, arguing that the latter may be more risk laden and therefore attract a higher standard of competence. This higher standard is justifiable, he submits, on the basis that *Gillick* only sanctions treatment that is in the best interests of the child. Maclean argues that parental power to consent is required where the risk of refusal justifies a higher standard of competence, implying that a competent veto should be respected.³¹

Gilmore and Herring cite Maclean’s article to support aspects of their argument, but seemingly put forward an alternative basis for the asymmetry. Rather than contrasting the decision to consent or decline consent and the decision to veto a treatment, they contrast consenting to or rejecting a particular treatment and refusing all treatment. They say of the latter, ‘It is not merely the patient’s wish to *decline particular treatment*, but a decision to refuse all treatment’.³² For them, rejecting the proposed treatment is not simply declining to consent, it is refusing the particular treatment. This is also implied by their example of a 15 year old girl:

³⁰ A Maclean, ‘Keyholders and Flak Jackets: The Method in the Madness of Mixed Metaphors’ (2008) 3 *Clinical Ethics* 121, 121.

³¹ ‘The parents’ power, therefore, is still required, but only where the risk of the decision to refuse consent is sufficiently high to justify a more demanding standard of competence for that refusal to operate as a veto.’ *Ibid*, 124-125.

³² Gilmore and Herring, above, n 3, 7 (our emphasis).

She might say ‘I don’t want the heart transplant offered’ (a rejection of the proposed treatment). The girl might, however, add ‘but I might consent to other treatment for my condition’.³³

The obvious interpretation is that what Maclean would term vetoing the treatment (thereby accepting that a higher threshold for competence might apply), Gilmore and Herring would (provided the minor is willing to accept an alternative treatment) term a ‘rejection of the proposed treatment’ which is accorded the same level of competence as a decision to accept the treatment.

This is problematic because it is not clear that *W* was refusing all treatment.³⁴ In addition, there is *dicta* suggesting that the asymmetry in *Re R* and *Re W* lies purely in Lord Donaldson’s *obiter* statements that a competent refusal can be overridden by the court or a parent (an aspect of the judgments with which Gilmore and Herring disagree). Gilmore and Herring’s distinction between rejection of proposed treatment and refusal of treatment assumes that the minor is competent to reject proposed treatment (as part of his or her competence to consent to treatment), but not necessarily competent to reject all treatment. But Lord Donaldson speaks of *W* being unable to refuse *any* treatment (including specific treatment) for her anorexia nervosa³⁵ and *R*’s fluctuating lucidity arguably affected her ability

³³ *Ibid*, 8.

³⁴ *Re W* per Lord Donaldson, [79]: ‘*W* is not in fact refusing all treatment. Her attitude is that she wishes to continue with the treatment which she was receiving when the hearing of this appeal began.’ And see [89].

³⁵ *Re W* [80-81]. Lord Donaldson views the anorexia nervosa itself as preventing her from making a competent refusal. His Lordship questions Thorpe J’s assessment of *W*’s competence: ‘... I do doubt whether Thorpe J was right to conclude that *W* was of sufficient understanding to make an informed decision. ... What distinguishes *W* from [competent minors], and what with all respect I do not think that Thorpe J took sufficiently into account (perhaps because the point did not emerge as clearly before him as it did before us), is that it is a feature of anorexia nervosa that it is capable of destroying the ability to make an informed choice. It creates a compulsion to refuse treatment or only to accept treatment which is likely to be ineffective.’

to refuse any treatment.³⁶ If R and W lacked competence to refuse the particular treatment then, given that competence encompasses the ability to consent to and decline particular treatment, the incompetence to decline it would presumably rule out competence to consent to it.

This assumes that Gilmore and Herring require that in order to have capacity to consent, the minor must demonstrate understanding of both the proposed treatment and the implications of declining that treatment (in favour of an alternative). Yet they give examples which emphasise understanding of consent rather than also requiring the minor to comprehend what will happen if consent (in relation to a particular treatment) is declined. For example, they argue that a minor who has capacity to consent to having a plaster on his bleeding knee need not understand the possible consequences of not having a plaster.³⁷ This example seems to blur the distinction between a refusal of a particular treatment and a refusal of all treatment. They argue that the minor need not understand ‘the nature of septicaemia as a possible consequence of not having the plaster’.³⁸ Clearly this is true, but, in the unlikely event that a minor’s capacity to consent to a sticking plaster were formally assessed, Gilmore and Herring’s distinction between declining consent and refusing all treatment would imply that the minor’s capacity to consent to the plaster also extends to him refusing the plaster (though not refusing the administration of all treatment - for example the minor might accept antiseptic cream). If declining consent requires understanding over and above the understanding required to consent to treatment, it is implicit that the minor understands what

³⁶ Today section 3(3) of the Mental Capacity Act 2005 (which applies to over 16s) recognises that fluctuating capacity need not render a patient incapable of making a decision, but the Department of Health, above, n 5, para 8 recommends: ‘In some cases, for example because of a mental disorder, a child’s mental state may fluctuate significantly, so that on some occasions the child appears *Gillick* competent in respect of a particular decision and on other occasions does not. In cases such as these, careful consideration should be given as to whether the child is truly *Gillick* competent at the time that they need to take a relevant decision.’

³⁷ Gilmore and Herring, above n 3, 11.

³⁸ *Ibid*, 11.

the plaster is for and what it seeks to prevent – in other words, he understands what will happen if he rejects the plaster in favour of an alternative. To be clear, we are not advocating an interpretation of *Gillick* which insists on minors understanding the obverse of treatment in order to consent to it. As will be seen, we recommend a more context-driven approach. We do feel that Gilmore and Herring's interpretation of *Gillick* combined with their distinction between rejecting proposed treatment and refusing all treatment leads to a tension if the *Gillick* competent minor is not required to understand the implications of declining consent (in favour of an alternative treatment).

In light of this, an alternative interpretation is that Gilmore and Herring perceive the 'obverse to treatment', which they define as 'a rejection of the proposed treatment',³⁹ to be devoid of content (in other words, no specific understanding of what will happen if consent is declined is needed in order to consent to treatment). From this position, two outcomes would be possible:

1. The minor consents to a treatment (which may have meant rejecting an alternative)
2. The minor refuses all treatment

'Declining consent' would not constitute a relevant outcome. If there is only one available treatment then declining consent is refusing all treatment. If there is another option then either the minor chooses it or refuses all treatment. But as we shall see, this conception is of limited practical application, because rejecting treatment in favour of an alternative requires understanding of the relative merits of the alternatives. It does not simply require an understanding of a particular treatment.

³⁹ Ibid, 8.

C. *Treatment- or Decision-Specific Test?*

We question Gilmore and Herrings' firm division between consenting to and declining particular treatment and refusing all treatment and their interpretation of the 'full understanding' required in *Gillick*, rejecting their focus on a particular treatment and proposing a more contextual focus on the minor's understanding of the choice she has to make. On this definition the minor might, in some situations, need to understand the implications of refusal of all treatment in order to consent to treatment. As we will further explore in the next section, context, rather than a distinction between conceptions of 'no consent' would reflect the required level of understanding. In the clinical context, competence should reflect the minor's actual understanding of the decision she is called upon to make at the time she makes it. The more complex and life-restricting the treatment options are, the greater the demands are upon the minor to demonstrate capacity. Much depends on the manner and extent to which information is provided to the minor. Where possible doctors should maximise a minors' capacity by presenting information in a sensitive, timely and appropriate form, but this in turn is affected by the minor's potential to understand, the attitude of his parents and the nature of his illness which might restrict the time available for deliberation.⁴⁰

The inevitable decision-specific nature of *Gillick* competence can be explained by comparing it with adult consent. A doctor treating an *adult* patient will be guilty of a battery if he touches the patient without consent. Consent has three elements: there must be capacity, understanding and voluntariness. Capacity refers to capability to understand and is presumed. Definitions are provided in the Mental Capacity Act 2005. Understanding is conceived as

⁴⁰ See further E Cave, 'Maximisation of Minors' Capacity' (2011) 23(4) Child and Family Law Quarterly 431.

necessitating the provision of information to make a decision. Only a broad understanding is required. If these elements are satisfied, there is a 'real consent'. If inadequate information is provided and the patient suffers harm, then the doctor might be liable in negligence. The *Gillick* competent minor must also have the capability to decide, broad information and voluntariness, but the minor must prove capacity. This makes for a very different test. In relation to the minor, capacity concerns not only capability to understand but actual understanding of the specific issues in question. There is no presumption of capacity, therefore, it must be demonstrated in relation to the information given. From the court's perspective, the minor has made her decision and accepted a treatment or rejected all treatment, as Gilmore and Herring suggest. For clinicians, a test which focuses on a particular treatment is flawed. Instead capacity is frequently judged in relation to the minor's ability to evaluate a range of options which might involve consideration of and choosing between a range of complex treatments with varying levels of effectiveness and impact upon life-enhancing opportunities or, conversely, might relate to only one treatment which may be easier or more difficult to understand than any one of a range of treatment options. The minor may need to turn her mind in very different directions in a wider range of situations than those envisaged by Gilmore and Herring when differentiating consent and refusal of all treatment.

Gillick itself is ambiguous on the treatment/decision point. Lord Scarman stated that a minor would be considered competent when s/he '[a]chieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.⁴¹ Elsewhere the dicta refers both to treatment⁴² and the decision.⁴³ The ambiguity is unsurprising given that the

⁴¹ [1986] AC 112, [253].

⁴² For example, [189-190], Lord Scarman quotes Lord Nathan with approval: 'I feel that the law on this point is well expressed in the volume on *Medical Negligence* (1957), by Lord Nathan, p 176: 'It is suggested that the most satisfactory solution of the problem is to rule that an infant who is capable of appreciating fully the nature

House of Lords was contemplating consent requirements in relation to a specific type of treatment. The third legal proposition formulated by Mrs Gillick was:

a girl below the age of 16 is not capable in law of giving a valid consent to medical treatment and in the particular context of this case to contraceptive or abortion treatment.⁴⁴

Lord Scarman calls this the ‘age of consent’ point and it amalgamates the general and the context-specific; the issues relating to the contraception and abortion and more general medical decisions a minor might be called upon to make. In terms of how the ambiguity should be resolved, professional guidance favours a decision-specific test for competence. For example, the GMC recognises that the decision is frequently about weighing options rather than whether or not to consent to a given treatment:

The capacity to consent depends more on young people’s ability to understand and weigh up options than on age. ...⁴⁵

The courts are, necessarily, viewing the decision with the benefit of hindsight and are therefore more likely to assess competence in relation to the specific treatment and the outcome of their decision. There has been criticism of some of the refusals cases which have

and consequences of a particular operation or of particular treatment can give an effective consent thereto, and in such cases the consent of the guardian is unnecessary; but that where the infant is without that capacity, any apparent consent by him or her will be a nullity, the sole right to consent being vested in the guardian.’

⁴³ For example, Lord Scarman says at [188]: ‘a minor’s capacity to make his or her own decision depends upon the minor having sufficient understanding and intelligence to make the decision.’ And Lord Fraser says at [169]: ‘Provided the patient, whether a boy or a girl, is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises.’ The emphasis is on understanding what is proposed.

⁴⁴ [1986] AC 112, [177] per Lord Scarman.

⁴⁵ GMC, *0-18 Guidance for all Doctors* (2007), para 25.

demanded a level of understanding which is higher than that required of adults and arguably impossible to achieve.⁴⁶ Harris argues that where the threshold for competence is raised whenever the minor refuses treatment, the right of a competent minor to consent becomes nothing more than ‘a right to acquiesce in a decision which has already been taken’.⁴⁷ Some academics have proposed a different test. Brazier and Bridge recommend a functional approach, whereby competence is a matter of choosing and deciding as well as understanding. Indeed, the functional decision-specific test is embraced in the Mental Capacity Act 2005.⁴⁸ Gilmore and Herring accept that the principles contained in the Mental Capacity Act 2005 might have wider application,⁴⁹ in which case in order to consent, the minor must understand ‘the likely effects of deciding one way or another, or making no decision at all’.⁵⁰ However, it might not apply, in which case their conception of full understanding as an understanding of the proposed treatment is a potential interpretation of what *Gillick* requires. However this conception works best when the assessment of competence is made in light of the outcome.

A consequence of adopting, as we propose, a decision-centred interpretation of *Gillick* competence is that it can lead to concurrent powers to consent to the same treatment. This is because there can be more than one decision about the same treatment and potentially more than one treatment encompassed in the same decision. An example of the latter is this: a minor consenting to a heart transplant must also consider the drug therapy required throughout her life to prevent her body from rejecting the heart. If competent she may later have the right to refuse that treatment, but her capacity to understand the necessity of the drug

⁴⁶ See for example A Bainham, ‘The Judge and the Competent Minor’ (1992) 108 *Law Quarterly Review* 194, 200.

⁴⁷ J Harris, ‘Consent and End of Life Decisions’ (2003) 29 *Journal of Medical Ethics* 10, 12.

⁴⁸ Mental Capacity Act 2005, ss2 and 3.

⁴⁹ Gilmore and Herring, above, n 3, 12.

⁵⁰ Department of Constitutional Affairs, *Mental Capacity Act Code of Practice* (TSO, London 2007), para 4.16.

therapy is judged when making the decision concerning the original heart transplant. The counter-argument might be raised that the heart surgery and drug therapy form one treatment. But whilst both treatments relate to the same condition, the processes relating to each are likely to be different. They will be administered by different doctors. The drug therapy is unlikely to be referred to on the consent form for surgery. Still, the patient's understanding of one treatment might be required in order for them to understand and thus to establish competence in relation to the other. For some surgical procedures, the surgeon might require a demonstration of understanding of the necessity of post-operative drug compliance in the form of pre-operative compliance.

There are a number of ways in which it might be necessary in practice for different decisions (with potentially varying levels of capacity) to be taken about the same treatment. Provided we are right and capacity is specific to the decision (rather than the treatment), the minor might be able to consent to one issue but unable to consent to another. One obvious way in which this can occur is when a factor changes which requires a reassessment of capacity. For example, a minor is thought to have sufficient understanding of the implications of having or not having a kidney transplant and the viable alternatives, but then she suffers a set-back in health which renders the transplant a more risk-laden prospect. It may be that a new assessment of competence will lead doctors to conclude that the minor is no longer competent to consent to the treatment and that the minor should be presented with updated information which she may or may not fully understand. For this reason, the GMC advises:

The capacity to consent can also be affected by their physical and emotional development and by changes in their health and treatment.⁵¹

⁵¹ GMC, *0-18 Guidance for all Doctors* (2007), para 26.

Another way there might be multiple decisions about the same treatment is in relation to separate aspects of law. For example, a minor may be owed a duty of privacy and confidentiality in relation to decisions about her treatment and be competent to make decisions in relation to treatment disclosure, but lack the competence to give consent to the treatment.⁵² Of course, a breach of confidentiality might be warranted so as to ensure that the parent has the requisite information to consent on the minor's behalf, but our point here is that there may be circumstances where confidentiality and consent in relation to the same treatment are viewed as different decisions.

A third way in which there might be more than one decision about the same treatment, is where the minor chooses something which the doctor did not contemplate when assessing the minor's capacity. If the minor makes a choice about which she has not received advice and information from the doctor, it might be necessary to make a separate assessment of capacity to make the new decision. Gilmore and Herring's example of a minor opting for 'no treatment' might fall into this category, but we refute the idea that she will inevitably do so whenever she rejects all treatment. It is the fact that the clinician did not contemplate this option when assessing competence which is important, not the fact that the minor has opted for 'no treatment'. We argue that in some contexts, clinicians can be expected to explore 'no treatment' as one of the minor's options.

Nor is this category limited to 'no treatment'. It might also apply if a minor rejects optimal treatment (as constructed by the health care professionals and the parents) in favour of an inferior treatment (for example, she rejects a kidney transplant in favour of homeopathic

⁵² See J Loughrey, 'Can You Keep a Secret?' (2008) 20(3) *Child and Family Law Quarterly* 312; and see E Cave, 'Adolescent Consent and Confidentiality in the UK' (2009) 16(4) *European Journal of Healthcare Law* 309.

therapy)⁵³ or makes a competent consent and later imposes conditions on consent which affect the viability of treatment (for example a minor consents to a heart transplant but then insists on having it after Christmas by which time her heart is likely to have failed).

In practice, clinicians must assess capacity in relation to the decision rather than each potential treatment, in which case his or her assessment of competence may cover more than one treatment and potentially also a refusal of all treatment. In the next section we show why it is important that a decision-specific interpretation of *Gillick* is adopted, in particular because different treatment options cannot always be viewed in isolation.

III. PROFESSIONAL / ETHICAL PRACTICE

In practice, there are a range of options in between accepting or rejecting the specific treatment and rejecting all treatment. In essence our problem with the distinction between ‘a rejection of proposed treatment’ and ‘a refusal of all treatment’ is that, empirically, many treatment decisions do not fall neatly within these boundaries. We appreciate that in practice minors might be called upon simply to decide whether or not to have treatment, but as frequently they may be given options and alternatives and asked to choose between them. On Gilmore and Herring’s interpretation, it is difficult to understand when and how far alternatives to treatment must be assimilated and understood by the minor.

Gilmore and Herring interpret the law to require competence to be assessed in relation to the particular treatment, whereas we interpret it to require a broader, decision-specific test. To consent to treatment they argue that the law requires of the minor ‘merely an understanding

⁵³ Or consider the example of Abraham Cherrix in the USA who chose herbal remedies over chemotherapy, explored in Cave, above, n 40.

of that which is proposed by way of treatment'.⁵⁴ As we have seen, Gilmore and Herring illustrate their distinction with an example in which a 15 year old girl refuses a heart transplant and adds 'but I might consent to other treatment for my condition'. Gilmore and Herring argue that this can be distinguished from a refusal of all treatment because 1) there might be a difference in capacity between the two and 2) the two decisions 'each requires the patient to direct his or her mind in very different directions, and thus to answer very different questions'.⁵⁵ But the applicability of these assertions depends on whether the alternative treatment is as efficacious as the optimal treatment. If the 15 year old in heart failure chooses drug therapy, for example, which let us say may keep her alive for six months, then drug therapy, just like 'no treatment at all' involves very different risks to heart transplant. A new assessment of capacity might be as much a requirement where the minor opts for drug therapy in preference to heart transplant, as it would be if she were to opt for no treatment at all. In short, Herring and Gilmore's justifications for distinguishing between a refusal of consent and a refusal of treatment can also apply to a refusal of treatment in favour of an alternative. The less efficacious the alternative treatment is, the narrower the distinction between alternative treatment and no treatment at all.

Alternatively, their argument might be understood in the following way: the doctor will explain relevant alternatives but when viewed retrospectively, the decision to consent to any one of those alternatives is only judged to constitute a battery if the minor did not have a full understanding of that particular treatment. We do not support this conception. If a minor's choice is between options A and B then she should understand A and B in order to choose between them. The choices are co-dependent and it would be artificial to assign different levels of competence to each potential outcome. The ethical obligation of the healthcare

⁵⁴ Gilmore and Herring, above, n 3, 10.

⁵⁵ Ibid, 8.

professional is to ensure that the adolescent understands the relevant range of options. Consider the following interpretation of Gilmore and Herrings' argument, which differentiates between the full understanding required of the chosen treatment and a partial understanding of other options to the extent that they enable the minor to fully understand the chosen treatment:

Clinicians decide that a girl is competent to consent to a heart transplant because she fully understands what the treatment involves and broadly understands the alternatives. If she consents, the fact that she did not *fully* understand the alternatives or the consequences of a complete failure to treat, will not lead to the clinician being liable in battery.

If she refuses the heart transplant and chooses an alternative, namely drug therapy, then to consent to it she must fully understand the implications of drug therapy and broadly understand the alternatives. If she does not fully understand the implications of drug therapy then her parent can consent on her behalf.

If the decision is viewed retrospectively then the girl either consented to one of the treatments (in which case she must have the requisite understanding of that treatment), or refused treatment (in which case Gilmore and Herring argue she needs to understand the implications of refusal). But the clinician does not have the benefit of hindsight. He must assess competence to make the relevant decision. In the example, the clinician has determined that the minor has enough of an understanding of what a heart transplant involves to refuse it in favour of an alternative which she broadly understands is less efficacious than heart transplant. But what if the minor's failure to understand the implications of drug therapy flow

from her lack of understanding of the limitations it will place on her life, or of the likely manner of her death in a short space of time? Could the parent consent to the heart transplant even though the minor is competent to refuse the operation in favour of an alternative?

In practice, separating understanding of the heart transplant and drug therapy is artificial and unworkable. From the clinician's perspective, competence tends to be assessed in relation to the decision rather than individual treatments. This decision might legitimately include whether or not to continue treatment. Although a great deal of responsibility is placed with the doctor, our proposal need not lead to the minor having to understand all treatment options or what it means to refuse all treatment in every case, because the range of choices in each case is context dependent. Whilst clinicians will assess competence in relation to the decision the minor is required to make, the role of the courts is to consider whether the clinician's assessment of competence was correct. They may decide that the medical assessment is erroneous, in which case the court will substitute its own assessment. Alternatively, they might decide that the minor's decision falls outside the assessment of his competence, in which case a new assessment of capacity is called for. Once competence is established, the court must decide whether to overrule the minor's competent decision in her best interests.

The difficulty with our interpretation is that it places a large amount of discretion in the hands of doctors in relation to what information to provide the minor and how much of that information the doctor will require the minor to fully understand in order to make a competent consent to treatment. The discretion might be limited by detailed professional guidance based on the principles of good practice which include (inter alia) the following: consent is decision-specific; the minor must fully understand all the options required to make the decision; doctors should maximise the minor's capacity to decide; and there may be

circumstances where more than one decision can be made about the same course of treatment, in which case the minor might be competent to make one decision but lack competence to decide another.

One possible criterion by which to limit the discretion of doctors might be to adapt Bodey J's concept of 'proximate medical issues'. In *A Local Authority v Mrs A*,⁵⁶ Bodey J was called upon to decide whether a vulnerable adult had capacity to decide whether or not to have contraceptive treatment. The Mental Capacity Act 2005 demands that the adult can understand the 'reasonably foreseeable consequences of deciding one way or another.'⁵⁷ The Local Authority argued that Mrs A must be able to appreciate the social context (in particular the effects of bearing and potentially having to give up a child to care). Ignoring the social context, it argued, would require 'considering capacity "in a vacuum" which would be "artificial and unrealistic"'.⁵⁸ The alternative (and preferred) argument was that this test would set the bar too high and be unworkable in practice.⁵⁹ Bodey J concluded:

So in my judgment, the test for capacity should be so applied as to ascertain the woman's ability to understand and weigh up the immediate medical issues surrounding contraceptive treatment ("the proximate medical issues" — per Mr O'Brien), including:

- (i) the reason for contraception and what it does (which includes the likelihood of pregnancy if it is not in use during sexual intercourse);
- (ii) the types available and how each is used;
- (iii) the advantages and disadvantages of each type;

⁵⁶ [2010] EWHC 1549 (Fam).

⁵⁷ Mental Capacity Act 2005, s. 3(4).

⁵⁸ [2010] EWHC 1549 (Fam), at [56].

⁵⁹ *Ibid*, at [56] and [60].

- (iv) the possible side-effects of each and how they can be dealt with;
- (v) how easily each type can be changed; and
- (vi) the generally accepted effectiveness of each.⁶⁰

Mrs A was capable of understanding the ‘proximate medical issues’ and therefore could decide whether or not to have contraceptive treatment. Gilmore and Herring cite this case to support their argument that doctors need not ensure that minors understand the implications of a failure to treat.⁶¹ But imagine that in *A Local Authority v Mrs A* there was a *medical* consequence of refusing a particular type of contraception. If, for example, there was medical evidence that pregnancy could be fatal to Mrs A, ‘the reason for contraception and what it does’ would take on new meaning. Thus, Bodey J states:

I emphasise that this is not one of those cases where there are felt to be risks to physical or mental health through pregnancy, childbirth, or the removal of a child. There is nothing before me to suggest that Mrs A suffered thus when she had her two children. If she had, then different factors and a different balance of proportionality would be under consideration.⁶²

Bodey J argued that those who believed Mrs A’s capacity should be assessed on the basis of her understanding of wider social issues ‘... have transgressed section 1(4) [of the Mental Capacity Act 2005] by treating Mrs A as lacking capacity, because they think that she is making an “unwise” decision in refusing contraception, a decision which they regard as not

⁶⁰ Ibid, at [64].

⁶¹ Gilmore and Herring, above, n 3, 11.

⁶² [2010] EWHC 1549 (Fam), [75].

being in her best interests...'⁶³ and that to apply the wider test would 'risk a move away from personal autonomy in the direction of social engineering.'⁶⁴

Even if the principles of the Mental Capacity Act applied to under 16 year olds and even if the objective test for capacity and a firmer dividing line between best interests and capacity applied (and we have already considered reasons for and against), then it would be rare indeed that the consequences of refusing medical treatment could not be said to constitute 'proximate medical issues'. This is especially so when there is only one treatment and refusal will have grave implications for the health of the minor, or alternative treatments are considerably less efficacious than the optimal treatment. The requirement that the clinicians assess a minor's understanding of the decision in relation to 'proximate medical issues' might help to prevent the manipulation of the test for capacity to suit paternalistic ends, but we see no reason why it would or should lead to clinicians limiting their assessment of the minor's understanding to the proposed treatment rather than the consequences of refusal.

Significant discretion necessarily will remain in the hands of doctors specifically, because consent does not operate on a 'one size fits all' basis. It is inevitably subject to bias, and context-dependent. Whilst these features might be viewed as weaknesses they can also be strengths. The concept is dependent not only on the minor's age, experience and the clinical setting but also on her relationships with others. In conclusion, in order to consent to treatment, a minor might need to understand one or all of the following:

- A specific treatment and not having that treatment
- A range of alternative treatments and their respective risks and benefits

⁶³ Ibid, [62].

⁶⁴ Ibid, [63].

- The risks and benefits of having no treatment at all.

The doctor must make a judgement about which to include. In some circumstances, the minor will need to demonstrate all three types of understanding in order to be able to consent to a specific treatment. For example, a minor nearing the end of life might be asked to consider one or more treatment options, or (if they are high-risk with a low likelihood of benefit) no treatment at all. We do not consider it desirable to have a general rule stipulating that some or all of these issues must always be understood by the minor in order for her to be able to consent to treatment. To insist that the minor understands all three would raise the threshold for consent to a potentially unattainable level. To insist that they only need attain the first level of understanding would reduce consent to a tick box exercise of limited meaning to the individual patient and limited workability for the clinician.

IV. RESPECTING AUTONOMY – THE THEORETICAL ARGUMENTS

If we are correct that a clinician must assess competence in relation to the decision rather than the treatment; and that examples of a minor being competent to consent to treatment but not to refuse it are limited to those situations where more than one decision is made about the same treatment, then consent in such situations is not truly concurrent - the minor has the power to make one decision and the parent the power to make a different one. If so, then the coincidence that a parent can provide consent where a refusal falls outside the ambit of the minor's decision is not based on differing levels of autonomy attached to consent and refusals. Nevertheless, we have expressed practical concerns about Gilmore and Herrings' distinction between different types of consent and in this section we turn to their discussion of the ethical arguments which might support a distinction between the legal principles governing consent and refusal.

Central to Gilmore and Herring's discussion is the observation that much of the criticism of Lord Donaldson's judgment stems from the failure to distinguish between what the law requires of a minor to provide a valid consent, to 'act autonomously in refusing treatment', and to decline consent (leaving open the possibility of override).⁶⁵ The distinction is interesting for the way that Gilmore and Herring conceptualise a refusal, but not necessarily the provision of consent as an autonomous act. It might be argued that their distinction is misconceived as the provision of consent *may* be as much an act of autonomy as the refusal is. What matters to both the valid consent and the refusal is the quality of the decision and that the threshold for capacity is set against each decision as we outline further below. Consent and refusal can both be autonomous decisions if all the necessary conditions are fulfilled. However, we think that the obliteration of autonomy from the discussion of the minor's decision to provide consent is symptomatic of the way that a child's medical interests come to be constructed as entirely within the health care professional's remit. To a great extent the minor's choices about treatment options are framed by healthcare professionals in the first place and the attitudes and approach of healthcare professionals is fundamental to facilitating autonomous decision-making. The clinician is charged with assessing the minor's competence in respect of the decisions being made about the range of treatments they have forwarded. The healthcare professional therefore holds much power.

The minor's consent to the proposed treatment might be based upon one of the three conceptions of autonomy which are drawn upon by Gilmore and Herring from the work of John Coggon.⁶⁶ Coggon's first conception of autonomy is '*ideal desire autonomy*' and is

⁶⁵ Gilmore and Herring, above, n 3, p 5.

⁶⁶ J Coggon, 'Varied and Principled Understandings of Autonomy in English Law: Justifiable Inconsistency or Blinkered Moralism?' (2007) 15 Health Care Analysis 235.

defined as reflecting what a person *should* want as adjudicated by reference to ‘purportedly universal or objective standard of values’.⁶⁷ The second form ‘*best desire autonomy*’ is defined by Gilmore and Herring (appropriating Coggon’s definition) as leading to an action decided upon because it reflects a person’s overall desire given his inherent values, even if this runs counter to immediate desire. The third form is ‘*current desire autonomy*’. According to Gilmore and Herring *best desire autonomy* is the strongest form as it involves the patient in reflecting upon the range of options to reach a decision which encompasses her or his inherent values, even if the decision conflicts with the person’s immediate desires. Current desire autonomy is the weaker form of autonomy as it relies on a person’s immediate inclinations which do not include any reflection.⁶⁸ When a minor consents to the treatment proposed by health care professionals who are presumed to be acting in their best interests (as measured against accepted standards), then that decision may not be subjected to much scrutiny (unless the parent challenges the consent) because she is reaching a decision based upon ideal desire autonomy, reflecting what the patient should want as assessed against universal standards. In other words, the assessment of whether or not a minor is providing consent on the basis of best desire autonomy will be adjudicated against the ideal desire standard. There is a greater link between these two forms of autonomy that remains unexplored by Gilmore and Herring in respect of refusals. Indeed, they do very little with ideal desire autonomy, perhaps because Coggon suggests it is relevant when a patient cannot exercise one of the other two of the three forms.⁶⁹ In other words, where a patient is permanently without capacity or because she has temporarily lost capacity but we cannot ascertain what they would want. As discussed above, Bodey J.’s warning about the risks of moving away from personal autonomy towards a test which necessitates an appreciation of the wider social issues highlights one of the central problems of relying solely on ideal desire

⁶⁷ Ibid, 240.

⁶⁸ Ibid.

⁶⁹ J Coggon, *ibid* i.e. *Best desire autonomy* and *current desire autonomy*.

autonomy which draws upon purportedly universal objective standards. We argue however, that ideal desire autonomy is also influential over the test for child competence when looking specifically at the context in which the decision arises. Indeed, Coggon himself explains that if a person acts in a way that is incompatible with ideal desire autonomy then that person may well find it very difficult to establish autonomy as this form requires ‘responsible decision-making.’⁷⁰ The influence of ideal desire autonomy is present in the case law, where minors are ‘questionably’ deemed incompetent where respecting a refusal would almost certainly lead to death.⁷¹

Gilmore and Herring maintain that because decisions may restrict the way that the minor is able to live her life in the future, not all autonomous decisions should be allocated the same level of respect. It is suggested that a distinction between strong and weak autonomy be made. Those decisions which are ‘richly autonomous’ should be respected; they are ‘made with a full understanding of the consequences’. Those which are constructed as weakly autonomous, as a ‘whim’ or ‘casual preference’ are also worthy of respect but they do not, according to Gilmore and Herring, deserve the same level of respect. In legal terms, the suggestion is that a weak notion of autonomy is insufficient to amount to a legally effective refusal of treatment. Gilmore and Herring suggest that if minors’ refusals are ‘typically weakly autonomous’, that might explain why they are sufficient for consent, but do not justify non-treatment.⁷² In the most serious contexts where the decision to consent or refuse to consent to a particular treatment may have serious and lasting implications, it is highly unlikely that minors will reach their decisions lightly. For example, in the case of our minor with a heart condition, the optimal treatment would be a heart transplant. The minor has been

⁷⁰ Ibid, 241.

⁷¹ Ibid, 244.

⁷² Gilmore and Herring, above, n 3, 22.

treated for the heart condition over a number of years and has undergone many procedures to prolong her life in the hope that a suitable donor will be found. According to the values of the medical profession, her parents and also the best interests standard (ideal desire autonomy), the responsible decision may be viewed to consent to the surgery. However, the minor's decision is not necessarily based solely on her assessment of the prognosis and her ability to exercise future autonomy, it will also be based upon her past experiences of corrective surgeries which are invasive, involve extensive rehabilitation periods and drug therapies. She reaches the decision to refuse surgery according to best desire autonomy and accepts a less 'good' treatment of palliative care. To construct autonomy rather simplistically as strong or weak in the context of life threatening medical conditions is somewhat unreal, as it is unlikely that minors will approach treatment refusal in a casual fashion. What does become clear however, is the influence that ideal desire autonomy has had and may have in refusal cases where refusal will inevitably result in death. Gilmore and Herring rather neglect the significance of ideal desire autonomy and they also ignore Coggon's warnings about using the equivocal nature of autonomy as a means for judges to impose their own moral judgments on the legitimacy of the minor's decision which might have been reached as a result of best desire autonomy. One of the problems with the welfare principle is that it allows for the mapping of the judge's own values or those which he views as of the wider community, including the medical profession, on top of, and overriding the best desire autonomy of the minor. In other words, in the most serious contexts, ideal desire autonomy might be employed to overwhelm best desire autonomy. One of the difficulties for minors arises when parents object to the minor's decision to refuse consent to treatment to prolong life. In such situations there is a real danger that the minor's best desire autonomy risks being overwhelmed, especially if the healthcare professionals and the parents agree. Coggon suggests, rightly in our view, that a minor who withholds consent will have the greatest

chance of exercising best desire autonomy when she has the empathy of the judge. This can be extended to both the parents and healthcare professionals. Where that is lacking the patient may face an indifferent or even punitive understanding of autonomy, with ideal desire autonomy being employed instead of best desire autonomy because of its link with best interests.

Acknowledging the individualistic nature of the discussion of autonomy and capacity, Gilmore and Herring continue by expounding an alternative relational approach to autonomy which is more contextual in that it stresses the relational nature of decision-making. Their point is that both parents and minors have interests in the treatment choices and that all the professionals involved should listen closely to what is being said by all the parties. However, the discussion of relational rights and strong autonomy sit uncomfortably together. Gilmore and Herring suggest that there is a danger, particularly in serious medical conditions, of ignoring parental interests in whether the minor receives treatment or not. These are defined as ‘relational rights’.⁷³ We have much sympathy for the acknowledgement of the relationship between parents’ and minors’ interests in treatment and refusal and understand that ‘careful attention to the individual relationships concerned and the responsibilities that arise from them’ must be given.⁷⁴ However, there are drawbacks to this approach too.

To return to our example of the heart patient; she has reached the decision to refuse another heart surgery to prolong her life having exercised best desire autonomy, which might include (though not necessarily) a consideration of how her decision may affect her parent. In this example, the parent is a single father as a result of his wife’s (the mother’s) death several years earlier. The father has since dedicated his entire life to caring for the child and loves the

⁷³ Ibid, 23.

⁷⁴ Ibid, 24 referring to J Bridgeman, *Parents, Young Children and Healthcare Law* (CUP, Cambridge 2008).

child with all his heart. The minor knows this and has indeed fully considered the devastating effect that her death will have on her father. She had wanted to refuse life-prolonging treatments on previous occasions, but had reluctantly consented to protect her father from the pain of her death. Her need to protect her father has been experienced as somewhat of a burden, albeit one stemming from the greatest love and appreciation for all her father has done for her. However, she has now reached a decision having full appreciation of the past and of the consequences of her death. Although the relationship between carers and patients is important, there are dangers in privileging those of the carer over those of children. Whilst Gilmore and Herring say that no deference will be given to one view or the other, they acknowledge that Lord Donaldson's approach which gives weight to the doctor being guided by ethical constraint when choosing to act on parental consent rather than on that of the minor, does indeed allow for potential misuse by healthcare professionals. When a minor reaches her decision by exercising best desire autonomy, it is difficult to see why parental consent should be able to override it.

CONCLUSION

Gilmore and Herring build their argument in the following way. The understanding required in order for a minor to consent to or decline a particular treatment is different to the understanding required to refuse all treatment. For a minor to be viewed competent to consent, *Gillick* requires 'merely an understanding of that which is proposed by way of treatment'.⁷⁵ Therefore, the competence required to consent to or decline a particular treatment may be different to the competence required to refuse all treatment. As a result, the minor and her parent might have concurrent powers to consent even though the minor is

⁷⁵ Gilmore and Herring, above, n 3, 10.

incompetent to refuse all treatment. *Re R* and *Re W* might be sidelined on the basis that the court should have tested R and W's understanding of a total refusal of treatment.

Whilst we accept that the understanding required in order to be competent to consent to treatment will not always be the same as the understanding required to be considered competent to refuse it, we offer a different interpretation of *Gillick* to that accepted by Gilmore and Herring. We argue that *Gillick* requires the minor to fully understand the implications of her *decision*, which might involve more than one treatment. Equally, there might be more than one decision about the same treatment. This leads us to conclude that the distinction between consenting to or declining a particular treatment and refusing all treatment is unhelpful. Whilst it might explain aspects of *Re R* and *Re W* and enable them to be sidelined, adoption of Gilmore and Herring's interpretation of *Gillick* would make for an unworkable test for competence from the perspective of clinicians. As the test for competence must be viable in both the courts and in clinical practice, a different means of explaining the perceived asymmetry between consent to treatment and refusal of treatment should be sought. Were a wider, more context-driven interpretation of the understanding required in *Gillick* to be adopted by the courts and medical practice, doctors would assess a minor's understanding of the *decision* rather than the treatment. Where cessation of treatment is clinically indicated or the minor states it as a preference, she will be required to demonstrate understanding of both having and not having the treatment in order to choose between these options. Where such a case comes before the court, the judges might ask; 'Does this minor have the requisite understanding of the implications of refusal?'. The court might find that the minor lacks the requisite understanding, even if it accepts that the same minor would have been competent to choose between the treatment and an alternative of equivalent efficacy. There would be no 'asymmetry' because either capacity to consent to treatment will denote capacity to refuse

treatment, or the consent to refuse can be seen as a separate decision to the decision to consent.

In the event that a minor is viewed competent to refuse treatment, another legal dilemma is whether or not the court or the minor's parents should have the power to overrule the competent refusal in the minor's best interests. The parental right to veto the minor's competent decision is relatively weak.⁷⁶ The court's jurisdiction is stronger. The difficulty in distinguishing between richly autonomous decisions and undue influence provides one reason for retaining it. Jane Fortin has given other valid reasons, based on the application of the Human Rights Act and respective case law.⁷⁷ We leave this debate for another time.

⁷⁶ R Taylor, 'Reversing the Retreat from Gillick? R (Axon) v Secretary of State for Health' (2007) 19(1) *Child and Family Law Quarterly* 81.

⁷⁷ J Fortin, 'The *Gillick* Decision - Not Just a High Water Mark', in S Gilmore, J Herring, R Probert (eds) *Landmark Cases in Family Law*, (Hart Publications, Oxford 2011).