

Adolescent Consent and Confidentiality in the UK

Emma Cave*

Keywords:

Consent, confidentiality, privacy, children, *Gillick*, *Axon*.

Abstract:

In *R (Axon) v Secretary of State for Health* the Gillick competence test was confirmed. Commitment to childhood autonomy and privacy rights caused renewed academic criticism of the ‘refusal’ cases. This paper considers the form any changes to the law may take, and the potential consequences for the rights of parents and young people. Silber J.’s contention that parental Article 8 rights cease when the child makes a competent decision is potentially problematic if applied to refusal cases, especially in the context of the distinction between competence to consent to treatment and to the disclosure of information.

Adolescent Consent and Confidentiality in the UK

Emma Cave*

A. Introduction

The interest theory and the will theory of rights inform debate as to the moral rights of children. Adolescents, who seek to have their choices respected to the extent that they impose obligations on others to treat or to withhold treatment or disclosure of information, may rely, as younger children may not, on the will theory. The interest theory too may be called upon to protect their moral rights, provided it can be shown that having the right will make them better-off. Translating moral rights into law, international guidance suggests a minimal level of protection. The UN Convention on the Rights of the Child 1989, which is ratified by the UK (though it has no legal force) requires that: ‘Article 12: 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 view of the child being given due weight in accordance with the age and maturity of the child.’ Signatories to the Council of Europe’s European Convention on Human Rights and Biomedicine¹ must abide by article 6, which leaves each country to define when a minor is viewed as competent to give a valid consent, but insists that for those viewed in law as not capable of providing consent, the treatment must directly benefit the minor; the authorisation of a legal representative is obtained and; ‘the opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of

*School of Law, University of Leeds.

Thanks to my colleagues, Julie Wallbank and Joan Loughrey for their comments on an earlier draft. Any remaining errors are mine.

¹ Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Oviedo, 4.IV.1997.

maturity'². Across Europe, most countries, whether or not they are signatories of the Convention (which England and Wales are not), abide by these requirements.

Beyond this, children's rights are vaguely constituted. This is, in part, a result of conflict between children's rights to autonomy and their right to protection. Archard,³ for example, suggests that there are rights shared by adults and children, but also rights exclusive to each, including elements of the right to protection. Eekelaar⁴ talks of the importance of basic interests (relating to children's physical and emotional well-being) and developmental interests (in reaching their potential) over their autonomy interests (in personal choice). Bridgeman argues that it is not always appropriate to address legal dilemmas involving children through 'abstract, objective determination and prioritisation of conflicting rights of the individuals involved'.⁵ Emphasis on relational autonomy has championed the importance of familial relationships over individual rights.⁶

In England and Wales, the clash between rights- and welfare-based principles seems most profound in light of the enactment of the Human Rights Act 1998 which applies to all, regardless of age. It incorporates the European Convention of the Protection of Human Rights and Fundamental Freedoms 1950 (the European Convention on Human Rights) into English law. The Convention is a living document and the initial adult focus is broadening to also encompass children's rights. But not only do children's individual rights potentially conflict with one another. Their rights may also clash with rights held by their parents. Whilst both parent and child may

² European Convention on Human Rights and Biomedicine, Article 6(2).

³ Archard, D.W., *Children, Family and the State*, Surrey: Ashgate, 2003, 4.

⁴ Eekelaar, J., "The Emergence of Children's Rights", *Oxford Journal of Legal Studies* 6 (2) (1986), 161.

⁵ Bridgeman, J. *Parental Responsibility, Young Children and Healthcare Law*, Cambridge: Cambridge University Press, 2007, 21.

⁶ Herring, J., "Relational Autonomy and Family Law" in: J. Wallbank, S. Choudhry, J. Herring (eds.) *Rights, Gender and Family Law*, London: Routledge-Cavendish, 2009, chapter 12.

claim protection for their personal choices under Article 8(1), the flexibility of Article 8(2) allows domestic courts to protect the best interests of the child, though, as Fortin points out,⁷ the prevalent analysis is of the child's interests being subsumed within their welfare rather than them having independent claims under Article 8(1).

Consequently, when it comes to defining which decisions are competent, and the rights afforded to adolescents at that time, there is substantial divergence across Europe. Many countries adopt a status-based approach, but it is arbitrarily applied. Some countries insist that minors cannot consent until the age of 18,⁸ whilst others fix a lower age of 'medical majority' - 15 in Denmark and Slovenia, and 16 in Spain⁹. In England and Wales, minors aged 16 and over can consent to medical treatment under section 8 (1) of the Family Law Reform Act 1969¹⁰ and in *Gillick v. West Norfolk and Wisbech Area Health Authority*¹¹ the House of Lords rejected a common law status-based test¹² and held that children under the age of 16 could consent provided they understand the nature and consequences of the proposed treatment and can retain, use and weigh the information.¹³ However, the case of *Gillick* left open a number of issues. First it left unclear the extent to which parents have rights to consent on their

⁷ Fortin, J. *Children's Rights and the Developing Law*, Cambridge: Cambridge University Press, 2003, 57.

⁸ Art 87(3) Health Act, Bulgaria: Goffin, T., D. Zimovieva, P. Borry, K. Dierickx, H. Nys, "Patient Rights in the EU – Bulgaria." *European Ethical-Legal Papers N°8*, Leuven, 2007, 24. Retrieved 29 July 2009.

http://www.eurogentest.org/patient/info/public/unit4/ethical_legal_papers.xhtml#legal_8;

Article 13 (3) of the Patient Rights Act: Goffin, T., et al., "Patient Rights in the EU – Cyprus", *European Ethical-Legal Papers N°10*, Leuven, 2007, 16. Retrieved 29 July 2009.

http://www.eurogentest.org/patient/info/public/unit4/ethical_legal_papers.xhtml#legal_8.

⁹ Stultiens, L., T. Goffin, P. Borry, K. Dierickx, H. Nys, "Minors and Informed Consent: A Comparative Approach" *European Journal of Health Law*, 14 (2007), 21, p.39.

¹⁰ Family Law Reform Act 1969, s 8 (1) 'The consent of a minor who has attained the age of 16 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.'

¹¹ [1986] AC 112.

¹² *Ibid.*, 171, per Lord Fraser.

¹³ *Gillick, ibid*, 188-189 per Lord Scarman: 'It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law.'

child's behalf, and to information about their child's treatment. Lord Fraser considered that parental rights gradually dwindle, whilst Lord Scarman stated: '...parental rights yield to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.'¹⁴

Silber J.'s high court judgment in *R (Axon) v Secretary of State for Health*¹⁵ (hereafter *Axon*) lends support to Lord Scarman's approach, but how far will it be taken? Adult rights to give informed consent to treatment have recently been given additional prominence by the House of Lords in order to protect privacy and autonomy rights.¹⁶ Whilst *Axon* is only a first instance decision, it may, together with the European Court of Human Rights jurisprudence Silber J. calls upon, herald increased protection for the rights to privacy and autonomy of competent minors in England and Wales.

Second it was left open whether or not *Gillick* applies to refusals of treatment. Does the ban on parents vetoing their child's consent extend to their being unable to provide a valid consent to medical treatment the minor refuses? Subsequent cases drew a distinction between competent children's rights to consent and their right to withhold it, but, as we shall see, these cases resulted in extensive academic criticism. Taylor has suggested that, post-*Axon*, the refusal cases which retreat from the autonomy principle laid down in *Gillick* might be challenged.¹⁷ If the step is taken to deny parents a right to consent to treatment their competent child has refused, will

¹⁴ *Gillick, ibid.*, 186.

¹⁵ [2006] EWHC 37 (Admin).

¹⁶ *Chester v Afshar* [2004] UKHL 41, at 24, per Lord Steyn, 'I have come to the conclusion that, as a result of the surgeon's failure to warn the patient, [Miss Chester] cannot be said to have given informed consent to the surgery in the full legal sense. Her right of autonomy and dignity can and ought to be vindicated by a narrow and modest departure from traditional causation principles.'

¹⁷ Taylor, R., "Reversing the retreat from *Gillick*? *R (Axon) v Secretary of State for Health*" *Child and Family Law Quarterly*, 19 (1) (2007), 81.

parents also lose the right to information about the minor's treatment? The Gillick competence test is decision-specific and the threshold for competence to consent to or refuse treatment may be set higher than the threshold for competence to consent to or refuse disclosure to a parent. Will parents retain a right to information even if they lose the right to consent to treatment their child has refused? A related issue concerns the application of the best interests test. In *Gillick* it was a condition that the treatment consented to by the minor was in her best interests. If *Gillick* is applied to refusals, at what level will the best interest test apply? Will health care professionals be called upon to decide whether the treatment or refusal is in the best interests of the child? Or will this assessment be left to the competent minor? Will the courts retain a power to overrule decisions in the best interest of the minor under its *parens patriae* jurisdiction?

Third, the test for competence is unclear. Whilst Lord Fraser set out a list of conditions specific to sexual advice and treatment,¹⁸ Lord Scarman required a full understanding of the treatment proposed – a high and flexible threshold. What is clear, is that there is a higher threshold for competence for minors under the age of 16, than for those of 16 and over which fall within the presumption of capacity in the Mental Capacity Act 2005.¹⁹ Post *Axon*, Rachael Taylor questions whether, in an era of greater respect for the autonomy of young persons, this aspect of *Gillick* might also be challenged.²⁰

The following sections explore each of these three issues in turn.

¹⁸ *Gillick*, *supra* n. 11, 174: '(1) that the girl (although under 16 years of age) will understand his advice; (2) that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice; (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.'

¹⁹ Mental Capacity Act 2005, s. 1(2) 'A person must be assumed to have capacity unless it is established that he lacks capacity.'

²⁰ Taylor, R., *supra*, n. 17.

B. Can parents veto their child's consent?

Ms. Axon challenged Best Practice Guidance promulgated by the Department of Health which recommended that competent children under the age of 16 could be given confidential advice and treatment on sexual matters.²¹ Her claim was rejected. *Axon* confirms *Gillick* post Human Rights Act 1998 - it reiterates that parents cannot veto informed consent provided by a competent minor. The controversial aspect of the judgment lies in the human rights analysis, for Silber J. states that the rights of the parent under Article 8(1) are extinguished²² once the minor's decision is *Gillick* competent.

Parental responsibility is defined in section 3(1) of Children Act 1989 as including 'all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property'. Parental responsibility is normally held by the legal parents or carers, who will be called upon to consent to medical treatment on behalf of incompetent minors. But in the context of medical treatment, their power is limited. The duty of care owed by the holder of parental responsibility is to act in the best interests of the child. The medical team will seek the views of the child (where he is old enough to hold views) which will be relevant to their assessment of his best interests.²³ Where the holders of parental responsibility and the medical team disagree as to the child's best interests, the court may resolve the dispute by making an order under section 8 of the Children Act 1989, or by making the child a ward of court under Part III of the Children Act. The court has a

²¹ Department of Health, *Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People under Sixteen on Contraception, Sexual and Reproductive Health*, London: Department of Health, 2004.

²² *Axon*, *supra*, n. 15, 132.

²³ General Medical Council, *0-18: Guidance for all Doctors*, London: GMC, 2007, para 12(a).

power of *parens patriae* under which decisions will be governed by the paramountcy principle whenever the child's upbringing is determined by the court.²⁴

In *Axon*, Silber J. was primarily concerned with Ms. Axon's parental rights. Article 8(1) of the European Convention on Human Rights provides that 'Everyone has the right to respect for his private and family life, his home and his correspondence'. There have been a number of excellent articles questioning the compliance of the paramountcy principle with the European Court of Human Rights' interpretation of Article 8(1).²⁵ The *paramountcy* of children's welfare, as opposed to primacy (which supposes a balancing of parental and child rights and interests),²⁶ is a challengeable concept. Silber J. did not engage in this debate and took a narrow reading of the ECtHR jurisprudence.²⁷ For example, Silber J. considered that the 1988 decision of *Nielsen v Denmark*,²⁸ in which a parent was said to have the power to impose hospitalisation on her twelve-year-old son under Article 8(1), was 'not relevant to the present application'.²⁹ Silber J. also relied upon the domestic case of *Mabon v Mabon*³⁰ in which three boys were given a right to separate representation in their parents' contact dispute. It was held that the paternalistic welfare considerations conflicted with the mature minors' autonomy rights.

²⁴ Children Act 1989, s. 1(1) 'When a court determines any question with respect to- (a) the upbringing of a child; or (b) the administration of a child's property or the application of any income arising from it, the child's welfare shall be the court's paramount consideration.' Treatment decisions relate to upbringing which is defined in s. 105 as 'the care of the child but not his maintenance'.

²⁵ For example, Choudhry, S., H. Fenwick, "Taking the Rights of Parents and Children Seriously: Confronting the Welfare Principle under the Human Rights Act" *Oxford Journal of Legal Studies* 25 (2005), 253.

²⁶ *Ibid.*

²⁷ See Hall, A., "Children's Rights, Parents' Wishes and the State: The Medical Treatment of Children" *Family Law* 36 (2006), 317.

²⁸ (1988) 11 EHRR 175.

²⁹ *Axon*, *supra* n. 15, [126]. Silber J. reasoned that *Neilsen* was brought under Article 5 and not Article 8.

³⁰ [2005] EWCA Civ. 634. Discussed in Fortin, J., "Children's Rights – Substance or Spin?" *Family Law* 36 (2006), 757.

Since *Gillick* a shift has occurred in which the autonomy rights of competent minors have been given increased recognition.³¹ For Silber J., parental rights under Article 8(1) to veto medical treatment decisions made by their child dwindle until the child has capacity to make his own decisions, at which point they disappear altogether. Silber J.'s judgment envisaged the child having not just the right to a voice, but the right, if competent, to be the only relevant voice.

This interpretation generated criticism. Taylor suggests that it is the parental right to *authority* that dwindles and terminates rather than all parental rights to family life (which do not necessarily involve a right to control).³² Hall³³ and Fortin³⁴ question why rights under Article 8(1) should be extinguished, as opposed to trumped, by the minor attaining rights under Article 8(1). As we shall see in a later section, when combined with the common law duty of confidentiality, Silber J.'s argument that parental rights cease when the child becomes maximally autonomous might result not only in parents losing their powers to veto treatment, but also in their losing a right to information about their child's treatment, should the child request that the information is kept secret. Silber J. went on to consider the position 'if I am wrong and the 2004 Guidance interferes with a parent's article 8(1) rights'.³⁵ In that case the interference with the parental rights under Article 8(1) would be justified under Article 8(2):

Article 8(2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of

³¹ Perera, A., "The State of Children's Consent in the UK" *European Journal of Health Law* 15 (4) (2008), 411.

³² Taylor, R., *supra*, n.17.

³³ Hall, A., *supra*, n. 27.

³⁴ Fortin, J., *supra*, n. 30.

³⁵ Axon, *supra*, n.15, 135. Hall, A., *supra* n. 27 finds this alternative reasoning more compelling.

disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Silber J. cited four grounds for this.³⁶ The first two related to the public policy implications of children being deterred from seeking confidential sexual advice and treatment. Another related to the importance of deferring to the Executive on matters of social policy. Most importantly, citing *Yousef v The Netherlands*³⁷ Silber J., acknowledged that ‘a child’s article 8 rights override similar rights of a parent’.³⁸

Thus if, contrary to Silber J.’s belief, the parental right under Article 8(1) is engaged, even when the child is Gillick competent, it is (in this context at least) overridden under Article 8(2). Fortin criticises this reasoning too, as it focuses on justification of the breach of the parental right rather than the establishment of the minor’s right.³⁹ Fortin’s preferred analysis would have been to balance the Article 8(1) rights of parent and child and conclude that the parent’s right is subordinate to that of the minor.⁴⁰

The practical effects of Silber J.’s interpretation of Article 8 are likely to be minimal, provided *Axon* is not extended. Silber J. successfully articulated a means by which minors under the age of 16 can, if sufficiently mature, receive medical advice and treatment on sexual matters without the consent or knowledge of their parents. However, with respect, he might have achieved the same end whilst allowing parental rights to continue alongside the minor’s rights, by recognising that, in this context, parental rights are necessarily subordinate to the rights of the minor. If challenges to

³⁶ *Axon*, *supra*, n. 15, 141 – 148.

³⁷ (2003) 36 EHRR 345. See also *Johansen v Norway* (1996) 23 EHRR 33 and *Hoppe v Germand* [2003] 1 FCR 176.

³⁸ *Axon*, *supra*, n. 15, 144-146.

³⁹ Fortin, J., *supra*, n. 30.

⁴⁰ Following the reasoning in *Paton v UK* (1980) 3 EHRR 408 where the husband’s article 8 rights were subordinate to his wife’s.

Gillick are raised, adoption of this reasoning might adversely affect the parental right to information about their child and the ability of our legal system to effectively protect the welfare of minors. The next section considers the potential for *Axon* to be extended to apply to treatment refusals, and the likely consequences of doing so.

C. Should there be a distinction between consent and refusal?

i. The refusal cases

The *Gillick* decision was widely celebrated. Lord Scarman's dicta implied that the ratio would apply to all treatment decisions rather than just contraceptive decisions. Some saw it as a transferral of rights from the parent to the competent child.⁴¹ This accorded with society's increasing concern with autonomy rights. State intervention was conceivable when individuals lacked autonomy and could not make decisions themselves, but autonomous agents should have a legal right to make their own decisions.⁴² Eekelaar said of the decision: 'Children will now have a wider measure than ever before, that most dangerous but most precious of rights: the right to make their own mistakes.'⁴³ A minor's capacity to self-govern heralded a *right* to self-govern. This decision addressed the illogicality of a status-based test for capacity whereby a sixteen year old suddenly gained a right to make a decision regardless of his experience and maturity.

However, this view was short-lived. The test for *Gillick* competence was vague and easily manipulated. If the treatment or lack of treatment would harm the

⁴¹ Eekelaar, J., *supra*, n. 41, pp. 180-182.

⁴² See for example Bainham, A., "The Judge and the Competent Minor" *Law Quarterly Review* 108 (1992), 194.

⁴³ Eekelaar, J., *supra*, n. 41, 182.

medical interests of the child, it was all too easy to conclude that the child was not Gillick competent.⁴⁴ And even if the minor were competent, the courts were reluctant to accept their refusal of life-saving treatment. Section 8(3) of the Family Law Reform Act states that: ‘Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.’

Five years after *Gillick*, Lord Donaldson accepted that the consent of someone with parental responsibility remains ‘effective’. In *Re R (A Minor) (Wardship: Consent to Medical Treatment)*, he stated: ‘I do not understand Lord Scarman to be saying that, if a child was ‘Gillick competent’ ... the parents ceased to have an independent right of consent as contrasted with ceasing to have a right of determination i.e. a veto.’⁴⁵ The competent minor’s right to consent did not extend to the right to withhold consent to treatment required to save his life or to save him from grave or permanent injury.⁴⁶

Ten years ago a 15½ year old girl known as M suffered acute heart failure.⁴⁷ A heart transplant was needed to save her life. Johnson J applied *Re R* in which Lord Donaldson made a distinction between giving and withholding consent. Johnson J considered M to be a mature child, but was nevertheless prepared to authorise the transplant. Eventually M consented. For M, competence did not carry with it a corollary right to determine what was in her own best interests.

⁴⁴ Brazier M., C. Bridge, “Coercion or Caring: Analysing Adolescent Autonomy” *Legal Studies* 16 (1996), 84.

⁴⁵ *Re R (A Minor) (Wardship: Consent to Medical Treatment)* [1991] 4 All ER 177 at 185.

⁴⁶ *Re W (A Minor) (Medical Treatment)* [1993] Fam. 64 per Nolan J at 94 the minor’s refusal should be overruled if ‘the child’s welfare is threatened by a serious and imminent risk that the child will suffer grave and irreversible mental or physical harm’. Per Balcombe LJ at 88 the minor’s refusal should be overruled if it ‘will in all probability lead to the death of the child or grave permanent injury’.

⁴⁷ *Re M (Medical Treatment: Consent)* [1999] 2 FLR 1097.

In *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)*⁴⁸ Lord Donaldson applied the same reasoning to 16-17 year olds. Brazier and Bridge criticise both Lord Donaldson's 'flak jacket' analogy which 'reduces the function of consent to treatment to a mere formality designed to protect doctors from litigation ...'⁴⁹ and the outcome-based decision in *Re W* which was not commensurate with the Law Commissions' recommendations for adults which have since been incorporated into the Mental Capacity Act 2005. Neither 16-17 year olds nor Gillick competent minors have a right to withhold consent provided someone with parental authority provides it. This position has been subjected to criticism on the basis of the incoherent application of the autonomy principle.⁵⁰ As Jonathan Herring explains:

This is because the law is not respecting the more important right (the right to refuse treatment), but *is* respecting the less important right (the right to have the treatment requested). It is a greater infringement on someone's liberty to carry out an operation on them against their wishes and a lesser infringement to deny them the treatment they seek.⁵¹

The most recent refusals case was reported in 2004. In *Re P*⁵² Johnson J held that it was in the best interests of the Jehovah's Witness to receive a life-saving blood transfusion if his condition became life-threatening and there were no alternative treatments. 'John' was 16 years and 10 months old, and withheld his consent to a

⁴⁸ [1993] Fam. 64.

⁴⁹ Brazier M., C. Bridge, *supra*, n. 44.

⁵⁰ Brazier M., C. Bridge, *ibid*, 87.

⁵¹ Herring J., (ed.), *Family Law: Issues, Debates, Policy*, London: Willan Publishing, 2001, 152. Others are more vehement in their response. For example, J. Harris, "Consent and End of Life Decisions" *Journal of Medical Ethics* 29 (2003), 12: 'The idea that a child (or anyone) might competently consent to a treatment but not be competent to refuse it is palpable nonsense ... there cannot be things that we are competent to do but not competent to refuse to do.'

⁵² *Re P (Medical Treatment: Best Interests)* [2003] EWHC 2327 (Fam.). See G. Douglas, "Case Report – Medical Treatment" *Family Law* [2004] 716.

blood transfusion ‘in any circumstances’.⁵³ John’s parents supported his decision. In the short judgment Johnson J relied upon *Re W* but gave no consideration to the rights of either the parents or John under the Human Rights Act 1998. Johnson J did recognise that there might be cases where the child is nearing 18 where respecting his competent refusal might be appropriate, especially where treatment will merely postpone inevitable death.⁵⁴ This was not one of those cases. Yet neither was the media-reported case of Hannah Jones in 2008. Hannah was not approaching the age of 18, nor was death inevitable. Her competent refusal was nevertheless respected.

ii. Hannah Jones

Hannah was diagnosed with leukaemia at age four. The treatment caused cardiomyopathy and Hannah was fitted with a pacemaker. She has spent significant time in hospital. Without a heart transplant, Hannah could die. But when the operation was recommended at Great Ormond Street Hospital for Children, Hannah made the decision, for now at least, to withhold her consent. Her parents, one a retired intensive care nurse, supported her decision. The heart transplant carried a risk of failure (around 5%⁵⁵) and anti-rejection drugs would weaken her immune system and leave her vulnerable to a recurrence of leukaemia.

According to her family, it was a local locum doctor at Hereford County Hospital who notified Herefordshire Primary Care Trust (PCT). The Trust made the headlines when it considered court proceedings. Hannah’s case evoked national sympathy and provoked criticism of the healthcare professionals who were portrayed by some as inflexible, paternalistic and compassionless. For example, one report

⁵³ *Re P ibid.*, 11.

⁵⁴ *Re P, ibid.*, 9.

⁵⁵ Midgley, Carol. 2008. “Doctors Fear Hannah Jones Case may Blight Heart Swaps” *The Times* November 15.

stated: ‘Grotesque as it sounds to the non-medical world – and maybe even to you – this long-suffering, terminally ill girl has been threatened with being removed by court order from the custody of her parents and forced to have the operation.’⁵⁶

The Trust dropped the case after Hannah was interviewed by a Child Protection Officer. Whilst there is no official transcript of that conversation, it must be assumed that the Child Protection Officer concluded that Hannah was competent and that accepting her refusal to consent was in Hannah’s best interests. Hannah handled events with a maturity which at once impresses and dismays, given the tragic circumstances through which it was acquired.

The press hailed the decision a victory for adolescent rights,⁵⁷ but Hannah’s parents supported her decision and forcing an unwanted transplant and subsequent medication on an unconsenting recipient would present serious challenges.

Consequently there is an argument here too that the minor’s autonomy rights and welfare were aligned. Arguably this decision would have been upheld in a court of law, and the distinction between giving and withholding consent still kept in tact.

iii. A right to refuse?

We have seen that in *Gillick*, Lord Scarman spoke of parental rights yielding once the minor became Gillick competent and that in *Re R*, Lord Donaldson separated the right to consent from a wider right to determination. Parents lost the right to veto the child’s valid consent once their child was Gillick competent, but they did not lose the right to consent where the child failed to provide consent.

⁵⁶ Grice, E. 2008. “Hannah Jones: I Have Been in Hospital too Much” *The Telegraph*, November 12.

⁵⁷ See for example the Children’s Legal Centre website which says that Hannah ‘won the right to refuse a heart transplant that could have saved her life’. Retrieved 29 July 2009.
<http://www.childrenslegalcentre.com/Legal+Advice/Child+law/Youngpeopleandmedicaltreatment/Canayoungpersonrefusemedicaltreatment.htm>

Silber J. frames his confirmation of the Gillick principle carefully so as to limit the application of the decision to consent rather than refusals:

... the reasoning of the majority [in *Gillick*] was that the parental right to determine whether a young person will have medical treatment terminates if and when the young person achieves a sufficient understanding and intelligence to understand fully what is proposed, with the result that the doctor was entitled in cases in which it was appropriate to do so, to provide advice and treatment to a young person on sexual matters without parental knowledge ...⁵⁸

Yet, Silber J.'s interpretation of the European Court jurisprudence and his application of Article 8 suggest a merging of the right to consent and the right to determination which Lord Donaldson so carefully separated. Might Silber J.'s reasoning be applied to refusals? A minor might argue that a decision to override his autonomous refusal breaches Articles 8, 5 and 3,⁵⁹ but, even if successful in establishing a right to refuse treatment, two arguments may thwart it.

The first would be the minor's parent's argument (based on Article 8(1)) that he has a right to provide a valid consent to his child's medical treatment. As we have seen, this position is supported in the refusals cases. Taylor suggests that Silber J.'s interpretation of the European Court jurisprudence and the increasing judicial emphasis on childhood autonomy might be utilised to challenge this opinion.⁶⁰

Interestingly, the Law Reform Commission of New South Wales, Australia,⁶¹ has

⁵⁸ *Axon, supra*, n. 15, 56.

⁵⁹ And potentially Articles 9 and 14.

⁶⁰ Taylor, R., *supra*, n.17.

⁶¹ Report 119 (2008) *Young People and Consent to Health Care*, tabled in the Legislative Assembly, 24 March 2009. Retrieved 29 July 2009.
http://www.lawlink.nsw.gov.au/lawlink/lrc/ll_lrc.nsf/pages/LRC_r119toc.

recently recommended the codification of the test for child competence to medical procedures. Clearly relevance is limited given the variations in our legal systems, especially in relation to human rights, but it is pertinent to note the Commission's critique of *Gillick* and their insistence on the absence of parental rights to veto competent decisions to consent *or* to provide consent when their child has made a competent decision to withhold it.⁶² We can tentatively conclude that the analysis of adolescent privacy and autonomy in *Axon* might in future lead the courts in England and Wales to a similar conclusion.

At this point, you will recall Silber J.'s contention that parental rights under Article 8 cease when the child makes a *Gillick* competent decision. If the refusals cases are challenged and this reasoning adopted, then parents would lose the right to provide consent to treatment their competent child has refused, as their Article 8(1) right is not engaged. If so, only the minor or the court can give the doctor the 'flak jacket' he needs in order to lawfully treat the patient.

The second, more powerful argument is that the courts retain the power to exercise their discretion in the welfare interests of the child. The courts have shown a willingness to override a minor's consent or refusal to protect his welfare interests and are unlikely to adopt the position that some believe exists in Scotland.⁶³ There, the Age of Legal Capacity (Scotland) Act 1991 fixes the age of legal capacity at 16 and provides that:

s. 2 (4) A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment

⁶² Report 119, *ibid*, recommendation 4.

⁶³ Elliston, S., *The Best Interests of the Child in Health Care*, New York: Routledge-Cavendish, 2007, 114. Indeed, the GMC, *supra*, n. 23, para. 28(d) states: 'In Scotland parents cannot authorise treatment a competent young person has refused.'

where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.

The Act is not limited to treatment and arguably covers refusals. The Children (Scotland) Act 1995 lists various medical procedures which a child might be obliged to undergo but section 90 states that where a child is able to give consent under section 2 (4) of the Age of Legal Capacity (Scotland) Act 1991, those procedures cannot be carried out without his consent. Nor is it clear whether the courts would challenge a competent minor's refusal under its inherent jurisdiction on the basis that treatment is in the child's welfare interests. To do so might undermine the Age of Legal Capacity (Scotland) Act which was enacted specifically to deal with the capacity of minors.⁶⁴ If this is the case, and it has yet to be tested, then the law in Scotland gives tremendous power to the medical team, which must decide whether or not the child is competent and can therefore consent or withhold his consent, no matter what the consequences are.

In England and Wales, orders under section 8 of the Children Act 1989 relate to decisions that a parent could make. If the parent no longer has a right to interfere with the decision of the competent minor, then neither, it might be argued, has the court under section 8. However, even if this is true,⁶⁵ the court might still invoke its inherent jurisdiction and order a competent minor to accept treatment, or prevent treatment which the court considers to be against the welfare interests of the minor.

Interference with the minor's Article 8(1) rights is likely to be justified under Article 8(2) where there is a serious risk to the life or health of the child. Article 3 is

⁶⁴ Elliston, S., *ibid.*

⁶⁵ Herring, J., *Family Law*, London: Pearson Longman, 2007, pp. 263-264.

an unqualified right, and in *Denmark, Norway, Sweden and the Netherlands v Greece*⁶⁶ the European Commission on Human Rights stated that: ‘Treatment or punishment of an individual may be said to be degrading if it grossly humiliates him before others or drives him to act against his will or conscience’. But in *Nevmerzhitsky v Ukraine*⁶⁷ the European Court of Human Rights held that force-feeding would not offend Article 3 provided it was a medical necessity. The same reasoning is likely to be applied to medical treatment which reaches the threshold of therapeutic necessity. Article 5 usually relates to unlawful detention, but may be raised by a child forced to submit to medical treatment against his will. However, Fortin⁶⁸ argues that whilst Articles 3, 5, 8, and also Article 14 might be utilised in objection to the *parental* right to consent to treatment a competent child refuses, a *court* could counter each of these objections by reference to Article 2 which imposes an obligation on the state to protect life.⁶⁹ Thus, where the treatment is necessary to protect the life or health of the unconsenting competent minor, the courts’ authorisation of treatment is likely to constitute a justifiable breach of the minor’s human rights.

Therefore, whilst human rights arguments might be utilised to challenge the right of parents to consent on behalf of their competent child who refuses medical treatment, the ability of the court to override the child’s competent decisions is less vulnerable.

⁶⁶ (1969) 12 Y.B. 1 at [186].

⁶⁷ (2005) 19 BHRC 177.

⁶⁸ Fortin, J., *supra*, n. 7, 113.

⁶⁹ Taylor, R., *supra* n. 17.

iv. Privacy and refusals

Whilst the European Convention was framed to protect adult rather than minor's rights under Article 8,⁷⁰ the Convention is a living instrument⁷¹ and children's rights, (or at least, the overriding of parental rights where the child's welfare demands it) are of paramount importance.⁷²

Article 8(1) protects minor's autonomy rights and also their rights to privacy. *Axon* confirmed that any minor who satisfies the test for *Gillick* competence has a corresponding right to confidentiality. The contention of the claimant mother of five in *Axon* was that her daughters (two of whom were then 12 and 15) receiving an abortion without her knowledge could not be in their best interests due to the essential support and aftercare a parent would provide. This claim was rejected. Under the common law duty of confidentiality, which has been transformed in recent years by the application of Article 8 of the Human Rights Act 1998,⁷³ the public interest would best be served by permitting minors to keep this type of information from parents.

Silber J. argued that the European Convention on Human Rights and the United Nations Convention on the Rights of the Child:

... show why the duty of confidence owed by a medical professional to a competent young person is a high one and which therefore should not be overridden except for a very powerful reason. In my view, although family

⁷⁰ Fortin J., *supra*, n. 7, 55.

⁷¹ Hall, A., *supra*, n. 27.

⁷² Choudhury S., H.M. Fenwick, *supra*, n. 25, 479 argue that the paramountcy principle enshrined in the Children Act 1989 is incompatible with the European Convention. 'Paramountcy', they argue, should be replaced with a concept of 'primacy' so as to ensure the appropriate balancing of family rights.

⁷³ *Campbell v MGN* [2004] UKHL 22.

factors are significant and cogent, they should not override the duty of confidentiality owed to the child.⁷⁴

Some have argued that, in respect to disclosure of information relating to medical treatment, non-competent children cannot prevent disclosure to parents.⁷⁵ Thus a lack of competence to consent carries a corollary lack of competence to prevent disclosure of the information to a parent. As a result, parents of non-competent children automatically have a right to know about the medical advice and treatment they are given. *Axon* dealt only with Gillick competent minors, but Silber J.'s contention that the parental right to family life ceases (in respect to medical treatment decisions)⁷⁶ when the child attains Gillick competence applies to Article 8 generally. Thus it might be assumed that the onset of Gillick competence is a turning point in the balance between children's and parental rights. Until the minor is Gillick competent, he cannot usually prevent disclosure to the parent. After that event the minor's rights, to both autonomy and privacy, are paramount. Thus, Silber J. stated: '[P]arents do not have article 8 rights to be notified of any advice of a medical professional after the young person is able to look after himself or herself and make his or her own decisions.'⁷⁷

For a doctor the conflation of the right to consent and the right to prevent disclosure is arguably workable and realistic. In *Gillick* Lord Scarman seemed to envisage the doctor determining whether or not the minor comprehended the effects of secrecy when determining competence. The minor must demonstrate 'sufficient understanding of what is involved to give a consent valid in law' which includes

⁷⁴ *Axon supra*, n. 15, 64, per Silber J.

⁷⁵ See for example I. Kennedy *Treat Me Right*, Oxford: Oxford University Press, 1988, 114.

⁷⁶ At 130.

⁷⁷ At 132.

‘moral and family questions, especially her relationship with her parents; ...’⁷⁸ In *Axon* too, the competence required to consent and the competence required to withhold consent to disclosure were linked. Silber J. states: ‘[O]nce the child is sufficiently mature in this way, the parent only retains such rights to family life and to be notified about medical treatment if but only if the young person so wishes’.⁷⁹

However the converse does not necessarily apply – whilst the effect on the minor of a refusal to disclose information may form part of a doctor’s decision as to the competence of a child to consent to medical treatment, it is not necessarily acceptable for the minor’s competence to consent to medical treatment to form part of the decision about his ability to withhold consent to disclosure.

Thus, Loughrey⁸⁰ argues that the right to confidentiality is not necessarily linked to Gillick competence. Historically there was no such link and disclosure may potentially lead to harm of non-autonomous individuals. The right to privacy is not necessarily restricted to the autonomous. In *Murray v Express Newspapers*⁸¹ it was held that JK Rowling’s baby son had a reasonable expectation of privacy. In the sphere of medical information, a child’s view that information should be kept secret is worthy of respect. ‘Where children are capable of forming their own opinions regarding disclosure, and the information is obviously private, it is submitted that a legal obligation of confidence attaches to their medical information, which can be asserted even against parents.’⁸²

Consequently, in a medical treatment case, a non-Gillick competent child has a limited right to autonomy (in that they cannot provide a valid consent) but a wider

⁷⁸ *Gillick, supra*, n. 11, 189 C-D.

⁷⁹ *Axon, supra*, n. 15, 130.

⁸⁰ Loughrey, J., “Can you Keep a Secret?” *Child and Family Law Quarterly* 20 (3) (2008), 312.

⁸¹ [2008] EWCA Civ. 446.

⁸² Loughrey, J., *supra*, n. 80.

right to privacy and confidentiality. The two do not exist in tandem but are distinct and separate claims.

There is much to recommend this argument. To take it further, one might contend that if minors who are not competent to make treatment decisions are owed a duty of confidentiality, their (express or implied) consent is required in order to make a disclosure. But how should one judge their ability to consent? For very young children, there may rarely be situations where disclosure to a parent may prove harmful, but in the vast majority of cases, consent to disclosure will be implied. Once the child can express an opinion, a decision must be made as to whether it is a competent opinion. Their ability to consent to disclosure might be judged according to the test for Gillick competence, but as the test is decision-specific, the threshold will be different for the decision to consent to treatment and the decision to consent to disclosure to parents. The threshold is likely to be substantially lower for disclosure decisions. Thus a child may fall below the threshold for competence to make a treatment decision, but be able to express a view about disclosure. Disclosure to parents would constitute a breach of confidentiality, though that breach would usually be acceptable under the public interest defence and Article 8(2). Imagine 12 year old James wants a life-saving blood transfusion but does not want his parents to know about it. James cannot provide a valid consent to treatment, but the court may do so whilst respecting his right to confidentiality by keeping the information from his parents. If doctors tell his parents, they breach James's confidentiality. Whether or not that breach is defensible is quite another matter.

A child indicating that he wishes medical information to be kept secret is withholding his express consent. In this case disclosure can only be made in the public interest and if justified under Article 8(2). Loughrey argues that:

Where a child, even one who is non-competent [to consent to medical treatment], wants his medical information to be withheld from his parents, and disclosure is neither necessary to obtain parental consent to treatment nor justifiable by reference to the child's best interests, there are strong grounds for allowing the child's right to privacy to outweigh a parent-centred right to disclosure.

If Silber J. is right in his contention that parental rights under Article 8 cease when the minor attains Gillick competence, then given that the test is decision-specific, parents will generally lose the right to disclosure far earlier than they will lose the right to veto their child's medical decision. Of course, the tort of breach of confidence is subject to defences and it will often be possible to demonstrate a public interest in disclosing the information to parents that is required by them to consent on behalf of their child where he is not competent to do so himself. Once the child is able to consent to treatment, parental rights to information about his decision, whether relating to sexual treatment or otherwise, are much harder to defend.

In conclusion, if the autonomy-based arguments are utilised to found a right for competent minors to refuse treatment and Silber J.'s contention that parental rights cease when the minor's decision is Gillick competent is accepted, then not only will parents lose the right to provide that consent but they may also lose the right to information about their child's treatment. Whilst disclosure may be justified in the public interest, that disclosure must satisfy Article 8(2) and if the consent of the parent is not required this may be difficult to demonstrate.

In Finland⁸³ the medical team will assess whether or not a minor has capacity to give an informed consent. If the minor is deemed competent then he has a right to insist that information is not disclosed to his parents. The legal representative has a right to information only in so far as it enables him to give an effective consent.

Other countries differ in their approach. In *Axon*, Silber J. considered the US perspective whereby states may impose parental consent or parental notification prior to an abortion.⁸⁴ He did not consider this approach relevant given, amongst other things, the differences between the Charter of Rights and the ECHR. Yet in Europe too, some countries insist on greater rights for parents. We have already seen that some countries insist on a status-based approach whereby treatment of a minor requires parental consent. We have also seen that some countries require dual consent. In Denmark,⁸⁵ section 17(1) of the Health Act 2005 includes a presumption of capacity from 15 years of age. However, the ability to consent does not carry an automatic ability to withhold disclosure from parents. Parents / guardians of minors under the age of 18 must usually be informed, and s. 16 states that parental consent is preferable, but not essential. Thus, unlike in Finland, the parent is not intended merely to provide consent in the best interests of the minor when the minor is incapable of giving it. The law gives recognition to the parent's interest in knowing what treatment his child is undergoing, even if he lacks the right to veto his child's consent or prove consent in the event of his child's refusal.

⁸³ EuroGentest project website, co-ordinated by the Centre for Biomedical Ethics and Law at the Catholic University of Leuven, Belgium. Retrieved 29 July 2009.

http://europatientrights.eu/countries/signed/finland/finland_right_to_informed_consent_minors.html.

⁸⁴ *Planned Parenthood of South East Pennsylvania v Casey* 505 U.S. 833 (1992) referred to by Silber J. in *Axon*, *supra*, n.15, 32.

⁸⁵ Nys, H., et. al., "Patient Rights in the EU – Denmark", *European Ethical-Legal Papers N°2*, Leuven, 2007, 16. Retrieved 29 July 2009.
http://www.eurogentest.org/patient/info/public/unit4/ethical_legal_papers.xhtml#legal_8.

The decision in *Axon* veers closer to the Finnish than the Danish position, for it supports the idea that parental rights cease once the minor is deemed competent. If parental consent is required, then breach of the minor's Article 8(1) right is justified under Article 8(2) in order that treatment can commence. Conversely, if the minor has attained Gillick competence in relation to the treatment decision, parental consent is not required and it is more difficult to justify disclosure to parents against the wishes of the minor.

If, however, Silber J.'s view is challenged, and the position is adopted that parents and minors retain their rights under Article 8(1), but the minor's right will take precedence, then breach of the minor's right might be justified in order to protect his welfare. In Lithuania,⁸⁶ for example, there is a presumption of competence from 16 and those under 16 may be judged competent by the medical team. The parent has a right to information about the treatment of his non-competent child so that he can provide consent on his behalf. He also has a right to information about his competent child unless both the minor withholds consent to disclosure, *and* disclosure might considerably harm the interests of the minor. Thus, the parental right continues alongside the competent minor's right but will be 'trumped' if the interests of the minor require it. In Spain,⁸⁷ parents lose the right to consent or refuse consent on behalf of their child when he is 16. However, article 9.3 of Patient Rights Law of 2002 states that parents will be informed and their judgement borne in mind where the treatment or non-treatment entails serious risk, and their opinions will be a relevant consideration.

In *Axon*, there was substantial evidence that disclosure against the wishes of the minor could cause considerable harm – it was against the public interest. Thus, if

⁸⁶ Article 6(8) Law on the Rights of Patients, Lithuania: L. Stultiens, et. al., *supra*, n. 9, 32.

⁸⁷ Stultiens, L. et. al, *ibid*, 38.

it is accepted, contra Silber J., that parental rights under Article 8(1) are engaged, then in addition to Silber J.'s requirements for disclosure to a parent may be warranted. Silber J. argued that disclosure relating to a competent child should be made 'if the young person so wishes'. If applied in a wider context where the welfare interests of the minor and non-disclosure are not necessarily aligned, then one might even go so far as to add, 'and disclosure to a parent would be in the public interest'. The General Medical Council states that disclosure is in the public interest 'if the benefits which are likely to arise from the release of information outweigh both the child or young person's interest in keeping the information confidential and society's interest in maintaining trust between doctors and patients'.⁸⁸ If Silber J.'s contention that parental Article 8 rights cease when the minor makes a Gillick-competent decision is accepted, this advice needs to be reconsidered. As Loughrey points out,⁸⁹ in the context of adults, the public interest defence is used to protect third parties but not the individual's own health. Arguably the same caution is now owed to competent minors. If, however, parental rights to Article 8(1) co-exist with the minors', this aspect of the GMC advice is a correct and proper interpretation of the law. On this interpretation *Axon* can be celebrated for recognising and developing children's rights to privacy and autonomy, but its impact limited so that as long as we retain a system whereby the *courts* can overrule a competent minor's decision, parents too retain an integral role unless the welfare of their child demands otherwise.

Thus, Article 8 might be utilised to support the parental right to information, even though it would interfere with the minor's right to privacy, provided the disclosure does not operate against the welfare interests of the minor. At its widest, this would establish a parent-centred right – parents could argue that their right to a

⁸⁸ GMC *supra*, n. 23, para 47.

⁸⁹ Loughrey, J., *supra*, n.80.

family life includes a right to this information. The minor's right to privacy would not trump this unless it could be established that it is required to protect his welfare.

Alternatively, a narrower interpretation would insist on a child-centred right whereby the parent could only insist on disclosure against the wishes of the child where his argument is based on the child's welfare. Consider, for example, a minor who selflessly refuses potentially life-saving treatment because the success rate is low and she wishes to avoid putting her family through further emotional trauma, or because she considers herself a financial burden on them. In these cases the parental right to information might conceivably trump the competent minor's right to privacy.

Parents might be made aware of the fact that there is a treatment option, even if the law develops to bar them from vetoing their competent child's refusal. They at least retain the chance to influence the minor, and also potentially to petition the court so that it might authorise the treatment in the minor's welfare interests. Whilst the disclosure would breach the minor's confidentiality, that breach might be justified under the public interest exception.

Thus, with respect, Silber J.'s contention that parental rights cease when minors attain *Gillick* competence warrants careful consideration before being extended to cases in which the welfare interests of the minor are not aligned with respect for his competent decision regarding treatment and disclosure. If Silber J.'s reasoning is applied to treatment and disclosure issues, then parents who have lost the rights both to veto treatment and potentially to consent to treatment the minor has refused, may also lose the right to information about that decision. An alternative is that parental Article 8 rights continue but the minor's Article 8(1) right will generally be prioritised. Thus, parents would lose the right to veto consent and potentially to provide consent once their child is competent if it would unjustifiably interfere with

their child's autonomy rights. They would not necessarily lose the right to information about their child's decision at the same time. A different balancing exercise would be required relating to the disclosure issue. Where disclosure is in the best interests of the child, even if he is competent to withhold consent to disclosure, and even if the parent is not required to provide consent, the parent might justifiably be informed.

D. Is the test for competence satisfactory?

The third issue requiring clarification in *Gillick* is the test for competence. In England and Wales, the presumption of capacity encapsulated in section 1(2) of the Mental Capacity Act 2005 affects adults. 'Young persons' between the ages of 16-18 are also presumed capable to make a decision and any lack of capacity must be the result of 'an impairment of, or a disturbance in the functioning of, the mind or brain'.⁹⁰ The young person's age is not a relevant factor in overriding the presumption of capacity.⁹¹ Children under the age of 16, however, are not protected by the Act. As we have seen, those under the age of 16 must demonstrate that their decision is 'Gillick competent'.

England and Wales are not alone in adopting a functional test. In Belgium⁹² and Finland,⁹³ the Czech Republic⁹⁴ and Estonia⁹⁵ for example, minors (defined as those under the age of 18) may be judged competent to consent, depending on the nature of the decision and the age and experience of the minor. However, in those countries health professionals can overrule a competent minor's consent or refusal to

⁹⁰ Mental Capacity Act 2005, s. 2(1).

⁹¹ Mental Capacity Act 2005, s. 2(3)(a).

⁹² EuroGentest project website, *supra*, n. 85, Belgium. Retrieved 29 July 2009.

http://europatientrights.eu/countries/not_ratified_not_signed/belgium/belgium_right_to_informed_consent_minors.html.

⁹³ EuroGentest project website, *ibid.*, retrieved 29 July 2009.

http://europatientrights.eu/countries/signed/finland/finland_right_to_informed_consent_minors.html

⁹⁴ Article 9, Czech Civil Code: L. Stultiens, et. al., *supra*, n. 9, 24.

⁹⁵ *Ibid.*, 26.

avert a threat to his life or health. In England and Wales doctors do not have this right. They must seek authorisation from the court before they can force treatment on a competent minor who refuses it. However, as we have seen, if the minor's decision is deemed non-competent, the medical team can treat without his consent, providing a legal representative consents on behalf of, and in the best interests of the child. This may be one of the reasons why the test for competence is vague and, in the 'refusals' cases previously illustrated, has been so readily manipulated.

If minors are to mount a challenge to the test for Gillick competence, one ground might be the lack of guidance as to how far the supposedly 'functional' test is dependent upon outcome. Clearer guidance would reduce instances in which the bar is set so high as to be unattainable or so low as to result in unnecessary and controversial use of the court's inherent jurisdiction to force treatment on the unconsenting child. It will come as no surprise that some minors will be better equipped to consent to a procedure in which an infected toe nail will be removed than they would to an emergency operation for an acute and life threatening illness. However, the decision-specific test does not merely relate to the seriousness or complexity of the disease. It relates to the outcome or consequences of the decision. The more likely it is that the minor's decision operates against his best interests, the higher the threshold for competence. For example, it is unclear whether Hannah Jones's decision was respected because a) she was competent due to her life experience of hospitals and illness and / or b) she was competent because whilst the outcome of her refusal might result in her life ending, the consequences of forcing upon her both initial and long term non-consensual treatment would operate against her wider best interests. Had a heart transplant offered Hannah a better and more certain prognosis, not only might the courts have used their inherent jurisdiction or the Children Act 1989 to sanction

the non-consensual treatment against her will, but, at a more basic level, the better prognosis might have been utilised to demonstrate that Hannah's decision was not competent because the consequences of the refusal would be deemed more serious and therefore the threshold for competence raised to an unattainable level.

Just as the vagueness of the test for capacity can lead to a high and unattainable threshold for capacity, Brazier and Bridge assert that it has occasionally led to an unduly low threshold.⁹⁶ If the threshold is set too low and a minor is held to be competent, this might lead to the courts controversially utilising their inherent jurisdiction or a section 8 order to overrule the minor's competent decision.

Harris lists four defects which may undermine autonomous choice and justify paternalistic decision-making.⁹⁷ Using this model, Brazier and Bridge suggest that: 'Misunderstandings of what constitutes maximally autonomous choice resulted in judges apparently overruling 'competent' choices which analysis shows to be in no real sense 'autonomous' choice.'⁹⁸ The outcome of the decisions is less controversial than the means by which the decisions were made.

This is not to say that a firmer test for capacity would render the courts' inherent jurisdiction to order non-consensual medical treatment obsolete. Brazier and Bridge recognise that, even with a consistent threshold for capacity, society may still call for the decisions of competent minors to withhold consent to life-saving treatment to be overridden. Adoption of Harris's criteria in line with Brazier and Bridge's recommendations would help to ensure that paternalistic decisions are justified appropriately by reference to defects in the capacity of the minor and not purely by reference to the outcome of their decision. The current test, however, is vague and

⁹⁶ Brazier M., C. Bridge, *supra*, n.44; R. Taylor, *supra*, n.17.

⁹⁷ Harris J., *The Value of Life*, London: Routledge, 1995, pp. 195-205.

⁹⁸ Brazier, M., C. Bridge, *supra*, n.44, 109.

easily manipulated and if the reasoning in *Axon* is adopted in future decisions may even constitute a breach of Article 8.⁹⁹

One partial solution is to lower the age of the presumption of capacity. As we have seen, some countries impose a presumption of capacity at a lower age than 16. Others maintain a rebuttable presumption of capacity without age limit.¹⁰⁰ A lowering of the age of the presumption of capacity would prove more protective of the minor's autonomy. For example, it would in all likelihood prevent recurrences of cases where minors have been judged incompetent because of a lack of information. In *Re E (A Minor) (Wardship: Medical Treatment)*¹⁰¹ the refusal of a 15 year old Jehovah's Witness was overridden on the basis that he lacked understanding of the nature of his death and in *Re L (Medical Treatment: Gillick Competence)*¹⁰² a refusal of treatment from a Jehovah's Witness was overridden because she lacked information about the manner of her death. A presumption of capacity at a lower age would have given minors over the age limit a right to such information, though in these cases, it is possible that the presumption might have been rebutted on grounds other than their lack of information. Thus, one potential option by which the test for competence is made more meaningful would be to lower the age for a presumption of capacity. Any child falling below the age limit, however, would benefit from firmer guidance which supports a test for competence which, whilst sensitive to complexity, is not reliant on outcome.

⁹⁹ Taylor, R., *supra*, n.17.

¹⁰⁰ For example Canada, Ontario, Health Care Consent Act 1996, s. 4(2). See Report 119, *supra*, n.61, para. 5.26.

¹⁰¹ [1993] 1 FLR 386.

¹⁰² [1998] Fam. Law 591.

E. Conclusion

Recognition in *Axon* of limitations on the parental right to veto consent confirms *Gillick* post Human Rights Act 1998. More contentious is Silber J.'s view that parental rights cease when the minor attains *Gillick* competence. This analysis has been criticised on the basis that similar rights of minor and parent should co-exist and preference be given to the minor's. I have highlighted the practical significance of this distinction if, as others have suggested is possible, the refusal cases are challenged.

Wider application of Silber J.'s analysis might occasionally lead to competent minors making important decisions - even decisions about life-sustaining treatment - without the support or knowledge of their parents. Of course, most competent adolescents willingly agree to their parents being informed and in those cases where they do not agree, it will often be commensurate with their welfare interests to respect their view. Yet we have seen that other European countries have been careful to distinguish the right to withhold consent and the right to withhold information from parents. There are at least five reasons, three practical and two theoretical, for this. The first is the importance of accurately guiding the medical team in the advice they give to families. Even though there are likely to be few cases where parents will be able to assert their right to information against the wishes of their competent child, it is important that adolescents know when they can withhold information and parents know when they are entitled to it.

The second reason is the distinct nature of consent and confidentiality which should not always be conflated. Though both autonomy and privacy are protected by Article 8 of the Human Rights Act 1998, the defences to breach of confidentiality and treatment without consent are at common law quite distinct. Whilst competence to consent to treatment and disclosure of information were aligned in both *Gillick* and

Axon, there may be cases when a minor competent to make a treatment decision should not necessarily have a right to withhold consent to disclosure of confidential information to her parents.

The third reason is the importance, as long as the courts retain their inherent jurisdiction to overrule treatment decisions made by competent minors, of seeking the views of parents as to the child's welfare interests. Even where minors do not expressly withhold consent to disclosure to parents, a recognition that parents have no *right* to information, may lose them their status as 'the best judges of a young person's welfare'.¹⁰³ Whilst the competent child might argue that *he* is the best judge of his own welfare, as long as the court can overrule him, it makes practical sense to seek the views of parents rather than relying solely on doctors to supplement the views of the minor.

The fourth reason is the paternalistic goal of protecting the child's welfare. Fortin has gone so far as to argue that Article 8 (1) should be interpreted as integrating rights and welfare.¹⁰⁴ Accordingly, if the disclosure is in the child's welfare interests, then there is no breach of Article 8(1) at all. I have argued that any parental rights to information should be limited by a requirement that it does not harm the welfare interests of the child and highlighted situations where respecting the minor's wishes to keep information secret from parents may not be in her welfare interests.

The final reason is the desire to protect the rights of parents. If, in future, the refusals cases are challenged I have suggested that parental rights under Article 8 should be recognised to co-exist with those of the minor. Where the consequences of withholding information from parents might interfere with family life (for example, because the minor might die), their right to information may take precedence over the

¹⁰³ *Axon*, *supra*, n.15 per Silber J., at 2.

¹⁰⁴ Fortin, J., "Accommodating Children's Rights in a Post Human Rights Act Era" *Modern Law Review* 69 (3) (2006), 299, 311.

minor's right to privacy, provided it would not harm the minor's welfare interests to breach his rights.

Silber J.'s contention that adult rights under Article 8(1) cease when minors attain Gillick competence might fare better if the brave step is taken to formulate a stricter and fairer test for competence, and give minors who reach that threshold an unfettered right to consent to and refuse treatment. If minors' rights are recognised more incrementally, with safety nets operating to prevent them from significant harm, then parental rights should be allowed to exist alongside the developing rights of the minor.