

Goodbye *Gillick*? Identifying and Resolving Problems with the Concept of Child Competence

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Abstract

The landmark decision of *Gillick v West Norfolk Area Health Authority* was a victory for advocates of adolescent autonomy. It established a test by which the court could measure children's competence with a view to them authorising medical treatment. However, application of the test by clinicians reveals a number of ambiguities which are compounded by subsequent interpretation of *Gillick* in the law courts. What must be understood by minors in order for them to be deemed competent? At what point in the consent process should competence be assessed? Does competence confer on minors the authority to refuse as well as to accept medical treatment? These are questions which vex clinicians, minors and their families. Growing numbers of commentators favour application of parts of the Mental Capacity Act 2005 to minors. In this article, the limitations of this approach are exposed and more radical reform is proposed.

Introduction

*Gillick v West Norfolk Area Health Authority*ⁱ was a landmark decision,ⁱⁱ crystallising a new legal approach recognising minors as independent rights holders. The House of Lords held that competent minors under the age of 16 (referred to in this article as 'minors') could seek contraceptive advice and treatment in their own right. Lord Scarman held that a competent minor will have 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.ⁱⁱⁱ *Gillick* promised to make competent minors 'small scale sovereigns'.^{iv} It ostensibly gave them authority to make certain decisions. However the scope of the authority lacked clarity, enabling its limitation in subsequent cases.

ⁱ [1986] AC 112.

ⁱⁱ J Fortin, 'The *Gillick* decision - not just a high water mark', in S Gilmore J. Herring and R Probert (eds), *Landmark Cases in Family Law*, (Oxford: Hart Publications, 2011).

ⁱⁱⁱ [1986] AC 112, [253].

^{iv} HLA Hart, *Essays on Bentham: Studies in Jurisprudence and Political Theory*, (Oxford: Clarendon Press, 1982), 183.

As we shall see, problems with *Gillick* stem from both inherent limitations (it was designed to respond to a specific issue but has been applied in much wider contexts) and its subsequent judicial interpretation, particularly in a series of cases restricting the powers of competent minors to refuse life-sustaining treatment (collectively referred to in this article as the 'refusals cases'). These problems have existed for some time, but are increasingly pertinent as children's autonomy rights gain mounting recognition at both judicial and political levels. This article brings to the debate new emphasis on the problematic application of the test in clinical practice, which has been the focus of a recent research project^v and a novel proposal for reform.

The paper begins by setting out the ambiguities inherent in the current interpretation of *Gillick*. It is argued that the test is an inadequate tool for adjudicating the balancing exercise which clinicians and judges are sometimes called upon to perform between protecting minors' welfare by preserving life and health^{vi} and taking into consideration minors' views and giving them due weight.^{vii} Turning to potential solutions, emphasis is placed on a recent Court of Appeal decision in which it was recognised that adults who have capacity under the Mental Capacity Act 2005 (MCA) may nevertheless lack capacity at common law.^{viii} McFarlane LJ was careful to formulate the common law test in line with the facilitative approach of the MCA. An extension of the same principle to minors might enable the law to adopt a universal approach to capacity whilst simultaneously ensuring that the welfare of minors is protected. If so, it may (at least in the field of competence to make medical treatment decisions) be time to say 'Goodbye' to *Gillick*.

Capacity and competence

At the outset, it is useful to put the *Gillick* competence test (which applies to under 16 year olds) in context. The law in England and Wales relating to two other age groups is worthy of comparison. The capacity of adults (over 18s) is governed by the Mental Capacity Act 2005 (and its accompanying Code of Practice), which provides a scheme to protect those who are unable to make decisions. Mental capacity is quite distinct from child competence.^{ix} Under the MCA, not only is capacity assumed,^x but '[a] person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success'.^{xi} The MCA test for capacity has a narrower scope than the *Gillick* competence test. Section 2(1) of the

^v [Ref removed to maintain anonymity]

^{vi} Protected by virtue of Children Act 1989, s. 1(1).

^{vii} For example, first on the 'welfare checklist' in the Children Act 1989, s. 1(3) is the court's requirement to take into account the ascertainable wishes and feelings of the child (considered in the light of his age and understanding). This applies in relation to care proceedings and opposed applications for s. 8 orders.

^{viii} *DL v A Local Authority* [2012] EWCA Civ 253.

^{ix} Her Honour Nasreen Pearce, 'Mental Capacity Act 2005: Not the Children Act for grown ups' [2011] July *Family Law* 697.

^x Mental Capacity Act 2005, s. 1(2).

^{xi} Mental Capacity Act 2005, s. 1(3).

MCA defines a person lacking capacity as someone, who is, on the balance of probabilities,

... unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain ...

on the basis that he cannot understand, retain, use or communicate his decision (section 3).

Much of the MCA also applies to 16 and 17 year olds. In addition, the ability of 16/17 year olds to consent to medical treatment is governed by section 8 of the Family Law Reform Act 1969. Consequently, 16/17 year olds are presumed both to be competent and to have capacity, but both presumptions are rebuttable. Where 16/17 year olds lack *competence* their guardian or the court will make decisions which prioritise the minors' welfare.^{xii} Where 16/17 year olds lack *capacity*, the MCA sets down a framework designed to ensure that decisions are taken on their behalf, in their best interests.^{xiii} There is overlap between the schemes but there are also points of departure. For example, a 16 year old who cannot make a decision because he lacks maturity is likely to have MCA capacity but lack competence under the Family Law Reform Act.

Gillick and treatment refusals

The *Gillick* competence test responded to the public policy requirement that some minors under the age of 16 should be able to access contraceptive treatment without necessarily having to involve their parents. The application of the test in this context was confirmed post Human Rights Act 1998 in *R (Axon) v Secretary of State for Health*.^{xiv} The *Gillick* test, like much of the common law, has developed in an *ad hoc* manner. As the test has been applied and interpreted in increasingly wider contexts (both medical and non-medical^{xv}), it has shown signs of strain.

This is particularly evident in a series of cases involving minors who elected to refuse life-sustaining treatment. Interpretation of the *Gillick* competence test in these cases led to much academic condemnation.^{xvi} Arguably the cases counter the emphasis on autonomy which is implied in *Gillick*^{xvii} and preserved in the Children Act 1989.^{xviii} Two separate grounds were developed for overriding a minor's treatment refusal. In *Re R (A Minor) (Wardship: Consent to Medical Treatment)*^{xix} and *Re W (A Minor)*

^{xii} Children Act 1989, s. 1.

^{xiii} Mental Capacity Act 2005, s. 4.

^{xiv} [2006] EWHC 37 (Admin).

^{xv} See for example *Re Roddy (A Child) (Identification: Restriction on Publication)* [2003] EWHC 2927 (Fam); *Mabon v Mabon* [2005] EWCA Civ 634.

^{xvi} Neatly summarised in S Gilmore and J Herring, 'No' is the hardest word: consent and children's autonomy (2011) 23 *Child and Family Law Quarterly* 3, p 4.

^{xvii} [1986] AC 112, [186] per Lord Scarman: '[the] parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and maturity'.

^{xviii} J Murphy, 'W(h)ither adolescent autonomy?' (1992) 14(6) *Journal of Social Welfare and Family Law* 529, 531.

^{xix} *Re R (A Minor) (Wardship: Consent to Medical Treatment)* [1992] Fam 11, [1992] 1 FLR 190, [1991] 4 All ER 177.

(*Medical Treatment: Court's Jurisdiction*)^{xx} it was stated (*obiter dicta*) that a competent decision to refuse treatment could be overridden provided another valid source of consent could be found. One potential source is parental consent, and this aspect of the law may be subject to challenge,^{xxi} but I have dealt with this related question elsewhere.^{xxii} My focus here is with another potential source of consent: the court's power to veto the minor's decision. Lord Donaldson stated:

[The court has the] right and, in appropriate cases, duty to override the decision of the parents or other guardians. If it can override such consents, as it undoubtedly can, I see no reason why it would not be able, and in an appropriate case, willing, to override decisions by 'Gillick competent' children ...^{xxiii}

Similar reasoning was applied in *Re W* in relation to minors aged 16/17, who are presumed competent to consent.

Alternative reasoning was developed in cases including *Re L (Medical Treatment: Gillick Competency)*^{xxiv} and *Re E (A Minor)*^{xxv}, where incompetence (rather than a judicial veto of competent decisions) was cited to justify the overriding of each minor's refusal. However, the ambiguous definition of competence enabled judges to raise the threshold to arguably unattainable levels.^{xxvi}

In both types of case, there is a lack of clarity as to the appropriate timing of the assessment of competence and the method of assessment. In addition, the value of competence – the authority it confers on the minor – is contentious because it was not made clear why minority status renders a competent decision subject to veto. It is to these three ambiguities that we now turn.

The trouble with *Gillick*

Timing of the assessment

Section 3 of the MCA requires, that capacity is, in part, a question of actually understanding the information relevant to the decision. On the basis of the *dicta* of Lord Scarman and Lord Fraser and the interpretation of *Gillick* in the refusals cases, there is doubt as to whether this is required of the *Gillick* competent minor.

According to the House of Lords, a competent minor is one who has the *capability* to understand. 'Capability' refers to the minor having the *ability* to understand which, in turn, will depend on the complexities of the particular decision. As Mostyn J

^{xx} *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam 64, [1993] 1 FLR 1.

^{xxi} Department of Health, *Reference Guide to Consent for Examination or Treatment*, 2nd ed (2009), Ch 3, para 15.

^{xxii} E Cave, 'Adolescent consent and confidentiality in the UK' (2009) 16(4) *European Journal of Healthcare Law* 309.

^{xxiii} *Re R (A Minor) (Wardship: Consent to Medical Treatment)* [1992] Fam 11, [25] per Lord Donaldson MR.

^{xxiv} [1998] 2 FLR 810.

^{xxv} (1990) 9 BMLR 1.

^{xxvi} M Brazier and C Bridge, 'Coercion or Caring: Analysing Adolescent Autonomy' (1996) 16 *Legal Studies* 84.

recognised in *D Borough Council v AB*: ‘The terms of [*Gillick*] show clearly that the capacity in question is act and not person specific.’^{xxvii} However, if capability to understand rather than actual understanding is required in order for a minor to be recognised as competent, then the assessment might legitimately be made before the minor has made a decision. Lord Scarman stated that a minor is competent ‘when he reaches a sufficient understanding and intelligence *to be capable* of making up his own mind on the matter requiring decision.’^{xxviii} Lord Fraser said:

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.^{xxix}

Capability to act autonomously is different from acting autonomously. If the Law Lords had been concerned solely with the latter, they would presumably have made reference to ‘whether a boy or girl understands ...’ rather than ‘whether a boy or girl is *capable* of understanding’.

There are sound reasons for capability forming *part* of the competence test. First it reflects the legal presumption that minors under the age of 16 lack competence. It is the duty of clinicians to establish how much information to give them and in what form, by assessing their capability. If, instead, the test required an assessment of minors’ *actual* understanding of the information, then the law would require full disclosure to all children, which has the potential to cause harm. Second, the emphasis on capability protects the physician who assesses the minor to be *Gillick* competent, provides the information and the treatment and finds subsequently that the minor did not fully understand it, from a claim in battery. By way of comparison, under the MCA, capability to understand is relevant to the assessment of capacity. A person (‘with an impairment of, or a disturbance in the functioning of, the mind or brain’) will lack capacity if they have an inability to understand the relevant information.^{xxx} The inability might be proved by incapability to understand or by a failure to actually understand. Reliance on the former is limited by a requirement to take all reasonable steps to help the person decide.^{xxxi}

If *Gillick* competence has been interpreted to relate purely to capability to decide (which, as shall be shown in the next section, is one potential interpretation of the subsequent case law), then this creates a tension between the application of the test in court and in practice. In the latter, as we shall see, the dynamic process of consent requires a consideration of both capability to understand and actual understanding.

^{xxvii} [2011] EWHC 101 (COP), [18].

^{xxviii} [1986] AC 112, [186]. My italics.

^{xxix} [1986] AC 112, [169]. My italics.

^{xxx} Mental Capacity Act 2005, s. 3.

^{xxxi} Mental Capacity Act 2005, s. 1(3).

Treatment / refusal distinction

It may be that reliance on competence as capability is in part responsible for the distinction which has emerged post-*Gillick* between consent and refusal. Two interpretations of the competence test are possible. On the first interpretation, competence is assessed as capability, so a minor capable of consenting but unable to understand or communicate a decision to refuse treatment might nevertheless be labelled 'competent', requiring the court to overrule the 'competent' decision in order to protect the minor's welfare. On the second interpretation, competence is assessed as both capability and actual understanding in which case the assessment might incorporate the minor's ability to choose between having and not having the treatment. On this interpretation, the court retains the power to consent if the minor refuses and treatment is in his best interests. Either interpretation is possible on the basis of *Re W*^{xxxii} which concerned the refusal of treatment by a 16 year old (who, it will be recalled, is presumed competent to consent to treatment under section 8(1) of the Family Law Reform Act 1969). Lord Donaldson did not decide one way or another:

No question of "*Gillick* competence" in common law terms arises. The 16- or 17-year-old is conclusively presumed to be "*Gillick* competent" or, alternatively, the test of "*Gillick* competence" is bypassed and has no relevance.^{xxxiii}

Section 8(3) of the Family Law Reform Act,^{xxxiv} which preserves existing law, was held to have the effect that parents and the court retain the ability to consent alongside minors. Lord Balcombe stated:

The purpose of [section 8] is clear: it is to enable a 16-year-old to consent to medical treatment which, in the absence of consent by the child or its parents, would constitute a trespass to the person. In other words, for this purpose, and for this purpose only, a minor was to be treated as if it were an adult.^{xxxv}

Some have interpreted this to mean that section 8(1) applies only to consent and not to refusal^{xxxvi} in which case the presumption of competence only applies to decisions to consent. Provided the presumption of competence is not rebutted, 16/17 year olds can consent but do not necessarily have the power to refuse treatment. If this is so, the competence relating to consent and competence relating to refusal must be assessed separately because a presumption of competence applies to one and not the other.

On the second interpretation, it could be inferred from *Re W* that competence applies to the *decision* rather than separately to consent and refusal. Lord Balcombe

^{xxxii} [1993] Fam 64.

^{xxxiii} [1993] Fam 64, [77] per Lord Donaldson MR.

^{xxxiv} FLRA 1969, s. 8(3) Nothing in this section shall be construed as making ineffective any consent which would have been effective if this section had not been enacted.

^{xxxv} [1993] Fam 64, [86].

^{xxxvi} A McFarlane, 'Mental capacity: one standard for all ages' [2011] 41 *Fam Law* 479, p 484, '...the provision in FLRA 1969, s 8 relates only to giving rather than refusing consent... '.

recognised that 'In logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment.'^{xxxvii} This interpretation is more readily applicable to clinical consent where competence is frequently assessed on the basis of the individual's ability to choose between options.^{xxxviii} For example, if a minor with an abscess is asked to choose between antibiotics and minor surgery, the clinician will want to ensure that the minor understands the alternatives in relation to each other. Similarly, when a minor chooses between radiotherapy and palliative care, the clinician is interested in the minor's ability to decide between the two rather than to understand each in isolation. On this interpretation, both capability and actual understanding are relevant. The presumption of competence applies to the decision and thus to both consent and refusal.

Ambiguity surrounding this issue leads to a potential distinction between treatment and refusal and potentially to assessment taking place before a decision is reached so that competence to assent requires the court to overrule refusals rather than assess the minor's competence to decide between having and not having the treatment.

Defining Competence

In terms of defining competence, it is apparent from the previous section that there is dissent regarding what must be understood in order for a minor to be viewed competent. In addition, there is uncertainty surrounding the required level of understanding. Lord Scarman requires the minor to 'understand fully what is proposed'.^{xxxix} Lord Fraser sets out what this entails in the context of contraceptive advice,^{xl} but in other contexts the required level of understanding will necessarily differ. Similarly, 'maturity' has proved difficult to define. It might incorporate physical, psychological, emotional, cognitive, and / or social maturity. Undeniably childhood has a biological component but how this is construed is based on the social construction of childhood.^{xli} Whilst it is necessary that the test is flexible enough to adapt to a wider variety of contexts, too much flexibility enables those assessing competence to focus less on the minor's functional ability to make the decision and more on the outcome of the decision. In some cases, because the outcome of the minor's decision would be so serious, it is difficult to see how the minor could prove competence.^{xlii}

^{xxxvii} [1993] Fam 64, [88].

^{xxxviii} E Cave and J Wallbank, 'Minors' capacity to refuse treatment: A reply to Gilmore and Herring' (2012) 20(3) Medical Law Review 423.

^{xxxix} [1986] AC 112, [253].

^{xl} [1986] AC 112, [189D].

^{xli} A Prout and A James, 'A new paradigm for the sociology of childhood?' In A James and A Prout (eds) *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood* (London: Routledge/Falmer, 1990), pp 7-33.

^{xlii} *Re L (Medical Treatment: Gillick Competency)* [1998] 2 FLR 810.

The authority conferred by virtue of competence

A third ambiguity concerns the relationship between competence and authority. For adults, the law on consent is gradually metamorphosing from a legal tool designed to transfer responsibility (and so defend doctors from a claim in battery) to a means of protecting patient autonomy.^{xliii} The concept of *Gillick* competence and its subsequent judicial interpretation acts as a barrier to the same process occurring in relation to child consent. Being competent only enables minors to authorise decisions which relevant others determine to be in their best interests. This position has potential to conflict with minors' rights.

Minors' moral rights are notoriously difficult to define. Baroness O'Neill has expressed doubt that 'rights' are necessarily the best way to protect children, preferring instead to articulate the relevant obligations of adults.^{xliiv} Expressing demands as rights claims when the group is made up of such a diverse range of individuals is challenging. Feinberg recognises that some rights belong only to adults, some are shared by adults and children and some belong to children only.^{xliiv} In its present form, the *Gillick* competence test is unhelpful in determining whether and in what circumstances minors have the same rights as adults or should be subjected to protections by virtue of the vulnerabilities inherent in youth.

In terms of legal rights, in England and Wales all people (including children) are protected by the Human Rights Act 1998 which gives effect to the European Convention on Human Rights 1950. Children's rights to make decisions about their treatment have traditionally been stymied by a 'Bolamite philosophy'.^{xlivi} In *Bolam*,^{xliiv} the court laid down a test for establishing the standard of care in relation to skilled professionals. A doctor was not to be found negligent if a responsible body of medical opinion would view the practice as proper. As a result the scope for external assessment of the clinical judgment was considerably reduced.^{xliiii} Likewise, in relation to the treatment of minors, Brazier and Miola recognise that:

The 'reasonable doctor' determines whether or not to override the adolescent's refusal of treatment, regardless of whether or not the young person is *Gillick* competent. ... [The refusals cases] grant the power to decide disputes about the treatment of a minor to the medical profession.^{xlix}

^{xliii} *Chester v Afshar* [2004] UKHL 41.

^{xliiv} O'Neill 'Children's rights and children's lives' (1998) 98 *Ethics* 445.

^{xliiv} J Feinberg, 'A Child's Right to an Open Future', in W Aiken and H LaFollette (ed), *Whose Child? Parental Rights, Parental Authority and State Power*, (New Jersey: Rowman and Littlefield, 1980), pp 124–153.

^{xlivi} M Brazier and J Miola, 'Bye-bye Bolam: A medical litigation revolution?' (2000) 8 *Medical Law Review* 85, p 94.

^{xliiv} *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

^{xliiii} H Teff, 'The standard of care in medical negligence: Moving on from Bolam?' (1998) 18(3) *Oxford Journal of Legal Studies* 473.

^{xlix} M Brazier and J Miola, above n xliiv, p 94.

The effect is that ‘human rights are squeezed out of health care law’.ⁱ Brazier and Miola argue that the decision in *Bolitho*ⁱⁱ signalled an intention to return *Bolam* to its proper limits and began a gradual reversal of this trend. However, the *Gillick* test (as subsequently interpreted) remains stubbornly resistant to change.

Arguably, developments in human rights jurisprudence require greater weight to be attributed to minors’ autonomy rights. Not all agree. Adjudicating the potential conflict between rights focused on welfare and autonomy goes to the very heart of the debate on child consent.ⁱⁱⁱ Minors are not the only ones who can be subjected to compulsory treatment in their medical interests, regardless of their competent refusal. For example, under the Mental Health Act 1983, an adult may have the requisite mental capacity to make a treatment decision, but lack the right to refuse treatment.ⁱⁱⁱⁱ In both cases, this position may be compatible with the European Convention on Human Rights, at least where the treatment prolongs life. Article 8(1) of the Convention^{lv} has been interpreted to protect autonomy rights, including the rights of minors^{lv} but it is subject to Article 8(2) for the protection of health and must be balanced with the positive obligation in Article 2 to preserve life.^{lvi}

Section 1(1) of the Children Act 1989 prioritises the welfare of the child. The Act gives effect to the United Nations Convention on the Rights of the Child (UNCRC), ratified by the UK in 1991. The treaty does not form part of our law but has markedly increased in relevance in recent years. This is evidenced in the *dicta* of Silber J in *R (Axon) v Secretary of State for Health*,^{lvii} legislation in Wales,^{lviii} and in recent recommendations by the Children and Young People’s Health Outcomes Forum that the NHS Constitution be revised to so as to be applicable to children, young people and their families and that the Department of Health produce a Children’s Health Charter based on the UNCRC.^{lix} The UK recently became a signatory to the Council of Europe Declaration on child friendly health care which recognises ‘children’s rights as a guiding principle in the planning, delivery and monitoring of health care services

ⁱ *Ibid.*, 95.

ⁱⁱ *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771.

ⁱⁱⁱ S Choudhry and H Fenwick, ‘Taking the rights of parents and children seriously: Confronting the welfare principle under the Human Rights Act’ (2005) 25 *Oxford Journal of Legal Studies*, 253.

ⁱⁱⁱⁱ Mental Health Act 1983, s. 83: ... consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering, not being a form of treatment to which sections 57, 58 or 58A applies, if the treatment is given by or under the direction of the responsible medical officer.

^{lv} Article 8(1): Everyone has the right to respect for his private and family life, his home and his correspondence.

^{lv} *R (Axon) v Secretary of State for Health* [2006] EWHC 37 (Admin); *Mabon v Mabon* [2005] EWCA Civ 634.

^{lvi} J Fortin, *Children’s Rights and the Developing Law*, (Cambridge: Cambridge University Press, 2003), p 113. See also E Cave, ‘Adolescent consent and confidentiality in the UK’ (2009) 16(4) *European Journal of Healthcare Law* 309.

^{lvii} [2006] EWHC 37 (Admin), [79].

^{lviii} Rights of Children and Young Persons (Wales) Measure 2011.

^{lix} I Lewis and C Lenehan (Co-Chairs), *Report of the Children and Young People’s Health Outcomes Forum* (July 2012).

for children'.^{lx} The UNCRC incorporates participatory rights (the right of a child 'who is capable of forming his or her own views ... to express those views freely ...' and assurance that the views will be '... given due weight in accordance with ... age and maturity' (Article 12) and rights to protection (including the right to 'primary consideration' of children's 'best interests' (Article 3) and a 'right to life' (Article 6)). Whilst there is potential conflict between Articles 3^{lxi} and 12(1),^{lxii} Eekelaar has demonstrated that they are not diametrically opposed.^{lxiii} Arguably the interests of minors are served by overriding their immediate decision where a failure to do so would prevent them from developing into functionally autonomous agents. Thus there are strong arguments for applying future-orientated versions of autonomy in cases where the decision would result in death or serious injury. Adults are not protected in this way, but perhaps they ought to be. Some feel that an objective measure of rationality should be applied, regardless of the age of the patient.^{lxiv}

On the other hand, the risk inherent in this position is that capacity is defined in relation to the outcome of the decision rather than the autonomous quality of the decision. The MCA takes a functional approach to capacity^{lxv} and recognition of minors as independent rights holders has led to pressure to move from a protective to an empowering position on welfare. This is discernable in the jurisprudence of both domestic courts^{lxvi} and the Europe Court of Human Rights.^{lxvii} Looking beyond the arena of refusals of treatment, the courts are increasingly willing to defer to minors who are capable of participating in or defining their own best interests. For example, in *R (Axon) v Secretary of State for Health*,^{lxviii} Silber J played down the significance of *Nielsen v Denmark*^{lxix} (which promoted parental powers to consent to treatment beneficial to their child) and demonstrated the dwindling rights of parents as their children mature. In *Mabon*, Thorpe LJ stated that the law must 'reflect the

^{lx} 9th Council of Europe Conference of Health Ministers, *Child-Friendly Healthcare: Building a Health Future for and with Children* (2011 Lisbon).

^{lxi} Article 3(1): In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

^{lxii} Article 12(1): States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

^{lxiii} J Eekelaar, 'The interests of the child and the child's wishes: The role of dynamic self-determinism (1994) 8 *International Journal of Law and the Family* 42.

^{lxiv} J Savulescu and RW Momeyer, 'Should informed consent be based on rational beliefs?' (1997) 23 *Journal of Medical Ethics* 282.

^{lxv} Mental Capacity Act 2005, s. 2(3).

^{lxvi} See, for example, *Re Roddy (A Child) (Identification: Restriction on Publication)* [2003] EWHC 2927 (Fam).

^{lxvii} J Fortin, 'Children's rights – substance or spin?' (2006) 36 *Family Law* 757; A Hall, 'Children's rights, parents' wishes and the state: The medical treatment of children' (2006) 6 *Family Law* 317; E Cave, 'Adolescent consent and confidentiality in the UK' (2009) 16(4) *European Journal of Healthcare Law* 309.

^{lxviii} Above n lv, [79]. See discussion in R Taylor, 'Reversing the retreat from Gillick? *R (Axon) v Secretary of State for Health*' (2007) 19 *Child and Family Law Quarterly* 81.

^{lxix} (1988) 11 EHRR 175.

extent to which, in the 21st century, there is a keener appreciation of the autonomy of the child'.^{lxx}

More generally, there is a rights-based paradigm shift in approach to the denial of legal capacity to those capable of its achievement.^{lxxi} This is true in relation to both minors and other vulnerable groups.^{lxxii} Charitable paternalism is gradually being supplemented by rights-facilitation - alongside the duty to measure capacity is an emerging duty to facilitate and develop capacity. This developing ethos is difficult to reconcile with *Gillick*. The distinction between competence and authority is becoming increasingly tenuous. We have seen that the *Gillick* test has led to minors being labelled incompetent when they are capable of making an autonomous decision and competent when they lack the functional capacity to decide.

It is possible to protect welfare without reliance on the court's inherent jurisdiction to veto competent decisions. A New South Wales Law Commission draft Bill^{lxxiii} defines competence^{lxxiv} and recommends that:

... [A] competent young person may accept or refuse health care and it is not necessary to obtain an acceptance or refusal of the health care from the young person's parent or other legal guardian.^{lxxv}

In Scotland, the age of majority is 16 and the right to consent to and (pending a test case) to refuse medical treatment^{lxxvi} arguably applies from that time.^{lxxvii} By adopting a specific and robust test for competence, minors are protected from making decisions which are not autonomous.

This does not deny the necessity to satisfy Article 3 of the UNCRC which makes the best interests of the minor a primary consideration. The application of the welfare principle does not of itself require that the court has the power to veto competent decisions. Provided the test for competence is clear and will correctly identify those who lack functional capacity in relation to the particular decision, it should be possible to protect welfare (at least on a rights-based account) by virtue of a facilitative rather than an authoritarian approach. If this is so then, as we shall see, intervention under the *parens patriae* aspect of the inherent jurisdiction could be limited to decisions on behalf of those who are shown to lack capacity.

^{lxx} [2005] EWCA Civ 634, [26].

^{lxxi} See, for example, Commissioner for Human Rights, *Who Gets to Decide? Rights to Legal Capacity for Persons with Intellectual and Psychosocial Disabilities* (Strasbourg, 2012) CommDH/IssuePaper (2012)2.

^{lxxii} See, for example, National Disability Rights Network, *Devaluing People with Disabilities: Medical Procedures that Violate Civil Rights* (May 2012).

^{lxxiii} New South Wales Law Reform Commission. 2008. *Young People and Consent to Healthcare*. Rpt. 119.

^{lxxiv} *Ibid.*, rec. 4.

^{lxxv} *Ibid.*

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

^{lxxvii} Age of Legal Capacity (Scotland) Act 1991, s. 2(4).

Competence in practice

Prior to exploring potential solutions, this section considers ways in which the legal ambiguities impact upon clinical practice. As part of the *Medical Practitioners, Adolescents and Informed Consent* project, we have held a series of multidisciplinary workshops focusing on the impact of the law on adolescent consent in practice. We have debated the current ambiguities in adolescent consent and alternatives for reform. The common law develops in response to cases which come before the court rather than by reference to clinicians' need for a comprehensive framework. Furthermore, the test has evolved with application by judges rather than doctors in mind. There are subtle differences in the way the test operates in the different arenas. For example, the court assesses competence in relation to a specific issue at a given time. Clinicians operate in a more volatile environment, where a minor's competence can change over time and in relation to different decisions. Underlying the differences in approach are the diverse functions of informed consent. The court traditionally focused on legal consent, which is designed to transfer responsibility.^{lxxviii} Clinical consent, on the other hand, aims to facilitate treatment by fostering co-operation, enabling decision-making, preventing harm and doing good.

As was highlighted in the previous section, it is apparent that, when the concept of *Gillick* competence is applied by clinicians, the ambiguities surrounding the assessment of competence, its timing and value can be accentuated. As we have seen, in addition to making things difficult for clinicians, the uncertainties have potential to pose significant barriers to the protection of children's rights.

Three additional effects of legal ambiguity on clinical practice are worthy of further explanation. Firstly, and most obviously the ambiguities highlighted in the previous section create uncertainty amongst doctors, minors and their families about the relevance of competence and when and how it should be assessed. The GMC,^{lxxix} Department of Health^{lxxx} and British Medical Association^{lxxxii} provide invaluable advice but are stymied by ambiguous and contradictory law. *Gillick* has been applied in New Zealand and Australia. There, the practical problems have been articulated more fully than is the case here. This is in part a result of the academic furore over the refusals cases in England and Wales. By comparison, *Gillick* has been referred to as the golden age of adolescent consent.^{lxxxii} In countries which do not have the unfavourable comparison of subsequent legal development against which to contrast the *Gillick* decision, there is a more candid appreciation of its inherent defects,

^{lxxviii} Though recently there are signs of change: *Chester v Afshar* [2004] UKHL 41, [24] where Lord Steyn recognised the role of informed consent in protecting the patient's right to autonomy and dignity.

^{lxxix} General Medical Council, *0-18: Guidance for all Doctors*, (London: GMC, 2007).

^{lxxx} Department of Health, above n xxi.

^{lxxxii} BMA, *Consent, Rights and Choices in Health Care for Children and Young People* (2007); *Children and Young Person Toolkit* (2011).

^{lxxxii} See, for example, I Kennedy, 'Consent to treatment: The capable person', in C Dyer (ed), *Doctors, Patients and the Law* (OUP, 1992), p 60.

particularly in relation to its application in clinical practice. In the words of a commentator from New Zealand:

The English House of Lords decision in *Gillick* has dominated the issue of minor capacity to consent for the last 25 years, but the decision has raised more issues and ambiguities than it hoped to solve.^{lxxxiii}

A New South Wales Law Reform Commission has drafted a Bill^{lxxxiv} building on *Gillick* on the basis that:

... the ambiguities in the common law are important enough to warrant closer attention and to be clarified in legislation. ... these ambiguities do not generally reflect simple technical uncertainties in the operation of the law, but relate to more substantive questions about the decision-making processes for young people's health care. Attempts at clarification should not be left to the necessarily ad hoc developments of the common law but should be based on considered policies...^{lxxxv}

In Australia, some states rely on *Gillick* but others have legislated to resolve the confusions. A recent survey found that in Queensland (which relies on *Gillick*), there was considerable variation in the responses from practitioners to a questionnaire asking how they would deal with a minor who sought to make a contentious medical decision.^{lxxxvi} In England and Wales too, there is evidence that practitioners find the law confusing and incoherent.^{lxxxvii} The uncertainty also affects minors and their parents.^{lxxxviii} This potentially acts as a barrier to the participation of minors in medical treatment decisions which Article 12 of the UNCRC require to be 'given due weight in accordance with the age and maturity of the child'.^{lxxxix}

The second practical implication of the ambiguity surrounding *Gillick* competence is that uncertainty regarding the definition and value of competence has implications in respect to other aspects of a minor's treatment. For example, it affects the minor's right to information (for example where a parent insists that information is withheld from a minor) and confidentiality^{xc} (for example where a minor requests that his decision to refuse treatment is kept from his parents).

^{lxxxiii} T Grimwood, 'Gillick and the consent of minors: contraceptive advice and treatment in New Zealand' (2010) 40 *Victoria University of Wellington Law Review* 743.

^{lxxxiv} New South Wales Law Reform Commission. 2008. *Young People and Consent to Healthcare*. Rpt. 119, para 5.4.

^{lxxxv} *Ibid*, para 5.4.

^{lxxxvi} A Teoludzka and TP Bartholemew 'Queensland general practitioners' applications of the "mature minor" principle: the role of patient age and gender' (2010) 18(2) *Journal of Medical Law* 390.

^{lxxxvii} See for example CS Ashteka, A Hande, E Stallard and D Tuthill, 'How much do junior staff know about common legal situations in paediatrics?' (2007) 33(5) *Child Care Health Development* 631.

^{lxxxviii} See, for example, E. Grice, 'Hannah Jones: "I Have Been in Hospital too Much"' *The Telegraph*, November 12 2008.

^{lxxxix} M Donnelly and U Kilkelly, 'Child-friendly healthcare: Delivering on the right to be heard' (2011) 19(1) *Medical Law Review* 27.

^{xc} E Cave, above n v; J Loughrey, 'Can you keep a secret?' (2008) 20(3) *Child and Family Law Quarterly* 312.

Thirdly, the very potential for court authorisation of treatment a competent minor refuses, significantly affects consent in practice. Where the minor is effectively told 'consent or we'll get the court's permission to treat you', the minor's agreement is a mere promise of co-operation, rather than a voluntary and informed consent.^{xcⁱ} This significantly limits the role relevant minors can play in the decision making process. As Alderson and Montgomery state, '[p]articipation can be worse than useless when used as a pretence of consultation, or to disguise the fact that no real choice is being given.'^{xcⁱⁱ} Clinicians are not necessarily doing anything wrong when they use the potential for court authorisation as leverage. The potential exists because the law has said that it should. A distinction can be drawn between a threat and a prediction.^{xcⁱⁱⁱ} 'Nudging' patients to do what is right for them (whether as a matter of policy, morality or law) is a soft form of paternalism which has recently received considerable support.^{xc^{iv}} The legal prominence of best interests, combined with the jurisdiction of the court to veto a minor's competent decision, legitimises medical predictions of court authorisation where the minor refuses to cooperate.

On the other hand, reductions in freedom and voluntariness affect the value of consent to the minor. As Baroness O'Neill recognises: 'Where free and informed consent is given, agents will have a measure of protection against coercion and deception.'^{xc^v} To discourage the use of predictions of court authorisations to persuade competent minors to accept treatment, the inherent jurisdiction would need to be limited so that competent refusals are honoured. The mode of leverage would have to be removed. In order to achieve this, a new method of protecting welfare would be needed. In the next section such a method will be proposed.

Solutions

A solution is needed which is relevant, applicable and which appropriately balances children's rights to participation and protection in both legal and clinical contexts. In this section, a number of potential solutions are rejected on the basis that they would fail to achieve these goals. An alternative solution is put forward.

The limitations of common law clarification

Ambiguities in the test for *Gillick* competence might be addressed through common law clarification. The Supreme Court of Canada ruled in 2009 that the application of

^{xcⁱ} Though minors' attitudes to compulsion is more dependent on their relationship with parents and clinicians than the degree of compulsion. See JOA Tan, A Stewart, R Fitzpatrick, and T Hope 'Attitudes of patients with anorexia nervosa to compulsory treatment and coercion' (2010) 33 *International Journal of Law and Psychiatry* 13.

^{xcⁱⁱ} P Alderson and J Montgomery, *Health Care Choices: Making Decisions with Children* (London: Institute for Public Policy Research, 1996).

^{xcⁱⁱⁱ} R Nozick, 'Coercion', in S Morgenbesser, P Suppes, and M White, (eds), *Philosophy, Science and Method: Essays in Honor of Ernst Nagel* (Sidney, 1969), p 440.

^{xc^{iv}} RT Thaler and CR Sunstein, *Nudge: Improving Decisions about Health, Wealth and Happiness* (Penguin, 2008).

^{xc^v} See O O'Neil, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002), p 97.

the best interests test to a 14 year old competent minor refusing a life sustaining blood transfusion for religious reasons did not breach her rights.^{xcvi} Abella J held that 'a thorough assessment of maturity, however difficult, is required in determining his or her best interests'^{xcvii} and that:

... in some cases, courts will inevitably be so convinced of a child's maturity that the principles of welfare and autonomy will collapse altogether and the child's wishes will become the controlling factor.^{xcviii}

The Canadian Supreme Court moved beyond the position taken in *Re R* and *Re W* that minors' views are of mere consultative value (in contrast to the views of competent adults which are authoritative).^{xcix} It moved closer to Archard and Skivenes' view that though the minors' views may not be authoritative, they are always relevant, because Article 12 of the UNCRC demands that *all* children are consulted about decisions made about them.^c

In England and Wales then, a subtle change in emphasis might place the best interests test more squarely within a rights-based agenda by enhancing the relevance of minors' views.^{ci} This would make it most unlikely that a competent decision would be vetoed. The court would seek evidence of a minor's view and assess maturity and understanding. However, there are two flaws in this approach. First, reducing reliance on the best interests test by labelling more minors incompetent is objectionable if some of those minors are in fact maximally autonomous. Second, this option would have minimal impact in clinical practice. In relation to the second issue, this is not to say that doctors are not interested in the views of minors, just that the relevance would remain focused on ensuring their cooperation and making treatment feasible, rather than the question of whether or not to accept their autonomous decisions. Arguably, as long as the best interests test applies (regardless of competence), clinicians will focus on clinical rather than emotional and psychological interests. Clinicians might argue, like Abella J, that some minors are so competent that their best interests are served by accepting their view, but in doing so, clinicians would face a risk which judges avoid – namely, that the patient or his next friend might later challenge the clinician's assessment of best interests. If minors are deemed vulnerable by virtue of minority (rather than competence) then they might claim that they should be protected from decisions which limit the length or quality of their lives. Take, by way of example, a minor whose refusal of a lung transplant at the age of 13 is respected and at 15 she finds that she is no longer eligible for transplant and will be dead within a year. Might the

^{xcvi} *AC v Manitoba (Director of Child and Family Services)* 2009 SCC 30.

^{xcvii} *Ibid*, [4].

^{xcviii} *Ibid*, [87].

^{xcix} In support see H Brighthouse, 'How should children be heard?' (2003) Fall *Arizona Law Review* 691.

^c D Archard and M Skivenes, 'Balancing a child's best interests and a child's views' (2009) 17(1) *The International Journal of Children's Rights* 1.

^{ci} An argument I explored in E Cave, 'Maximisation of a minors' capacity' (2011) 4 *Child and Family Law Quarterly* 42.

minor complain that doctors should have done more to persuade or even compel her to have surgery? Section 5 of the MCA protects doctors acting in good faith but this does not extend to doctors treating a *Gillick* competent minor. Consequently, whilst a rights-based perception of best interests might limit the incidences of minors' competent decisions being overridden in court, the paternalistic test is likely to continue to facilitate more subtle forms of compulsion in practice.

The court might reduce reliance on the best interests test further still if it can rely on a robust conception of competence. Some commentators^{cii} have suggested that this might be achieved through reliance on parts of the MCA. As we have seen, the MCA does not currently apply to minors under the age of 16.^{ciii} They are required to prove their competence and subjected to a different test. Brazier and Bridge argued that in the treatment refusals cases of *Re R* and *Re W*: 'The notion of *Gillick* competence in particular as applied to minors was fundamentally flawed.'^{civ} This resulted in 'judges apparently overruling 'competent' choices which analysis shows to be in no real sense autonomous'.^{cv} They suggested that the functional test for understanding – the second part of the test for capacity now laid down in the MCA – offers a superior test.

In an article in the *Family Law Journal*, Andrew McFarlane, appointed Lord Justice of Appeal in 2011, suggests that the MCA scheme for evaluating capacity is likely to be applied to 'otherwise *Gillick* competent'^{cvi} children who come before the High Court having refused medical treatment, so as to effect a refined definition of competence 'in place of the blunter instruments of 'age', 'intelligence' and 'understanding''.^{cvi} This would make for a more robust definition of competence and, because the threshold is set high, give judges scope to veto harmful decisions on the basis of incompetence, rather than vetoing a competent decision because it is in the minor's best interests. According to McFarlane, this interpretation would effect 'a move from paternalistic and protectionist approach to a rights based evaluation of each child as an individual against the context of the facts in a particular case'^{cviii} which is surely to be welcomed. However, whilst this approach might lead to greater judicial respect for minors' autonomous decisions, such a result is by no means inevitable, as is demonstrated by McFarlane's example:

By way of example, in the case of an adult who refuses to consent to a life saving blood transfusion the Court of Protection, on the current case law, is likely to override that refusal on the ground that the patient lacks capacity to refuse consent at that time.^{cix}

^{cii} A McFarlane, above n xxxvi; and see V Chico and L Hagger, above n cxxiii.

^{ciii} Mental Capacity Act 2005, s. 1(5).

^{civ} M Brazier and C Bridge, above n xxvi, p 85 and p 91.

^{cv} *Ibid*, p 109.

^{cvi} A McFarlane, above n xxxvi, p 484.

^{cvii} *Ibid*, p 485.

^{cviii} *Ibid*, p 484.

^{cix} *Ibid*, p 484.

For the COP to come to this conclusion, the adult in this scenario would need to be shown to be unable to make a decision for himself due to a lack of capacity. The Act makes clear that: 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision' (Section 1(4)). Consequently it is far from clear that the Court would routinely protect adults in this manner. The scope to override minors' decisions, however, would be much more extensive.

The rights-based evaluation, to which McFarlane refers (and which the MCA extends to adults), would be subject to considerable dilution when applied to minors. First, McFarlane does not envisage the presumption of capacity applying to minors.^{cx} The presumption operates in relation to adults to prevent decisions being overruled on the basis of lack of understanding alone, which might be demonstrated by virtue of the fact that the decision is contrary to the person's best interests. It is this feature which effectively renders the best interests test inapplicable unless incapacity is demonstrated.

Second, in relation to adults, the high level of understanding required by section 3(1) (incorporating not only understanding but also retaining, using, weighing or communicating the decision) is balanced by virtue of the fact that it will only come into question if section 2(1) is satisfied, namely that the patient has 'an impairment of, or a disturbance in the functioning of, the mind or brain'. If, unlike adults, minors bear the burden of proof of capacity, then the same high threshold which serves to protect adults from being labelled as lacking capacity, makes it all the harder for minors to *prove* capacity. If the result of applying the MCA test to minors is that they would find it impossible to demonstrate their capacity to refuse life sustaining treatment, then McFarlane's suggested change in approach would have minimal impact on the protections of their human rights. Furthermore, the high level of understanding required in the MCA could have negative implications for minors' rights to consent. Assuming that the MCA test would not be reserved for cases where the court adjudicates refusals^{cxⁱ} and should also be applied in clinical practice, the implication of fewer minors being considered competent to refuse treatment, is that fewer will be able to consent.^{cxⁱⁱ}

Thus, incorporating aspects of the MCA into *Gillick* competence would be problematic. The MCA is designed to empower and protect the autonomy rights of adults. Cherry-picking the scheme for evaluating capacity and rejecting those provisions designed to protect adults from an outcome-based capacity test is a limited victory for children's rights even if it does enable the court to rely on the combined doctrines of competence and capacity rather than best interests to justify their overruling minors' decisions.

^{cx} Ibid, p 484.

^{cxⁱ} Ibid, p 484.

^{cxⁱⁱ} See discussion in S Gilmore and J Herring, above n xvi, p 12.

One test for all

Hagger and Chico suggest that an opportunity was missed in not applying the MCA to minors:

If we adopt the position that children's rights are important, we should allow those children who are capable of demonstrating instrumental rationality ... to make their own decisions whether they want to forgo their future autonomy in favour of their present autonomy.^{cxiii}

They argue that mature minors should be able to prioritise their current desire autonomy in the same way as competent adults. This is a proposition which has been shown to be effective in Ontario, Canada, where a single test for and presumption of capacity applies to all. A competent minor can consent to and refuse medical treatment and neither parents nor the court have a power of veto. In Ontario, the Health Care Consent Act 1996 presumes capacity^{cxiv} defined in section 4(1):

A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Capacity is time specific,^{cxv} applied regardless of age and is accompanied by a duty to take steps to help the person achieve the necessary understanding.^{cxvi} However, unlike the MCA, the Health Care Consent Act definition of capacity is based entirely on a functional test, without additionally requiring proof of mental impairment. As a result, minors who are overwhelmed, immature or subject to undue influence are likely to be considered to lack the required mental capacity to make a decision. They would be protected by virtue of application of the best interest test. In England and Wales, the same minors would be unlikely to be caught within the terms of the MCA, in which case they would be deemed capable of consenting. Clearly this would be unworkable for very young children and would subject older ones to considerable danger. As a result, the MCA could not be extended to apply to minors without concurrent reform of the test for capacity. This would be problematic. Not only does it raise definitional quandaries, but universal application of the revised test would have the effect of limiting the protections afforded by the Act to those *over* the age of 16. The absence of a requirement of maturity, freedom from undue influence and life experience from the MCA is quite deliberate. It is intended to ensure that capacity is based on a functional rather than an outcome based test.

^{cxiii} V Chico and L Hagger, 'The Mental Capacity Act 2005 and mature minors: A missed opportunity?' (2011) 33(2) *Journal of Social Welfare and Family Law* 157, p 165. They recognise that restrictions on minors' autonomy rights would be necessary, p 166.

^{cxiv} Health Care Consent Act 1996, s 4(2).

^{cxv} Health Care Consent Act 1996, s 15(1).

^{cxvi} Mental Capacity Act 2005, ss 1(5) and 3(2).

At this point, it would seem that the MCA is an unsuitable mechanism to protect under 16 year olds. We have seen that partial application of the MCA is problematic because it would insufficiently protect minors' autonomy interests; full application would fail to protect their welfare interests; and altering the terms of the Act to extend the definition of incapacity to incorporate inexperience, immaturity and undue influence would limit the effectiveness of the Act in protecting adults.

Concurrent tests for capacity

One way forward would be to apply the MCA test for capacity to minors alongside another test for incapacity which is specifically designed to encapsulate those factors which render some young people functionally incapacitated. As we have seen, the law takes this approach to protect 16/17 year olds. The MCA applies in conjunction with the Family Law Reform Act 1969. Pre-MCA, the Law Commission^{cxvii} advised that this safeguard was necessary so that immature minors (who may have MCA capacity) would be protected by the best interests test where the presumption of competence is rebutted. One possibility would be to extend the dual application of competence and capacity which applies to 16/17 year olds, to younger minors. However, this would fail to tackle the inherent problems with *Gillick* competence which have been highlighted in this paper. An alternative would be abandon *Gillick* and develop a new test which can apply conjointly with the MCA. The first question this raises is whether this is possible, the second is whether it would be desirable. We will take each in turn.

Pre-MCA, the High Court operated an inherent jurisdiction to protect vulnerable people who lacked capacity to consent. There has since been uncertainty as to whether it survives the MCA.^{cxviii} Dual application of the statutory and common law tests is contentious. One of the protections the MCA offers is preventing people who satisfy the test for capacity from being labelled 'incapacitated' and thus being robbed of the opportunity to make a decision for themselves. Arguably the Act is intended to be exhaustive. On the other hand, conferring legal capacity on those whose decisions are not autonomous may inadequately protect their welfare. The law was recently clarified in *A Local Authority v DL*.^{cxix} In *DL* the Local Authority had evidence that DL was physically and verbally controlling his elderly parents. McFarlane LJ (whose insightful article was referred to earlier in the paper) confirmed that the High Court's inherent jurisdiction survives the MCA. The Court of Appeal recognised that the parents had MCA capacity, but due to DL's undue influence, it was held that they lacked capacity at common law. There is no express provision in the MCA limiting the inherent jurisdiction and it was felt that the MCA alone was insufficient to protect vulnerable adults.

^{cxvii} Law Comm Report No 231 *Mental Incapacity* (London, 1995), para 2.52.

^{cxviii} See, for example, *SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam); *LA X v MM and KM* [2007] EWHC 2003 (Fam); *A LA v A* [2010] EWHC 978 (Fam); *A LA v Mrs A* [2010] EWHC 1549 (Fam).

^{cxix} *DL v A Local Authority* [2012] EWCA Civ 253. And see *SA (A Vulnerable Adult)* [2005] EWHC 2942; *A Local Authority and Mrs A* [2010] EWHC 1549; and *L v J* [2010] EWHC 2665.

The jurisdiction has potential to apply beyond cases of undue influence. In *SA (Vulnerable adult with capacity: Marriage)*^{cxx} (which was heard prior to the MCA coming into force), Munby J recognised that the inherent jurisdiction acts as a wide safety net;

The inherent jurisdiction is not confined to those who are vulnerable adults, however that expression is understood, nor is a vulnerable adult amenable as such to the jurisdiction. The significance in this context of the concept of a vulnerable adult is pragmatic and evidential ...^{cxxi}

In *DL*, McFarlane LJ supported this wide definition.^{cxxii} In *SA*, Munby J recognised that ‘the jurisdiction in relation to incompetent adults ... is for all practical purposes indistinguishable from its well-established *parens patriae* or wardship jurisdictions in relation to children...’^{cxxiii} If the MCA were to apply to all regardless of age, the common law might limit and adapt its inherent jurisdiction in relation to minors in an extension of the approach taken in *DL*. Minors would be presumed to have capacity under the MCA, and at common law. The MCA would protect minors whose incapacity results from ‘an impairment of, or a disturbance in the functioning of, the mind or brain’. The common law could develop principles which prevent minors having the power to make decisions which are in no way autonomous.

Developing the ambits of a more limited inherent jurisdiction by which the capacity of minors could be assessed at common law, would have two distinct advantages over continued use of the *Gillick* competence test. First, it has potential to operate as part of a single test for all which would improve consistency and reduce confusion amongst patients and doctors. Second, by mirroring the facilitative approach adopted in the MCA, it might operate in a manner which is more conducive to protecting children’s rights. In *DL*, McFarlane LJ was careful to limit the ambits of the jurisdiction and to tie the development of the common law to the MCA principles. As Theis J recognised in the High Court, the jurisdiction will apply in relation to ‘persons who are deemed not to have capacity in the true sense, and not [to] persons where paternalistic authority considers the act unwise’.^{cxxiv} Thus, the duty complements the law on consent which recognises that consent must be ‘real’. It is not intended to overrule those who make autonomous decisions, but to recognise the reality that the MCA definition of capacity does not necessarily encapsulate all autonomous decisions or label as incapacitous all decisions which are not autonomous.^{cxxv} The inherent jurisdiction relies on close correlation with the MCA to achieve compatibility with Article 8. In determining the extent of the application of the inherent jurisdiction the court would consider whether the ruling is necessary and proportionate.

^{cxx} [2005] EWHC 2942 (Fam),

^{cxxi} *Ibid*, [83].

^{cxxii} [2012] EWCA Civ 253, [53], [64].

^{cxxiii} [2005] EWHC 2942 (Fam), [37]

^{cxxiv} *DL v A Local Authority* [2011] EWHC 1122 (Fam), per Theis J [6].

^{cxxv} J Coggon, ‘Varied and principled understandings of autonomy in English law: justifiable inconsistency or blinkered moralism?’ (2007) 15(3) *Healthcare Analysis* 235.

Interference with autonomy would only occur where it is justifiable to protect health or to promote autonomous decision making free of undue influence.^{cxxvi}

Conclusion

A number of problems with *Gillick* competence have been articulated. Some of these have existed for a long time but their effects in clinical practice have been under researched. The problems are rendered acute by virtue of a paradigm shift in relation to autonomy and its relationship with legal capacity.^{cxxvii} Those assessing capacity are increasingly recognised to have a parallel duty to facilitate, empower and develop capacity.^{cxxviii} Aspects of the decisions of *Re R* and *Re W* contradict this approach. This article has explored ways in which their worst effects might be bypassed if a case comes before the court, but in clinical practice their legacy serves as a barrier to the recognition and protection of children's autonomy rights. It has been argued that a robust test for capacity might potentially be utilised as a mechanism to protect the best interests of minors without recourse to the court's powers to veto competent decisions and that the *Gillick* competence test fails in this regard.

The MCA provides a definition of capacity which is significantly more developed and comprehensive than *Gillick* competence. The test is not perfect. It links informed consent to individual autonomy, and a growing body of literature questions critiques this approach.^{cxxix} On the other hand, the MCA promotes the enhancement of decisional autonomy, respect for decisions which are functionally autonomous and respect for the views of those whose lack of capacity renders the best interests test relevant to decisions about their care. It does not preclude a relational model of clinical consent, and incorporation of minors within its remit would not prevent them involving or deferring to their family and carers. The biggest challenge, however, is that the MCA is ill-suited to serving the minor's, the state's and parents' interests in protecting minors from harm. This article has explored suggestions by some commentators that parts of the MCA could be used to supplement *Gillick* competence. This approach would enable the court to overrule minors on the basis of their incapacity rather than overruling their competent decisions and it would give clinicians a more robust framework for defining capacity. It is a realistic and welcome way forward if a test case comes before the court. On the other hand it has limitations. It does little to improve the link between autonomy and the authority to make decisions. The test for capacity for minors would be likely to be heavily dependent on the outcome of the decision - something which the Act seeks to prevent in relation to adults. In clinical consent, it would not prevent the use of

^{cxxvi} [2012] EWCA Civ 253, [66].

^{cxxvii} See Commissioner for Human Rights, above n lxxi.

^{cxxviii} M Donnelly, *Healthcare Decision-Making and the Law: Autonomy, Capacity and the Limits of Liberalism* (CUP, 2010), ch 2.

^{cxxix} S Maclean, *Autonomy, Consent and the Law* (Routledge-Cavendish, 2009); D Beylveled and R Brownsword, *Consent in the Law* (Oxford: Hart Publishing, 2007); A Maclean, *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (CUP, 2009).

leverage which has potential to water down attempts to improve the participatory rights of children in the healthcare arena.

It has been suggested in this article that legislation might incorporate minors within the MCA in conjunction with a new common law test for child incapacity. Any minor with 'an impairment of, or a disturbance in the functioning of, the mind or brain' which leads to an inability to understand would be subject to the best interests test. Minors whose consent is rendered involuntary due to undue influence could, post *DL*, be subject to the High Court's inherent jurisdiction. By extension, the High Court could, in light of modern empirical evidence of children's abilities^{cxxx} and the MCA principles (such as the duty to maximise capacity), set down a revised test for child incapacity. Like the *Gillick* test this would leave gaps. However the gaps would be less extensive due to the presumption of capacity and the relevance of the MCA. Professional bodies, such as the General Medical Council, would be able to develop guidance which embraces the MCA principles and reflects recent jurisprudence on children's rights. By embracing one concept of capacity for all, the law would operate in a manner which is more coherent, consistent and comprehensible both to those applying and those subject to it. Andrew McFarlane wrote of the importance of effecting 'a move from paternalistic and protectionist approach to a rights based evaluation of each child as an individual against the context of the facts in a particular case'.^{cxxxi} Whilst acceptance of the arguments put forward in his Lordship's 2011 article would go some way towards achieving this goal, it is respectfully submitted that his Court of Appeal decision a year later represents an opportunity to truly embrace this philosophy and effect meaningful progress in the protection of children's healthcare rights.

^{cxxx} Eg P Alderson, 'Competent children? Minors' consent to health care treatment and research' (2007) 65 *Social Science and Medicine* 2272.

^{cxxxi} A McFarlane, above n xxxvi, p 484.